APPENDIX E

Health and Human Services Enterprise Workforce Plan

For Fiscal Years 2005–2009

HEALTH AND HUMAN SERVICES ENTERPRISE WORKFORCE PLAN

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OVERVIEW

CURRENT HHS ENTERPRISE AND AGENCIES

IMPACT OF HOUSE BILL 2292 ON THE HHS ENTERPRISE

The enactment of House Bill (HB) 2292 by the 78th Legislature (Regular Session, 2003) began a dramatic transformation of the health and human services system in Texas. This legislation required the consolidation of administrative and service delivery structures, policy changes to address higher demands for services with limited funds, and the use of outsourcing to achieve greater efficiency and effectiveness of the Enterprise as a whole. In addition, HB 2292 provided the authority to ensure effective implementation of these changes by expanding the leadership role of the Health and Human Services Commission (HHSC) and the Executive Commissioner for Health and Human Services. This legislation renamed one HHS agency, abolished 10 of 12 existing HHS agencies, and transferred their powers and duties to the HHSC and three entirely new agencies. The consolidated HHS Enterprise will be comprised of the following:

- Health and Human Services Commission (HHSC);
- Department of Aging and Disability Services (DADS);
- Department of Assistive and Rehabilitative Services (DARS);
- Department of Family and Protective Services (DFPS); and
- Department of State Health Services (DSHS).

The DFPS formally came in existence on February 2, 2004, with DARS following on March 1, 2004, though both agencies are still identifying and developing their management structures. The two largest agencies, DADS and DSHS, will not be fully operational until September 2004.

HB 2292 also abolished the governing boards of the existing HHS agencies. To replace these governing boards, this legislation established a network of advisory councils to advise the Executive Commissioner for Health and Human Services and ensure input from all stakeholders, both in the transition and on-going operations of the Enterprise. The *HB 2292 Transition Plan,* completed in November 2003, outlines the numerous projects and activities required to implement these major changes. The HHS Strategic Plan builds on the transition plan and the activities of the HHSC and Department Program Management Offices. The workforce plan described in this document is a component for the HHS Strategic Plan.

Currently, millions of Texans receive health and human services within a complex framework of policy-making, management and administration, and delivery systems. HB 2292 sought to contain rising costs while ensuring that the neediest Texans continue to receive essential services. Prior to FY 2005, 12 separate agencies administered over 200 programs, employed about 50,000 individuals, and operated from over 1,000 different locations across the state. Collectively, the HHS agencies provided programs and services throughout all 254 counties in Texas.

HB 2292 realigned the HHS Enterprise to broadly encompass an integrated service delivery model. Each of the new HHS agencies will provide services in a more cohesive environment than the previously fragmented system allowed.

VISION

Albert Hawkins, Executive Commissioner for Health and Human Services, articulated the following vision for the HHS Enterprise:

> We envision a health and human services enterprise that works better and costs less. Toward this goal, we will seek input and build partnerships with local communities, advocacy groups, and the private and not-for-profit sectors to put in place solutions that emphasize program efficacy and personal responsibility. We also envision a highly coordinated HHS system driven by motivated and talented workers focused not only on sound processes and procedure, but particularly on results.

MISSION

The mission of HHS agencies in Texas is to develop and administer an accessible, effective, and efficient health and human services delivery system that is beneficial and responsive to the people of Texas.

PHILOSOPHY

Every Texan should be able to access and utilize available health and human services provided by State agencies in the most integrated, cost-effective setting possible. The Texas Health and Human Services system is dedicated to developing client-focused program and policy initiatives that are relevant, timely and within the means of the taxpayers of the State of Texas. The HHS system will advocate for client-choice, appropriate funding, and streamlined service delivery. Additionally, we hold to these guiding principles:

> Every person, regardless of income, race, ethnicity, physical or mental limitation, gender, religion, or age, is entitled to dignity, independence, and respect.

> Texans deserve openness, fairness, and the highest ethical standards from us, their public servants.
>
> Taxpayers, and their elected representatives, deserve conscientious stewardship of public resources and the highest level of accountability.
>
> As agency representatives, we work in partnership with lawmakers, agency personnel, customers, service providers, and the public to continually improve the quality of our service.

In addition, the *H.B. 2292 Transition Plan* discusses the following tenets as guidance for the new system:

Focus on Client Needs and Program Delivery

A new, integrated, and well-coordinated HHS system will enter into partnerships with consumers, local communities, and the private and non-profit sectors to significantly improve the quality and level of services available to those in need. This transformed system will serve consumers better, be more responsive to local needs, and emphasize individual choice and personal responsibility.

Effective Stewardship of Public Resources

Taxpayers and legislators expect effective stewardship and management of the state's resources, particularly given the challenging economic times of recent years. More than ever before, state government must operate in a competitive environment, similar to private business. Key opportunities for success include: consolidating administrative support functions, consolidating program support services, increasing partnerships with local organizations and the private sector, and using state-of-the-art technology.

Cultural Change and Accountability

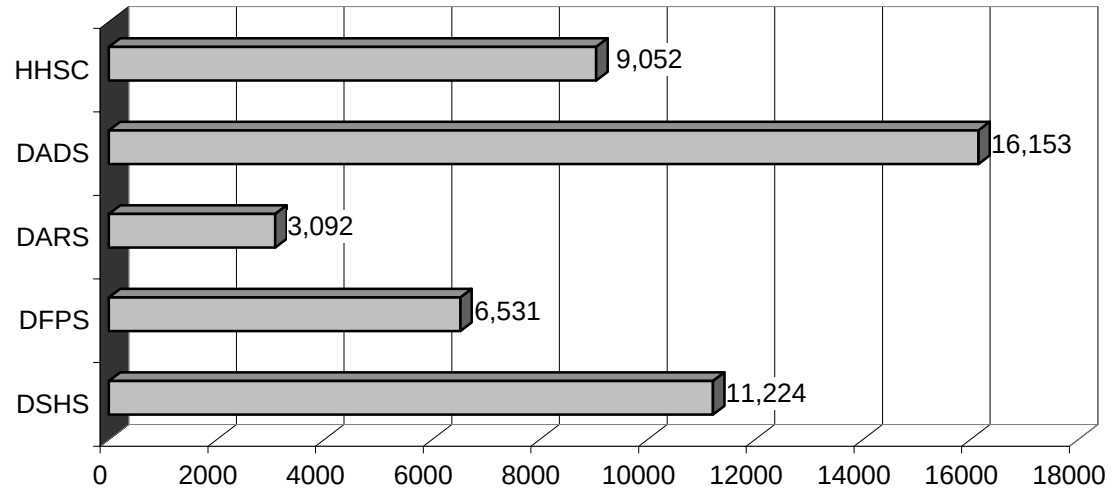
Implementing the major changes called for in H.B. 2292 requires a significant change in the organizational culture of the HHS agencies. The HHS leadership has established a "single-entity, outcome-focused" philosophy across the entire HHS system, viewing all five major components as a unified, high-functioning organization, with common goals and shared resources.

Health and Human Services leadership understands its direct accountability to the taxpayers, elected representatives, federal partners, and, most importantly, customers and clients of the system. This new level of responsibility will be extended continuously, with clear and specific responsibilities and performance expectations throughout the enterprise.

WORFORCE DEMOGRAPHICS

As of March 5, 2004 the HHS Enterprise workforce consisted of 46,052 individuals, including both full-time and part-time employees. Current data was used to project the workforce composition of the HHS agencies as of 9/1/04. As shown in Figure 1, approximately 20 percent, or 9,052 employees, will be assigned to the Health and Human Services Commission (HHSC); 35 percent, or 16,153 employees, will be assigned to the Department of Aging and Disability Services (DADS); seven percent, or 3,092 employees, are assigned to the Department of Assistive and Rehabilitative Services (DARS); 14 percent, or 6,531 employees, are assigned to the Department of Family and Protective Services (DFPS); and 24 percent, or 11,224 employees, will be assigned to the Department of State Health Services (DSHS). [1]

Figure 1: HHS Enterprise Workforce



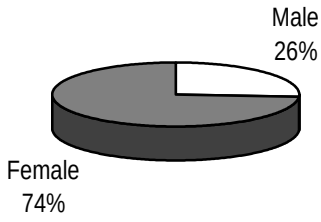
Note: Because it has not yet been determined how they will be distributed among HHSC, DADS, and DSHS, all current Mental Health and Mental Retardation (MHMR) central office and Texas Department of Human Services (DHS) administrative staff are included in the employee count for DADS.

[1] PeopleSoft HSAS Database as of 3/10/04.

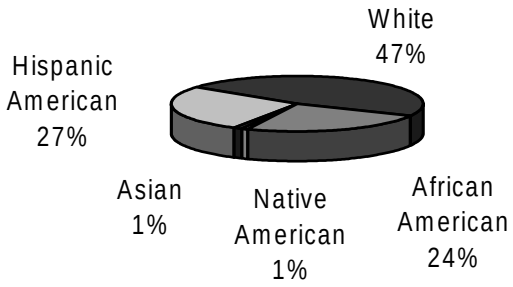
The demographic composition of the HHS Enterprise workforce is shown below. [2]

Figure 2: HHS Enterprise Workforce Demographics

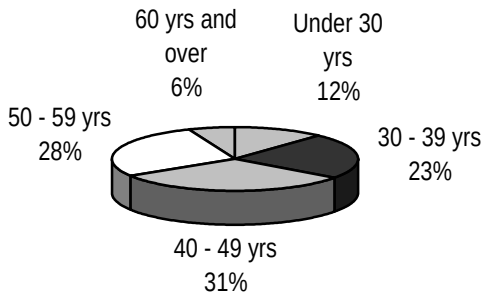
Gender



Ethnicity

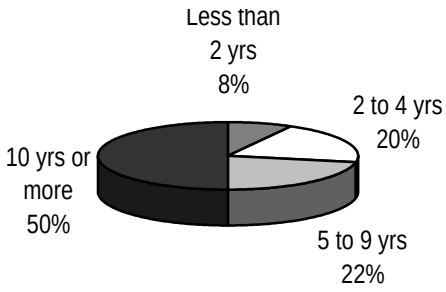


Age



Average age: 44 yrs old

Tenure



Note: State tenure was used instead of agency tenure due to limitations of the reporting system.

The Enterprise's workforce is mostly Female, 74 percent of the employee population. Although minority groups make up more than half of the Enterprise's workforce, Anglo employees are the largest racial or ethnic group at 47 percent, followed by Hispanic American employees at 27 percent, and African American employees at 24 percent. Sixty-five percent of the Enterprise's employees are 40 years old or older, with an average employee age of 44 years. Twenty-eight percent, almost one-third, of the Enterprise's employees have 4 or less years of state tenure.

[2] Ibid.

UNDERUTILIZATION OF COVERED CLASSES

Texas law requires the analysis of the racial and gender composition of each state agency's workforce as compared to the statewide civilian labor force, including the identification of covered classes that are underutilized in the workforce for each EEO job category. The covered classes are Females, African Americans, and Hispanic Americans.

As directed by the Texas Commission on Human Rights, the EEOC's Rule of 80 is used to determine underutilization. Underutilization is considered statistically significant if the percent utilized in the state agency's workforce is below 80 percent of that in the civilian workforce.

The workforce composition of the HHS Enterprise and the individual HHS agencies, as compared to that of the civilian labor force as reported by the Texas Commission on Human Rights, is discussed below. [3]

Note: Table 1 and Figure 3 are based on current data reflecting the projected workforce composition of the HHS Enterprise as of 9/1/04. Only underutilized EEO categories are reflected in the Underutilization of Covered Classes tables, therefore, the percentages will not total 100%.

As indicated in Table 1, HHS Enterprise is showing underutilization in the following areas: [4]

- African American, Hispanic American and Female Protective Services;
- African American and Female Skilled Craft; and
- Hispanic American Service Maintenance.

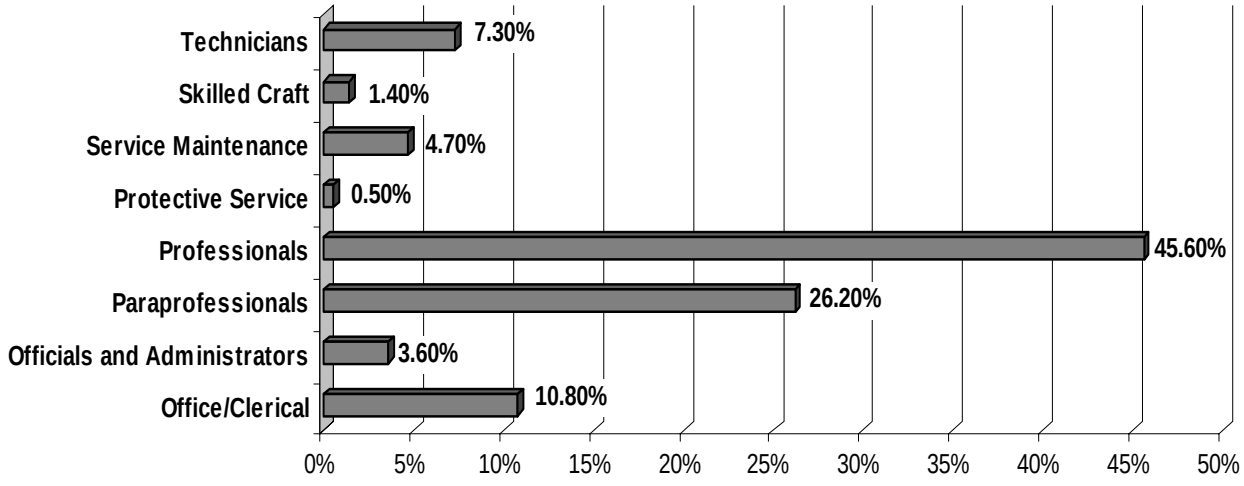
Table 1: Underutilization of Covered Classes

EEO4 Job Category	African American			Hispanic American			Female		
	Civilian	HHSE	Under	Civilian	HHSE	Under	Civilian	HHSE	Under
Officials and Administrators	7.27%	11.10%	No	11.61%	12.60%	No	31.63%	57.00%	No
Professionals	9.31%	18.60%	No	10.85%	25.90%	No	46.93%	76.00%	No
Technical	13.67%	20.60%	No	18.89%	23.40%	No	38.36%	70.00%	No
Protective Services	17.82%	9.00%	5.26%	22.02%	17.00%	0.62%	21.02%	18.00%	1.18%
Paraprofessionals	17.94%	36.40%	No	31.41%	26.10%	No	55.81%	73.00%	No
Administrative Support	19.59%	18.60%	No	25.62%	36.20%	No	79.87%	89.00%	No
Skilled Craft	10.36%	6.70%	1.59%	29.51%	25.20%	No	10.20%	5.00%	3.16%
Service Maintenance	18.36%	32.90%	No	44.15%	33.90%	1.42%	24.86%	67.00%	No

[3] Equal Employment Opportunity Commissions' National Employment Summary EE04 2000 and EE01-2001.
[4] PeopleSoft HSAS Database as of 3/10/04.

The HHS agencies prepare diversity recruitment plans each year to address any employee groups that are underutilized in an EEO job category as reflected in Figure 3. Because the HHS Enterprise values diversity in its workforce, these plans include both genders and all major racial and ethnic groups.

Figure 3: HHS Enterprise - Percent of Employees by EEOC Category



Health and Human Services Commission

MISSION

The mission of the Health and Human Services Commission is to provide the leadership and direction and foster the spirit of innovation needed to achieve an efficient and effective health and human services system for Texans.

SCOPE

Originally created in 1991 to provide strategic leadership to 12 HHS agencies, the Health and Human Services Commission (HHSC) now oversees the consolidation and operations of the entire health and human services system in Texas, and itself operates acute Medicaid, CHIP, and the former Texas Department of Human Services Temporary Assistance for Needy Family (TANF), Food Stamps, Family Violence Services, Disaster Assistance, and Refugee Assistance services. Thus, HHSC has responsibilities as a leadership, operational, and oversight agency. The agency is accountable to Texans for ensuring that the four, newly-consolidated HHS departments provide quality services in the most efficient and effective manner possible.

In addition, operational responsibility for the following programs have been moved to the HHSC:

- Temporary Assistance for Needy Families (TANF);
- Family Violence Services;
- Refugee Services;
- Nutrition Programs; and
- Early Childhood Coordination.

Note: The CHIP and Medicaid programs were consolidated under the HHSC during the 2002–2003 biennium.

Also, the functions of the Office of the Inspector General, as well as Ombudsman, have been consolidated at the HHSC.

The HHSC is currently examining ways to integrate eligibility determination for many of the HHS programs currently administered by several HHS agencies. Specifically, call centers are being considered as a mechanism to improve the efficiency of eligibility services and improve customer service. Also being considered are methods for formally evaluating and monitoring call center proposals and operations.

STRUCTURE

An Executive Commissioner appointed by the Governor and confirmed by the Senate leads HHSC. Albert Hawkins has served as the Executive Commissioner since December 2002.

The Health and Human Services Commission is divided into the divisions listed below. The System Oversight divisions work together to provide support and direction to the HHS departments in implementing legislation, streamlining services, and facilitating cross-agency innovation. The Commission Operations divisions are responsible for HHSC programs and administrative functions.

System Oversight

- Office of the Chief of Staff
- Office of Chief Legal Counsel
- Office of the Inspector General
- Social Services
- Financial Services
- System Support Services
- Health Services

Commission Operations

- General Counsel
- Internal Audit
- Office of the Chief Operating Officer
- Office of the Chief Financial Officer
- Office of External Relations
- Office of Family Support Services
- Eligibility Services
- Medicaid/CHIP

The Texas Council for Developmental Disabilities (TCDD) is a 30-member board dedicated to ensuring that all Texans with developmental disabilities—about 344,300 individuals—have the opportunity to be independent, productive, and valued members of their communities. With the recent organizational changes, responsibility for the TCDD has been transferred from the legacy agency Texas Rehabilitation Commission to HHSC.

GOALS AND SERVICES

HHSC Goal 1: Health and Human Services System

HHSC will improve the effectiveness and efficiency of the delivery of health and human services in Texas through the oversight and coordination of a prompt, accurate, and comprehensive service delivery system.

- Office of Inspector General
- Strategic Planning and Evaluation
- Consolidated Information Technology Support
- Consolidated Human Resources and Civil Rights Support
- Consolidated Procurement Support
- Ombudsman/Consumer Affairs
- Integrated Eligibility Determination
- Texas Council on Developmental Disabilities
- Texas Information and Referral Network

HHSC Goal 2: Medicaid

HHSC will administer the state Medicaid system efficiently and effectively, using a comprehensive approach to integrate Medicaid client health services with other direct service delivery programs.

- Aged and Disabled
- TANF Adults and Children
- Pregnant Women
- Children and Medically Needy
- Medicare Payments
- Integrated Managed Care (STAR+PLUS)
- Medicaid Vendor Drug Program
- Medical Transportation
- Health Steps – Medical and Dental
- Family Planning

HHSC Goal 3: CHIP Services

HHSC will ensure health insurance coverage for eligible children in Texas.

- Immigrant Health Insurance
- School Employee CHIP
- CHIP Vendor Drug Program
- State Employee Children's Insurance (SKIP)

HHSC Goal 4: Encourage Self-sufficiency

HHSC will encourage and promote self-sufficiency, safety, and long-term independence for families.

- TANF
- Food Stamps
- Family Violence Services
- Refugee Assistance
- Disaster Assistance
- Adult Protective Services Guardianship Program

WORFORCE DEMOGRAPHICS

The workforce composition for HHSC reflects all current programs and associated staff, and the following DHS programs, projected to be added as of 9/1/04:

- Texas Works;
- Medical Eligibility; and
- Family Violence.

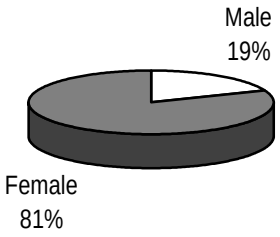
The largest classes of program area jobs include:

- Texas Works Advisor (3,715 employees);
- Medical Eligibility Specialist (541 employees); and
- Hospital Based Worker (379 employees).

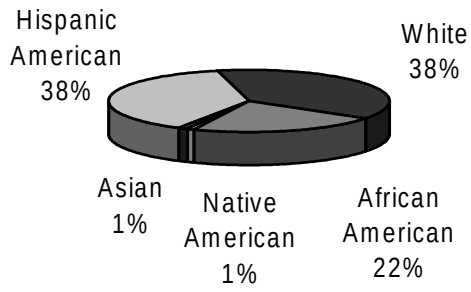
The demographic composition of the HHSC workforce is shown in Figure 4.[5]

Figure 4: HHSC Workforce Demographics

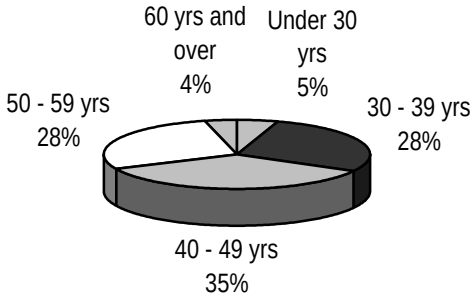
Gender



Ethnicity

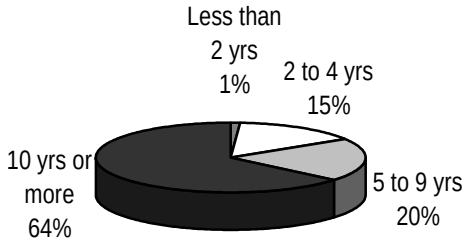


Age



Average age: 44 yrs

Tenure



Note: State tenure used instead of agency tenure due to limitations of the reporting system.

The Commission's workforce of 9,052 employees will be mostly Female, 81 percent of the employee population. Minority groups will make up over half of the agency's workforce, with the largest ethnic groups of employees (Anglo and Hispanic American employees) being equally represented at 38 percent, followed by African American employees at 22 percent. Sixty-seven percent of the agency's employees will be 40 years old or older, with an average employee age of 44 years. Only one percent of HHSC's employees will have less than two years of state tenure.

Note: Though this one percent with less than two years of state tenure may seem to indicate a major demographic shift when compared to the 74 percent reported by the HHSC in the FY 2003-2007 Workforce Plan, the two percentages are not comparable, since the current data are based on state tenure, while the previously reported data were based on tenure with the HHSC (data not available for the present analysis).

[5] PeopleSoft HSAS Database as of 3/10/04.

UNDERUTILIZATION OF COVERED CLASSES

As indicated in Table 2, HHSC is showing underutilization in the following area: [6]

- African American, Hispanic American, and Female Service Maintenance.

Table 2: Underutilization Of Covered Classes

EEO4 Job Category	African American			Hispanic			Female		
	Civilian	HHSC	Under	Civilian	HHSC	Under	Civilian	HHSC	Under
Officials and Administrators	7.27%	18%	No	11.61%	15.60%	No	31.63%	59%	No
Professionals	9.31%	21%	No	10.85%	34.50%	No	46.93%	79%	No
Technical	13.67%	16%	No	18.89%	22.20%	No	39.36%	80%	No
Protective Services	17.82%	0%	N/A	22.02%	0.00%	N/A	21.02%	0%	N/A
Paraprofessionals	17.94%	16%	No	31.41%	34.90%	No	55.81%	88%	No
Administrative Support	19.59%	21%	No	25.62%	47.90%	No	79.87%	93%	No
Skilled Craft	10.36%	0%	N/A	29.51%	0.00%	N/A	10.20%	0%	N/A
Service Maintenance	18.36%	0%	14.69%	44.15%	0.00%	35.32%	24.86%	0%	19.89%

Note: Table 2 is based on current data reflecting the projected workforce composition of the HHSC as of 9/1/04. Only underutilized EEO categories are reflected in the Underutilization of Covered Classes tables, therefore, the percentages will not total 100%.

[6] PeopleSoft HSAS Database as of 3/10/04.

Department of Aging and Disability Services

MISSION

To provide a comprehensive array of aging, disability, and mental retardation services, supports, and opportunities that is easily accessed in local communities.

SCOPE

The Department of Aging and Disability Services (DADS) administers human services programs for the aging and people with disabilities and mental retardation. The Department licenses and regulates providers of these services. The Department will begin its formal operations September 1, 2004.

Note: The HHSC has assumed responsibility of eligibility determination for long-term care and community-based support services.

STRUCTURE

The Executive Commissioner, with approval of the Governor, appointed James Hine as the DADS Commissioner. The agency is divided into the following programmatic and support divisions that report to the Commissioner:

- Internal Audit;
- Office of the Deputy Commissioner;
- Aging and Disability Access and Intake;
- Provider Services;
- Regulatory Services;
- Office of the Chief Financial Officer; and
- Office of the Chief Operating Officer.

GOALS AND SERVICES

DADS Goal 1: Long-Term Care Services

DADS will enable older Texans to live dignified, independent, and productive lives in a safe living environment through an accessible, locally-based, comprehensive and coordinated continuum of services and opportunities, to provide appropriate care based on individual needs ranging from in-home and community-based services for elderly people and people with disabilities who request assistance in maintaining their independence and increasing their quality of life, to institutional care for those

who require that level of support, seeking to ensure health and safety and to maintain maximum independence for the client while providing the support required.

Services for aging Texans are delivered through the 28 Area Agencies on Aging and include:

- Access and assistance services
- Nutrition services
- Support services
- National Family Caregiver Support.

Long-term care services for individuals who are aging or have disabilities are offered in community-based and facility-based settings. Long-term care services include:

- Meal delivery
- In-home services and supports
- Residential and foster care services
- Day activity and health services
- Hospice services
- Personal care services
- Medicaid waiver programs
- Nursing facilities
- Rehabilitative services
- Specialized services
- Emergency dental services
- Medicaid swing bed program

Mental retardation services are available in community-based and facility-based settings to individuals with mental retardation. All services are accessed through any of the 41 local mental retardation authorities. Mental retardation services include:

- Service coordination
- Community supports
- In-home services
- Day training services
- Residential services
- Community-based ICF/MR programs
- Medicaid waiver programs
- State Mental Retardation Facilities

DADS Goal 2: Regulatory and Licensing Services

DADS will provide licensing, certification, and contract enrollment services, as well as financial monitoring and complaint investigation, to ensure that residential facilities, home and community support services agencies, and individuals providing services in facilities or home settings comply with state and federal standards and

that clients receive high-quality services and are protected from abuse, neglect, and exploitation.

Survey, certification and/or licensing services are provided for all long-term care facilities that meet the definitions of nursing homes, assisted living facilities, adult day care facilities, intermediate care facilities for persons with mental retardation, and home and community support service agencies. Certification services are extended to all facilities participating in Medicaid or Medicare programs, such as home health services, home dialysis, hospice, and personal assistance services.

Credentialing services are also provided to license, certify, permit, and monitor individuals for the purpose of employability in facilities and agencies regulated by the Department. These include:

- Nursing facility administrators
- Medication aides
- Nurse aides
- Employee misconduct registry

Quality outreach services provide a non-regulatory framework for fostering improvements in the quality of resident services and are comprised of three components:

- Quality monitoring
- Joint training of service personnel and providers
- Long-term care facility/surveyor liaison

WORKFORCE DEMOGRAPHICS

The workforce composition for DADS reflects the following agencies, programs and associated staff projected to be included as of 9/1/04:

- MHMR - Mental Retardation;
- DHS - Long Term Care Regulatory;
- DHS - Community Care for the Aged and Disabled;
- TDOA;
- DHS - MHMR Administrative staff; and
- DHS - Administrative staff.

The largest classes of program area jobs include:

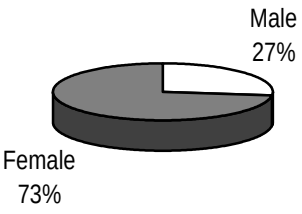
- MHMR Services Aide/Assistant (6,121 employees);
- Community Care Worker (743 employees); and
- Registered Nurse (656 employees).

Note: All current DHS and MHMR central office administrative staff are included in the employee count for DADS.

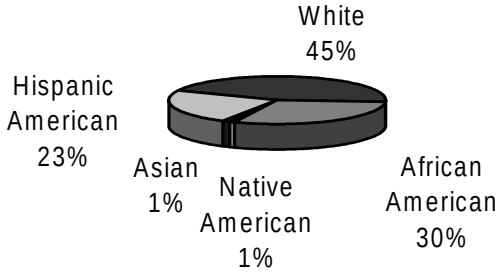
The demographic composition of the DADS workforce is shown in Figure 5.[7]

Figure 5: DADS Workforce Demographics

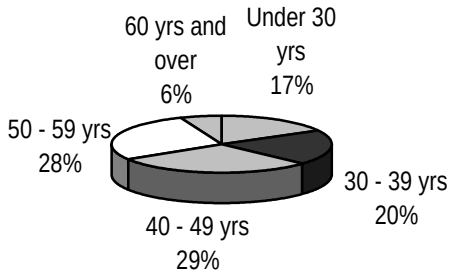
Gender



Ethnicity

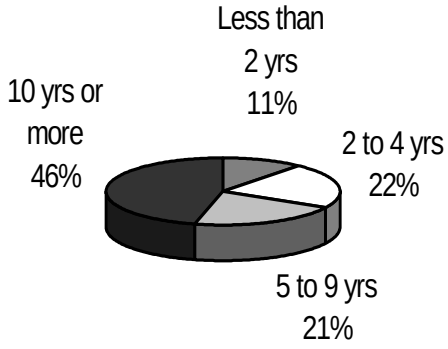


Age



Average age: 43 yrs

Tenure



Note: State tenure used instead of agency tenure due to limitations of the reporting system.

The DADS' workforce of 16,153 employees will be mostly Female, 73 percent of the employee population. Although minority groups will make up more than half of the agency's workforce, Anglo employees will be the largest racial or ethnic group at 45 percent, followed by African American employees at 30 percent and Hispanic American employees at 23 percent. Sixty-three percent of the agency's employees

[7] PeopleSoft HSAS Database as of 3/10/04.

will be 40 years old or older, with an average employee age of 43 years. Only eleven percent of DADS' employees have less than two years of state tenure.

UNDERUTILIZATION OF COVERED CLASSES

As indicated in Table 3, DADS is showing underutilization in the following areas: [8]

- African American, Hispanic American, and Female Protective Services;
- Hispanic American Paraprofessionals;
- African American and Female Skilled Craft; and
- Hispanic American Service Maintenance.

Table 3: Underutilization Of Covered Classes

EEO Job Category	African American			Hispanic American			Female		
	Civilian	DADS	Under	Civilian	DADS	Under	Civilian	DADS	Under
Officials and Administrators	7.27%	11%	No	11.61%	12%	No	31.63%	58%	No
Professionals	9.31%	14%	No	10.85%	20%	No	46.93%	73%	No
Technical	13.67%	24%	No	18.89%	22%	No	39.36%	75%	No
Protective Services	17.82%	11%	3.26%	22.02%	16%	1.62%	21.02%	14%	2.82%
Paraprofessionals	17.94%	44%	No	31.41%	23%	2.13%	55.81%	75%	No
Administrative Support	19.59%	19%	No	25.62%	27%	No	79.87%	87%	No
Skilled Craft	10.36%	7%	1.29%	29.51%	26%	No	10.20%	8%	0.16%
Service Maintenance	18.36%	36%	No	44.15%	30%	5.32%	24.86%	71%	No

Note: Only underutilized EEO categories are reflected in the Underutilization of Covered Classes tables, therefore, the percentages will not total 100%.

[8] PeopleSoft HSAS Database as of 3/10/04.

Department of Assistive & Rehabilitative Services

MISSION

To work in partnership with Texans with disabilities and families with children who have developmental delays to improve the quality of their lives and to enable their full participation in society.

SCOPE

The Department of Assistive and Rehabilitative Services (DARS) combines the efforts of four legacy agencies to provide services to Texans with disabilities and to families with children who have developmental delays. The Department began operations on March 1, 2004.

STRUCTURE

The HHSC Executive Commissioner, with the approval of the Governor, appointed Terrell I. Murphy, as the DARS Commissioner. The agency is divided into nine divisions that report to the Commissioner:

- Internal Audit;
- Office of the Deputy Commissioner;
- Rehabilitation Services;
- Deaf and Hard of Hearing Services;
- Blind Services;
- Early Intervention Services;
- Disability Determination Services;
- Office of the Chief Financial Officer; and
- Office of the Chief Operating Officer.

GOALS AND SERVICES

DARS Goal 1: Persons with Disabilities

DARS will ensure that families with children with disabilities receive quality services enabling their children to reach their developmental goals.

- Early Childhood Intervention Services
- Blind Services for Children

DARS Goal 2: Independence and Employment

DARS will provide quality services leading to employment and living independently.

- Vocational Rehabilitation Services
- Independent Living Services
- Blindness Education, Screening and Treatment
- Deaf and Hard of Hearing Services

DARS Goal 3: Disability Determination Services

DARS will enhance service to persons with disabilities by achieving accuracy and timeliness within the Social Security Administration Disability Program guidelines and improving the cost-effectiveness of the decision making process in the disability determination services.

- Disability Determination Services

WORKFORCE DEMOGRAPHICS

The workforce composition for the DARS reflects the following agencies and associated staff:

- ECI;
- TCB;
- TCDHH; and
- TRC.

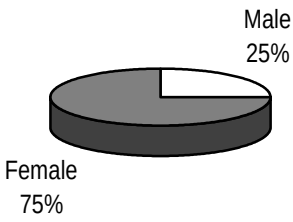
The largest classes of program area jobs include:

- Vocational Rehabilitation Counselor (592 employees);
- Disability Determination Examiner (418 employees); and
- Rehabilitation Teacher (88 employees).

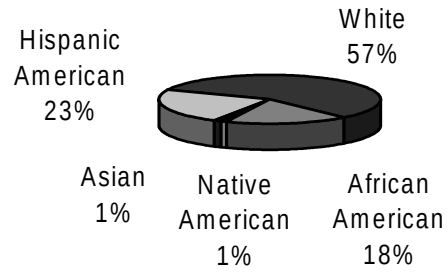
The demographic composition of the DARS workforce is shown in Figure 6.[9]

Figure 6: DARS Workforce Demographics

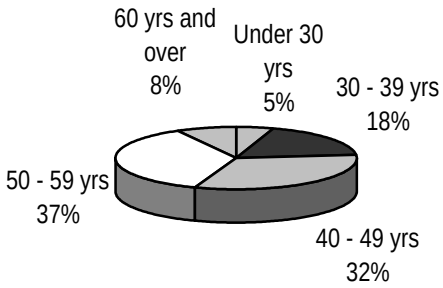
Gender



Ethnicity

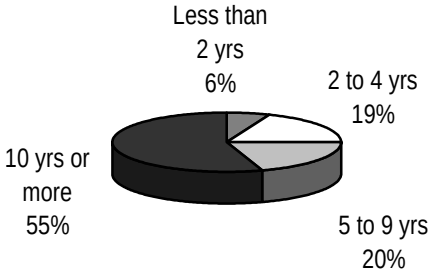


Age



Average age: 47 yrs

Tenure



Note: State tenure was used instead of agency tenure due to limitations of the reporting system.

The DARS' workforce of 3,092 employees is mostly Female, 75 percent of the employee population. At 57 percent, Anglo employees make up over half of the agency's workforce, followed by Hispanic American employees at 23 percent and African American employees at 18 percent. Seventy-seven percent of the agency's employees are 40 years old or older, with an average employee age of 47 years. Only six percent of the DARS' employees have less than two years of state tenure.

[9] PeopleSoft HSAS Database as of 3/10/04.

UNDERUTILIZATION OF COVERED CLASSES

As indicated in Table 4, DARS is showing underutilization in the following areas: [10]

- African American and Hispanic American Technical;
- African American, Hispanic American, and Female Protective Services;
- Hispanic American Paraprofessionals;
- Hispanic American Skilled Craft; and
- African American and Hispanic American Service Maintenance.

Table 4: Underutilization Of Covered Classes

EEO Job Category	African American			Hispanic American			Female		
	Civilian	DARS	Under	Civilian	DARS	Under	Civilian	DARS	Under
Officials and Administrators	7.27%	11%	No	11.61%	11%	No	31.63%	48%	No
Professionals	9.31%	13%	No	10.85%	15%	No	46.93%	71%	No
Technical	13.67%	6%	4.92%	18.89%	10%	5.21%	39.36%	52%	No
Protective Services	17.82%	0%	14.26%	22.02%	0%	17.62%	21.02%	0%	16.82%
Paraprofessionals	17.94%	15%	No	31.41%	22%	2.83%	55.81%	81%	No
Administrative Support	19.59%	21%	No	25.62%	32%	No	79.87%	92%	No
Skilled Craft	10.36%	13%	No	29.51%	13%	8.00%	10.20%	22%	No
Service Maintenance	18.36%	8%	6.69%	44.15%	2%	33.32%	24.86%	43%	No

Note: Only underutilized EEO categories are reflected in the Underutilization of Covered Classes tables, therefore, the percentages will not total 100%.

[10] PeopleSoft HSAS Database as of 3/10/04.

Department of Family and Protective Services

MISSION

To protect children, older persons, and people with disabilities from abuse, neglect, and exploitation by providing innovative and effective services to families and vulnerable individuals in their community.

SCOPE

The Department of Family and Protective Services (DFPS) began operations on February 1, 2004. The DFPS continues the work of the former Department of Protective and Regulatory Services to protect children, adults who are older persons or have disabilities and are living at home or in state facilities, and to license day-care homes, day-care centers, and registered family homes. The Department also manages community-based programs that prevent delinquency, abuse, neglect, and exploitation of Texas children.

STRUCTURE

The HHSC Executive Commissioner, with the approval of the Governor, appointed Thomas Chapmond, as the DFPS Commissioner. The Department is divided into operational and support divisions that work in concert to allow the Department to accomplish its mission of providing services to the State's most vulnerable citizens. Those divisions are listed here:

- Internal Audit;
- Office of the Deputy Commissioner;
- Adult Protective Services;
- Child Protective Services;
- Child Care Licensing;
- Purchased Client Services;
- Office of the Chief Financial Officer; and
- Office of the Chief Operating Officer.

GOALS AND SERVICES

DFPS Goal 1: Protective Services

In collaboration with other public and private entities, protect children, elder adults, and persons with disabilities, from abuse, neglect, and/or exploitation by providing an integrated service delivery system that results in quality outcomes, and reduce the incidence of abuse, neglect, and exploitation by maximizing resources for early intervention, prevention, and aftercare.

- Statewide Intake Services
- Child Protective Services
- Prevention and Early Intervention Programs
- Adult Protective Services
- Child Care Regulation

WORKFORCE DEMOGRAPHICS

The workforce composition for the DFPS reflects all current programs and associated staff for the PRS.

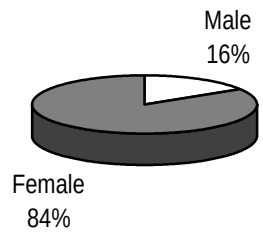
The largest classes of program area jobs include:

- Child Protective Services Specialist (2,146 employees);
- Adult Protective Services Specialist (498 employees); and
- Statewide Intake Specialist (261 employees).

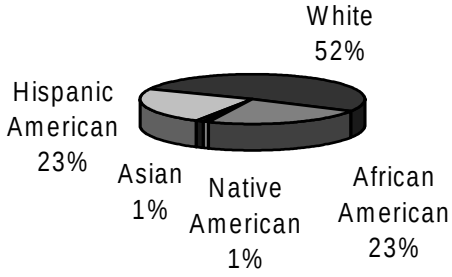
The demographic composition of the DFPS workforce is shown in Figure 7. [11]

Figure 7: DFPS Workforce Demographics

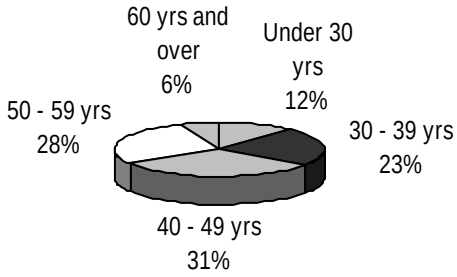
Gender



Ethnicity

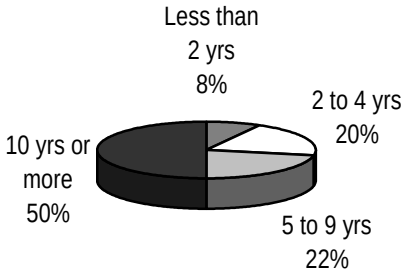


Age



Average age: 41 yrs

Tenure



Note: State tenure used instead of agency tenure due to limitations of the reporting system.

The DFPS' workforce of 6,531 employees is mostly Female, 84 percent of the employee population. At 52 percent, Anglo employees make up more than half of the agency's workforce, followed by Hispanic American and African American employees, who are both at 23 percent. Sixty-five percent of the agency's employees are 40 years old or older, with an average employee age of 41 years. Only eight percent of DFPS' employees have less than two years of state tenure.

Note: Though this eight percent with less than two years of state service may seem to indicate a slight demographic shift compared to the 51 percent reported in the FY 2003-2007 DPRS Workforce Plan, the two percentages are not comparable, since the current data are based on state tenure, while the previously reported data were based on tenure with DPRS (data not available for the present analysis).

[11] PeopleSoft HSAS Database as of 3/10/04.

UNDERUTILIZATION OF COVERED CLASSES

Table 5 indicates the DFPS as having no underutilization of covered classes. [12]

Table 5: Underutilization Of Covered Classes

EEO4 Job Category	African American			Hispanic American			Female		
	Civilian	DFPS	Under	Civilian	DFPS	Under	Civilian	DFPS	Under
Officials and Administrators	7.27%	10%	No	11.61%	10.20%	No	31.63%	70.41%	No
Professionals	9.31%	23%	No	10.85%	22.27%	No	46.93%	82.08%	No
Technical	13.67%	26%	No	18.89%	34.15%	No	39.36%	84.27%	No
Protective Services	17.82%	N/A	N/A	22.02%	N/A	N/A	21.02%	N/A	N/A
Paraprofessionals	17.94%	27%	No	31.41%	31.46%	No	55.81%	94.84%	No
Administrative Support	19.59%	24%	No	25.62%	30.92%	No	79.87%	91.55%	No
Skilled Craft	10.36%	N/A	N/A	29.51%	N/A	N/A	10.20%	N/A	N/A
Service Maintenance	18.36%	N/A	N/A	44.15%	N/A	N/A	24.86%	N/A	N/A

Note: Only underutilized EEO categories are reflected in the Underutilization of Covered Classes tables, therefore, the percentages will not total 100%.

[12] PeopleSoft HSAS Database as of 3/10/04.

Department of State Health Services

MISSION

The Texas Department of State Health Services promotes optimal health for individuals and communities while providing effective health, mental health and substance abuse services to Texans.

SCOPE

The Department of State Health Services (DSHS) administers and regulates health, mental health, and substance abuse programs. The Department began its formal operations September 1, 2004.

STRUCTURE

The HHSC Executive Commissioner, with the approval of the Governor, appointed Dr. Eduardo J. Sanchez as the DSHS Commissioner. The following divisions report to the Commissioner:

- Internal Audit;
- Office of the Deputy Commissioner for Behavioral and Community Health Services;
- Office of the Deputy Commissioner for Public Health Services;
- Mental Health and Substance Abuse Services;
- Family and Community Health Services;
- Prevention and Preparedness Services;
- Regulatory Services;
- Office of the Chief Financial Officer; and
- Office of the Chief Operating Officer.

GOALS AND SERVICES

DSHS Goal 1: Preparedness/Prevention Services

DSHS will protect and promote the public's health by decreasing health threats and sources of disease.

- Public Health Preparedness Services
- Infectious Disease Prevention, Intervention, and Treatment Services
- Health Promotion and Chronic Disease Prevention
- Specialty Care Services
- Laboratory Services

DSHS Goal 2: Community Health Services

DSHS will improve the health of children, women, families, and individuals, and enhance the capacity of communities to deliver health care services.

- Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Farmer's Market Nutrition Services
- Community Primary Care Services
- Mental Health Services for Adults
- Mental Health Services for Children
- Substance Abuse Services

DSHS Goal 3: Hospital Facilities Management and Services

DSHS will promote the recovery and abilities of persons with infectious disease and mental illness who require specialized treatment.

- Mental Health State Hospitals
- Public Health Hospitals

DSHS Goal 4: Consumer Protection Services

DSHS will achieve a maximum level of compliance by the regulated community to protect public health and safety.

- Health Care Facilities Licensing
- Professional Credentialing
- Consumer Safety

WORKFORCE DEMOGRAPHICS

The workforce composition for the DSHS reflects the following agencies, programs, and associated staff projected to be included as of 9/1/04:

- MHMR - Mental Health;
- TDH; and
- TCADA.

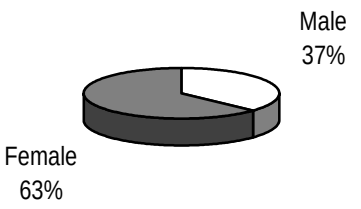
The largest classes of program area jobs include:

- MHMR Services Aide/Assistant (2,630 employees);
- Registered Nurse (603 employees); and
- Licensed Vocational Nurse (432 employees).

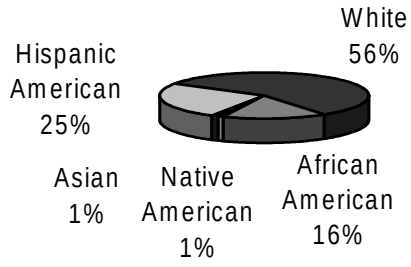
The demographic composition of the DSHS workforce is shown in Figure 8.[13]

Figure 8: DSHS Workforce Demographics

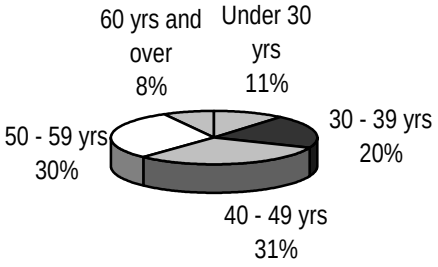
Gender



Ethnicity

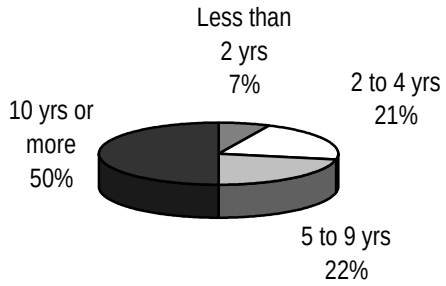


Age



Average age: 45 yrs

Tenure



Note: State tenure was used instead of agency tenure due to limitations of the reporting system. Workforce totals for DSHS include the data for the two employees of the Texas Cancer Council (TCC), which receives administrative support from HHSC.

The DSHS' workforce of 11,224 employees will be mostly Female, 63 percent of the employee population. At 56 percent, Anglo employees will make up more than half of the agency's workforce, followed by Hispanic American employees at 25 percent and African American employees at 16 percent. Sixty-nine percent of the agency's employees will be 40 years old or older, with an average employee age of 45 years. Only seven percent of the DSHS' employees will have less than two years of state tenure.

[13] PeopleSoft HSAS Database as of 3/10/04.

UNDERUTILIZATION OF COVERED CLASSES

As indicated in Table 6, DSHS is showing underutilization in the following areas: [14]

- African American Officials and Administrators;
- African American and Hispanic American Protective Services;
- African American Administrative Support; and
- African American and Female Skilled Craft.

Table 6: Underutilization Of Covered Classes

EEO4 Job Category	African American			Hispanic			Female		
	Civilian	DSHS	Under	Civilian	DSHS	Under	Civilian	DSHS	Under
Officials and Administrators	7.27%	5.74%	0.08%	11.61%	12.14%	No	31.63%	54.00%	No
Professionals	9.31%	9.49%	No	10.85%	18.75%	No	46.93%	66.00%	No
Technical	13.67%	13.15%	No	18.89%	21.08%	No	39.36%	59.00%	No
Protective Services	17.82%	7.53%	6.73%	22.02%	17.12%	0.50%	21.02%	21.00%	No
Paraprofessionals	17.94%	28.57%	No	31.41%	30.24%	No	55.81%	62.00%	No
Administrative Support	19.59%	10.83%	4.84%	25.62%	30.78%	No	79.87%	84.00%	No
Skilled Craft	10.36%	5.41%	2.88%	29.51%	23.99%	No	10.20%	1.00%	7.16%
Service Maintenance	18.36%	26.13%	No	44.15%	39.70%	No	24.86%	62.00%	No

Note: Only underutilized EEO categories are reflected in the Underutilization of Covered Classes tables, therefore, the percentages will not total 100%.

[14] PeopleSoft HSAS Database as of 3/10/04.

HHS ENTERPRISE RETIREMENTS, TURNOVER, AND CRITICAL POSITIONS

FUTURE RETIREMENTS

Currently only 2.8 percent of HHS Enterprise employees are eligible to retire. This low percentage is due in part to the large percentage of HHS Enterprise employees (26 percent of all terminations) who chose to take advantage of the retirement incentive offered in FY '03. However, over the next four years, approximately 11.9% percent of HHS Enterprise's workforce will become eligible to retire. Employees eligible to retire for the individual HHS agencies are shown in Table 7. [15]

Table 7: HHS Enterprise Projected Retirement Eligibility FY '04 – '08

Agency	Eligible as of March '04		Remainder of FY '04		FY 05		FY 06		FY '07		FY '08		Projected Retiree Totals		Total Number of Employees
HHSC	208	2.3%	15	0.2%	193	2.1%	218	2.4%	247	2.7%	203	2.2%	1,084	12.0%	9,052
DADS	525	3.3%	80	0.5%	345	2.1%	320	2.0%	325	2.0%	312	1.9%	1,907	11.8%	16,153
DARS	174	5.6%	21	0.7%	70	2.3%	74	2.4%	101	3.3%	75	2.4%	515	16.7%	3,092
FPS	121	1.9%	18	0.3%	87	1.3%	118	1.8%	142	2.2%	102	1.6%	588	9.0%	6,531
DSHS	425	3.8%	64	0.6%	217	1.9%	210	1.9%	261	2.3%	219	2.0%	1,396	12.4%	11,224
Grand Total	**1,245**	**3.4%**	**183**	**0.5%**	**719**	**1.9%**	**722**	**2.0%**	**829**	**2.2%**	**708**	**1.9%**	**4,406**	**11.9%**	**37,000**

Note: Retirement data are based on the projected workforce composition of HHS agencies as of 9/1/04.

[15] PeopleSoft HSAS Database as of 3/10/04.

Employees eligible to retire and receive the retirement incentive are shown in Table 8.[16]

Table 8: Number of HHS Enterprise Staff Projected To Retire With Retirement Incentive for FY'04 and FY'05

		DADS		DARS		DSHS		DFPS		HHSC		**HHSE Total**	
		Eligible Staff	Projected Retirements	Eligible Staff	Projected Retirements	Eligible Staff	Projected Retirements	Eligible Staff	Projected Retirements	Eligible Staff	Projected Retirements	Total Eligible Staff	Total Projected Retirements
FY '04	Currently Eligible	525		174		425		121		208		**1453**	
	April	13	5	1	0	12	5	7	3	2	1	**35**	**15**
	May	16	7	1	0	8	3	1	0	0	0	**26**	**11**
	June	14	6	3	1	11	5	4	2	3	1	**35**	**15**
	July	18	8	7	3	15	6	1	0	4	2	**45**	**19**
	August	19	8	9	4	18	8	5	2	6	3	**57**	**24**
Total FY '04		605	34	195	9	489	27	139	8	223	6	1651	84
FY '05	September	18	8	7	3	14	6	7	3	8	3	**54**	**23**
	October	30	13	4	2	14	6	2	1	17	7	**67**	**28**
	November	22	9	6	3	17	7	10	4	17	7	**72**	**30**
	December	27	11	10	4	21	9	9	4	18	8	**85**	**36**
	January	25	11	6	3	21	9	10	4	17	7	**79**	**33**
	February	37	16	7	3	17	7	19	8	20	8	**100**	**42**
	March	24	10	7	3	20	8	5	2	12	5	**68**	**29**
	April	34	14	6	3	15	6	4	2	12	5	**71**	**30**
	May	28	12	2	1	18	8	4	2	19	8	**71**	**30**
	June	28	12	5	2	14	6	5	2	14	6	**66**	**28**
	July	39	16	2	1	19	8	8	3	19	8	**87**	**37**
	August	33	14	8	3	27	11	4	2	20	8	**92**	**39**
Total FY '05		345	146	70	30	217	92	87	37	193	82	912	386
Total FY '04 - '05		**950**	**180**	**265**	**38**	**706**	**119**	**226**	**44**	**416**	**88**	**2563**	**470**

Note: The Employees Retirement System's (ERS) retirement projections were developed and presented by ERS in State Auditor's Office sponsored *Strategic Workforce Planning Workshop* on January 21, 2004. The projections are based on the actual number of HHS employees who, from August through December of FY 2003, took advantage of the retirement incentive by retiring. The ERS statewide retirement average of 42.3 percent was applied to the number of HHS Enterprise staff eligible to retire in order to project a retirement rate for the remainder of FY 2004 and for each month of FY 2005.

The steady increase in the number of employees eligible to retire means that the HHS Enterprise and individual HHS agencies may lose a significant portion of their most knowledgeable workers in the near future, including many employees in key administrative positions.

HHS AGENCIES TURNOVER

The HHS Enterprise's turnover rate for FY 2003 was 21.14 percent. Due to the consolidation and possible reduction of staff for the HHS agencies, it is not possible to calculate a turnover projection for the next four years. As shown in Table 9, the turnover rate increased in FY 2003 by 2.37 percent.[17]

[16] PeopleSoft HSAS Database as of 3/10/04.
[17] Ibid.

Table 9: HHS Enterprise Turnover for FY '00 – '03			
FY	**Average Employees**	**Terminations**	**Turnover Rate**
2000	49,908	12,305	24.65 %
2001	48,507	11,527	23.77 %
2002	48,245	9,058	18.77 %
2003	47,038	9,943	21.14 %
Average	**48,425**	**8,471**	**22.08 %**

Additionally, some HHS agency mission critical classifications are currently experiencing higher turnover than the current overall turnover percent (21.14) including MHMR Services Aides/Assistants/Supervisors at 33.27 percent, and Nurses at 25.39 percent. Mission critical classifications that are currently, and have historically, experienced high turnover are shown in Table 10.[18]

Table 10: HHS Enterprise Critical Classifications for FY '00 – '03					
Class	**FY '03**	**FY '02**	**FY '01**	**FY '00**	**Average**
MHMR services aides/assistants/supervisors	33.27	32.97	45.48	42.48	38.55
Nurses (RNs and LVNs)	25.39	20.93	24.20	22.29	23.21
Physicians	22.68	17.60	16.07	14.84	17.79
Pharmacists	24.06	37.55	13.17	12.83	21.90
Protective Services Specialists	22.80	23.46	27.67	24.65	24.65
Vocational Rehabilitation Counselors	19.68	22.12	23.45	29.87	23.81
Disability Determination Examiners	12.27	15.40	15.31	13.00	14.00

Length of service (shown in Figure 9) and age (shown in Figure 10) were two factors that characterized turnover for state government in general, and the HHS Enterprise in particular. [19] More than 50 percent of the total employee losses at the HHS Enterprise occurred during the first four years of employment. Additionally, approximately 28 percent of the total losses were under the age of 30. Of the total losses during this period, about 72 percent were voluntary terminations, and 28 percent were agency-directed terminations. [20]

[18] Ibid.
[19] State Auditor's Office. "Automated Applications for Risk Assessment, Planning, and Analysis." SAO web page http://www.sao.state.tx.us/Resources/AutoApps/default.cfm last accessed March 10, 2004.
[20] Ibid.

Figure 9: HHS Enterprise – FY '03 Turnover by Tenure

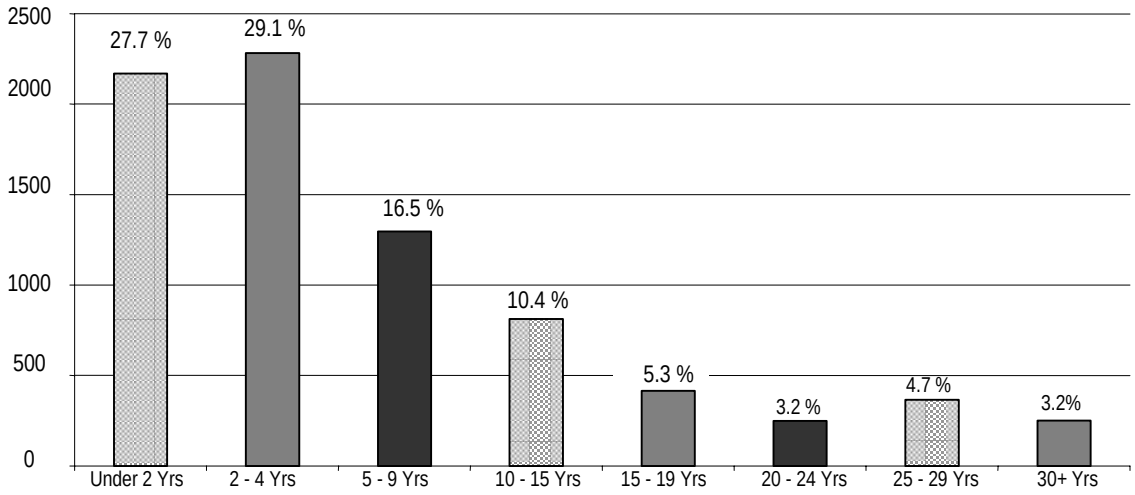
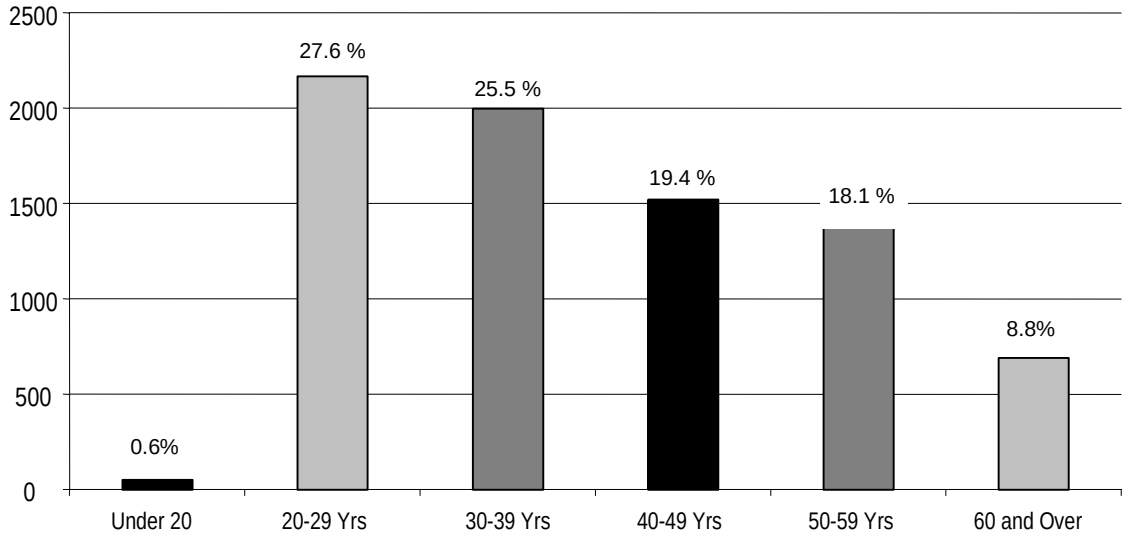


Figure 10: HHS Enterprise – FY '03 Turnover by Age



CRITICAL WORKFORCE SKILLS

The current climate of change and consolidation will continue to place increased emphasis on the enhancement of certain skill sets, including automation, public health administration, and managerial skills. Without these skills, the HHS Enterprise will not be able to maintain or exceed current levels of service delivery and client satisfaction.

Increased and ever-changing automation will make it critical for the HHS employees to improve and commit to a continual learning of computer skills. Managers, due to the continuing reduction in administrative support, need to continue to improve their computer skills.

It is critical for the HHS agencies to employ public health professionals who have the core set of competencies necessary for the development, implementation, and evaluation of the public health programs. These competencies are as follows:

- Analytic/Assessment Skills;
- Policy Development/Program Planning Skills;
- Communication Skills;
- Cultural Competency Skills;
- Community Dimensions of Practice Skills;
- Basic Public Health Sciences Skills;
- Financial Planning and Management Skills; and
- Leadership and Systems Thinking Skills.

Because most managerial positions require agency program knowledge, the majority of these jobs are filled from within the respective agencies through the promotion of current employees. As the HHS agencies continue to lose tenured staff due to retirement, increased training will be needed in order to ensure that the current workforce develops the skills necessary to move into management positions.

Making management training even more important is the fact that with the consolidation of the HHS agencies, the level of support human resources will be able to provide managers is expected to greatly decrease. Therefore, in order for managers to succeed in their expanded role, they would benefit from administrative training, including human resource policy, employee development, conflict resolution, time management, and project management.

ASSESSMENT OF ENVIRONMENT: AFFECTING TEXAS

ECONOMIC FACTORS

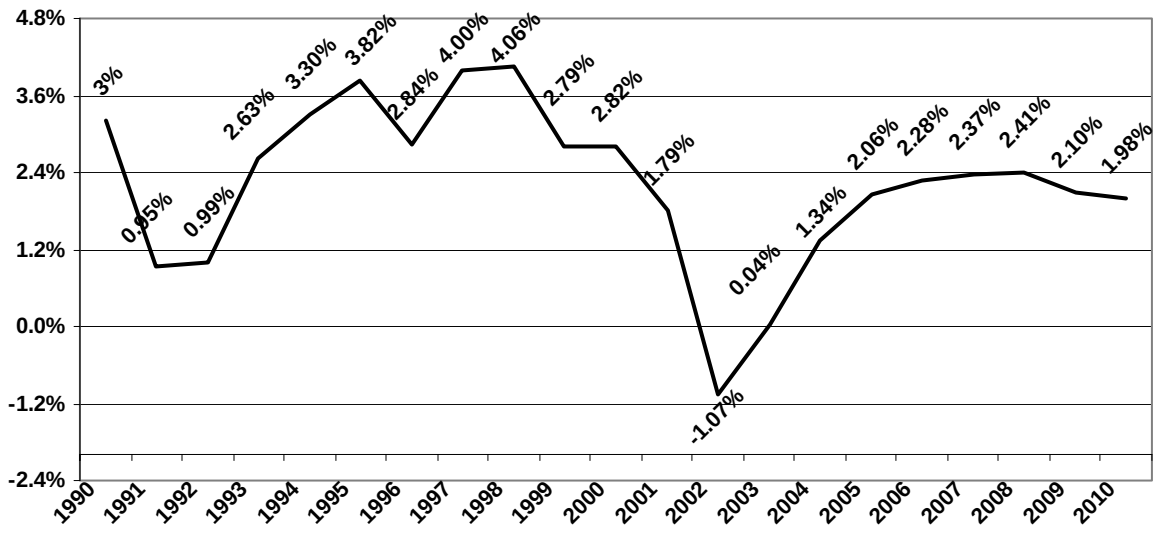
The continued sluggishness of the Texas and U.S. economy is a key concern for HHS agencies. Downturns in the economy have traditionally led to increased demand for social services accompanied by decreased financial resources for the provision of those services. With no increase in state revenue forthcoming, HHS agencies must attend to the increased demand through new and innovative means of providing services.

State economic forecasters have become guardedly optimistic about the current and future trends of the Texas economy. While leading economic indices have been slow to improve, renewed growth is now predicted. The Office of the Texas Comptroller's most recent state sales tax revenue receipts for February 2004 totaled more than $1.26 billion, a 6.2 percent increase from February 2003. This increase shows that the Texas economic recovery is gaining momentum, and the latest economic data indicate that Texas' economic growth will outpace the nation through 2005.[21]

While Texas' economy appears to be improving, the number of nonfarm jobs in Texas has changed little over the past three years. During the 1990s, Texas' job count increased by nearly 20,000 each month and had an average annual increase of 2.9 percent. This growth rate slowed dramatically in 2000, and reached a low of –1.07 percent in 2002 (see Figure 11).[22] In contrast to the previous decade, the number of nonfarm jobs in Texas for July 2003 (9,424,000) was the same as in the beginning of the summer of 2000.[23] According to data from the State Comptroller's office, job gains for the remainder of 2003 were less than one percent, and the average employment for the fourth quarter remained down by 86,500 jobs from December 2000.[24] However, projections from the State Comptroller's office in April 2004 indicate that job growth will slowly improve, with an annual increase of around two percent through 2010.

[21] Texas Comptroller of Public Accounts. "Comptroller Strayhorn Reports 6.2 Percent Increase in State Sales Tax Collections." TCPA web page http://www.cpa.state.tx.us/news/40312allocations.html last accessed on March 25, 2004.
[22] Texas State Comptroller's Office. Spring 2004 Economic Forecast.
[23] Texas Workforce Commission. "Texas and U.S. Unemployment Rates." TWC web page http://www.twc.state.tx.us/customers/rpm/rpmsub3.html last accessed on March 25, 2004.
[24] Texas Comptroller of Public Accounts. "Texas Economic Update – Summer 2003." TCPA web page http://www.cpa.state.tx.us/ecodata/teusum03 last accessed on February 25, 2004.

Figure 11: Annual Percentage Change in Texas Nonfarm Employment: State Fiscal Years 1990-2003 Actual, 2004-2010 Projected



As job growth slowed, unemployment rose to a peak of 6.6 percent in Texas for 2003. However, data indicate that unemployment in Texas and in the rest of the nation will gradually decrease and stabilize during the few years. Current projections show that the unemployment rate for Texas during FY 2004 is expected to average 6.4 percent and then slowly decline to 5.7 percent by 2010.[25] [26] [27]

CURRENT POVERTY RATES

In 2002, the U.S. Census defined the average poverty threshold for a family of four as $18,392 in annual income; $14,348 for a family of three; $11,756 for a family of two; and $9,183 for unrelated individuals.[28] The overall poverty rate in Texas is currently 15.6 percent; however, there is a significant variation in this rate by age, region and ethnicity in Texas.[29]

[25] Texas Comptroller of Public Accounts. "Spring 2003 State Economic Forecast." TCPA web page http://www.cpa.state.tx.us/ecodata/fcst03spr last accessed on March 25, 2004.
[26] Texas Workforce Commission, Labor Market Information.
[27] U.S. Congressional Budget Office, January 2004 Projections.
[28] U.S. Census Bureau, "Poverty 2003." Census Bureau Web page http://www.census.gov/hhes/poverty/threshld/thresh03.html last accessed on April 14, 2004.
[29] U.S. Department of Commerce. U.S. Census Bureau. March 2003 Current Population Survey (CPS) for Texas. Prepared by Texas Health and Human Services Commission Office of the State Demographer.

Figure 12 shows the difference in poverty rates by age group.[30] At 24.3 percent, the largest age group in Texas that lives in poverty is children under seven years of age followed by adolescents aged 17 and under at 20.4 percent. Adults aged 65 and older had 15.4 percent of their population living in poverty, while 13.8 percent of adults aged 18 to 64 lived in poverty.[31] Also, Hispanic American and African American groups continue to represent a disproportionate number of Texans living under poverty conditions (see Figure 13). The latest data available indicate that 18.7 percent of African Americans, 25.0 percent of Hispanic Americans, and 7.4 percent of Anglos are living at or below poverty.[32]

Figure 12: Percentage of Texans Living in Poverty by Age Group During 2002

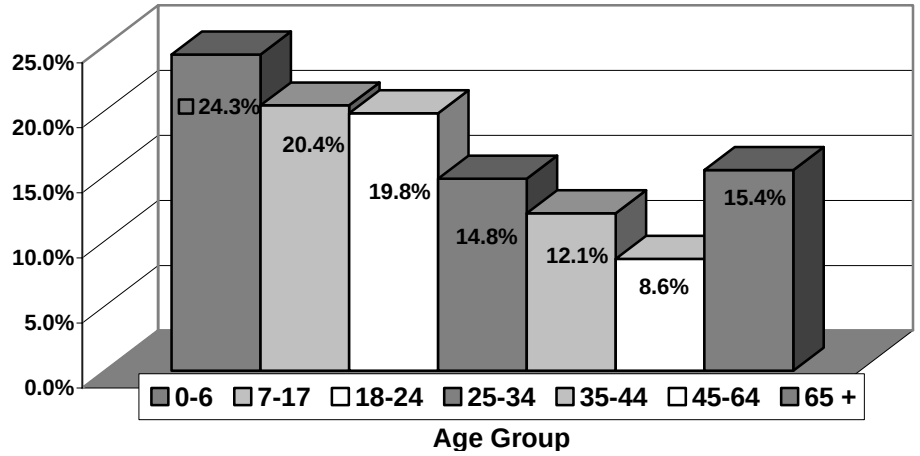
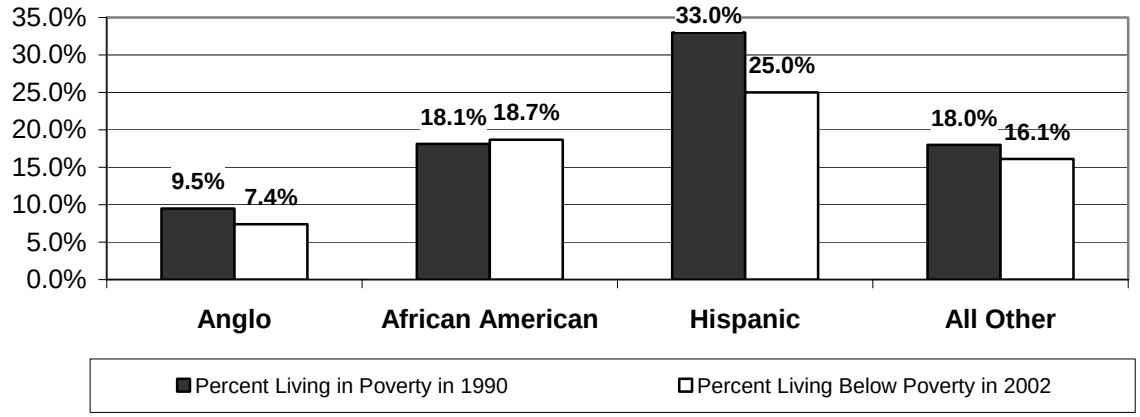


Figure 13: Texas Poverty Rates by Race/Ethnicity in 1990 & 2000



[30] U.S. Department of Commerce. U.S. Census Bureau. March 2003 Current Population Survey (CPS) for Texas. Prepared by Texas Health and Human Services Commission Office of the State Demographer.
[31] Ibid.
[32] Ibid.

DEMOGRAPHIC FACTORS

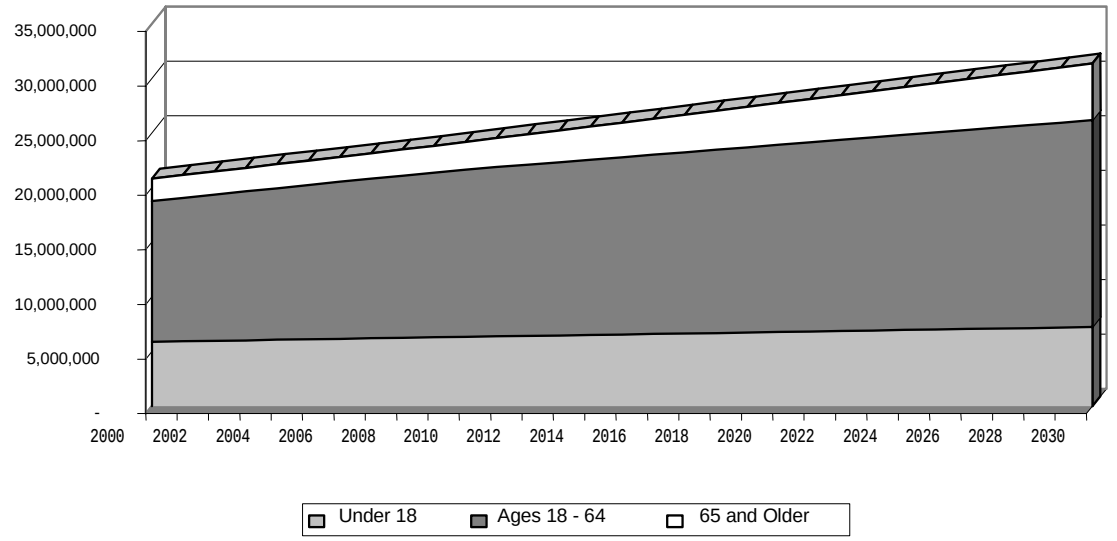
The population of Texas is expected grow and to change composition. The primary factors that effect these changes are the projected growth in the total population, and the larger-than-average projected growth of both the non-Anglo population and the population aged 65 or older. According to the 2002 U.S. Census, Texas had the second largest population of all states (behind California), with approximately 21.5 million residents. Of this population, approximately 10.0 million were Anglo, approximately 8.0 million were Hispanic American, approximately 2.3 million were African American, and approximate 1.0 million were in other racial/ethnic groups.[33] Of the 8.0 million Hispanic Americans in Texas in 2002, more than five million (76 percent) were of Mexican origin.[34]

The population of the state has risen noticeably in the last decade. Between 1990 and 2000, Texas' population grew by almost four million, from about 17 million to almost 21 million. Between 2004 and 2010, the state's population is expected to increase by about 2.5 million, or eleven percent. Robust growth is also expected over the long-term. Between 2000 and 2010, total population growth could reach 16 percent, and the growth rate could exceed 100 percent between 2000 and 2040, with the population essentially doubling in size.[35]

All major age cohorts are expected to expand in size over the short-term (see Figure 14). Population projections for 2005 through 2010 show that the number of children under 18 will increase by 200,000; the number of adults ages 18 through 64 will increase by about 1,200,000; and the number of adults over 64 will increase by about 284,000. Long-term projections of the state's population indicate that the proportion of children under 18 will shrink from 28 percent in 2000 to 26.2 percent in 2010, and then down to 23.1 percent in 2030. Meanwhile, adults over 64 years of age are projected to account for a larger share of the state's population. This age group is expected to increase from 10 percent of the total population in 2000 to approximately 16 percent in 2030, with the oldest members of the 'baby boom' generation turning 65 in 2011.[36]

[33] Office of the State Demographer, Texas State Data Center.
[34] U.S. Census, 2002.
[35] Office of the State Demographer, Texas State Data Center.
[36] Ibid.

Figure 14: Projected Growth in Age Group Cohorts: 2005 - 2030



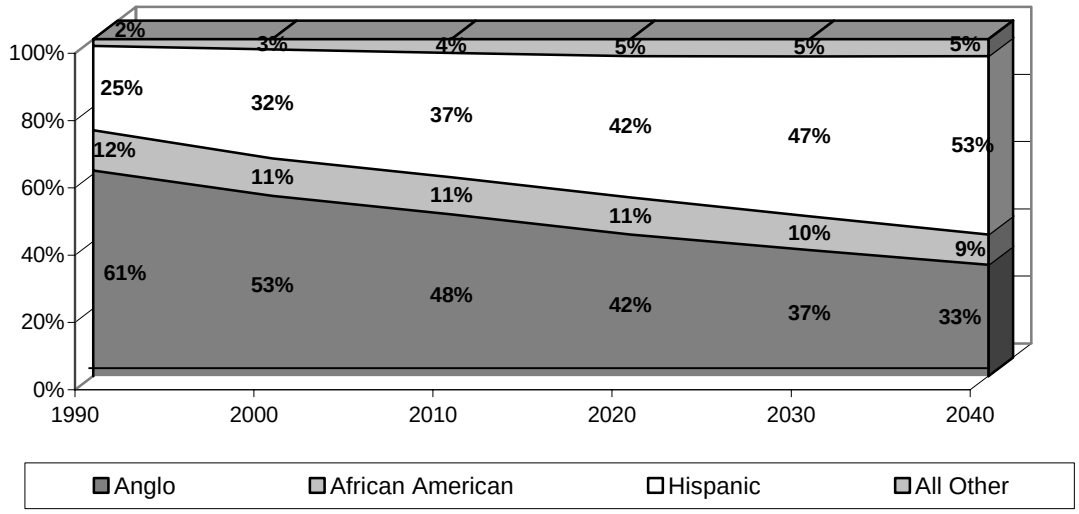
In terms of population distribution, the percentage of Texans living in metropolitan areas is expected to remain high. In 1990, approximately 83 percent of Texas' population lived in metropolitan areas. In 2010, approximately 86 percent of the population will live in the 58 counties currently designated as metropolitan. About 60 percent of the state's population currently reside in the largest metropolitan areas of the state: the Dallas-Forth Worth Metroplex region; the Houston-Galveston Gulf Coast region; and the Austin-San Marcos Central Texas region.[37]

In terms of race and ethnicity, a review of Texas' population in 2002 indicates that the largest relative concentrations of Hispanic American residents are located near or along the Texas-Mexico border, comprising about 80 percent of the total population in the Lower South Texas and Upper Rio Grande regions. African American residents are largely concentrated in Southeast Texas, Upper East Texas, and the Gulf Coast regions. In those regions, about 1 in 5 residents are African American. The Upper East Texas and Southeast Texas regions also have some of the largest relative concentrations of Anglo residents, and a lower than average relative concentration of Hispanic American residents. The Northwest Texas region has the largest relative concentration of Anglo residents in the state (76 percent).[38]

[37] Office of the State Demographer, Texas State Data Center.
[38] Ibid.

Several changes are projected in the current demographic picture (see Figure 15).

Figure 15: Percent Share of Texas' Population by Race / Ethnicity: Selected Years



First, Anglo's relative share of the state's population will continue to decrease over the foreseeable future. Their share may decrease from 53 percent in 2000 to about 33 percent in 2040. Moreover, African American's relative share is projected to decrease from 11 percent in 2000 to about nine percent in 2040. In contrast, Hispanic American's relative share is projected to increase, from 32 percent in 2000 to 53 percent in 2040. The relative share of all other groups combined is projected to remain relatively low, but will rise from three percent in 2000 to about five percent in 2040.[39]

[39] Office of the State Demographer, Texas State Data Center.

ASSESSMENT OF ENVIRONMENT: AFFECTING THE HHS ENTERPRISE

IMPACT OF HHS CONSOLIDATIONS

Texas is one of the faster growing states in the nation, with the fifth largest rate of population increase in the country between 1960 and 2000.[40] As the population increases, the demands for HHS program services will increase. To deal with some of the budgetary constraints associated with this projected increase in demand, HB 2292 has mandated that the HHS Enterprise reduce administrative costs to increase the percentage of funds available for direct client services. HHS agencies are being restructured and consolidated, and administrative support services across HHS agencies are being consolidated.

One outcome of this consolidation of support services will be the shift of administrative responsibilities and expectations from HHS administrative staff to program managers and supervisors, and an increase in the complexity of the jobs and the levels of responsibility of program supervisors at the regional and direct service levels. For example, the new HHS HR Manual requires managers and supervisors to assume many of the responsibilities that were previously assigned to HR staff. With these added responsibilities at the program level, agencies and program staff will need to develop structural and operational methods to effectively deal with these responsibilities and continue to effectively provide client services. Operational changes will probably include the expanded use of automation to enhance effectiveness and efficiency of support operations, and additional administrative and managerial skills training.

PROJECTED SHORTAGES FOR CORE HHS JOBS

The HHS agencies will need to continue to recruit and retain many public health professionals, including nurses, pharmacists, vocational rehabilitation counselors, epidemiologists, and sanitarians. Additionally, many core jobs will continue to be essential to the delivery of services throughout the HHS Enterprise, including many that are low paying, highly stressful, and experience high turnover. A continual supply of workers will be needed for these jobs, such as MHMR services aides/assistants/supervisors, Nurses (RNs and LVNs), Physicians, Pharmacists, Protective Services Specialists (Adult and Children), Vocational Rehabilitation Counselors, and Disability Determination Examiners.

[40] Steve H. Murdock, Steve White, Md. Nazrul Hoque, Beverly Pecotte, Xiuhong You, and Jennifer Balkam, “A Summary of the Texas Challenge in the Twenty-First Century: Implications for the Future of Texas,” The Center for Demographic and Socioeconomic Research and Education, Department of Rural Sociology, Texas A&M University System, December 2002.

Nursing Shortage

The Joint Commission on Accreditation of Healthcare organizations reports that over 126,000 nursing positions are unfilled in hospitals across the United States, with even greater shortages in long-term care organizations and home-health care agencies. Registered nurses constitute the largest healthcare occupation in the United States. [41] In addition, it is projected that there will be more new jobs for registered nurses during this period than any other occupation, with one million new registered nursing jobs by 2010.[42]

Texas is also experiencing a shortage in registered nurses. Currently, there are 782 employed registered nurses per 100,000[43] individuals in the U.S., while in Texas, there are only 606 per 100,000. Almost 37,000 more nurses would be needed in order to match the national average.[44] With Texas having one of the largest growing populations in the country, the nursing shortage continues to grow.

The primary reasons for the nursing shortage are the increased demand for nursing services due to the growing need to manage the chronic illnesses and conditions of the aging baby boom population; a decline in nursing school enrollments; and the aging of America's nurses.[45]

As the demand for nursing services increases and the supply decreases, and the recruitment and retention of nurses becomes more difficult, the need for competitive salaries will become more critical. Currently, the average annual salary for staff nurses in HHS agencies during the year ending February 6, 2004 was $41,442.[46] Nationally, the median annual earnings for registered nurses in 2002 were $48,090.[47] The average base salary for a mid-range staff nurse in Texas is approximately $44,000, without bonuses, and 44,889 with bonuses.[48]

While the salary range within the salary groups used for registered nurse classifications could accommodate increasing salaries to a competitive level, HHS agencies do not have the budgets to allow for these increases. With approximately

[41] National League of Nursing Preliminary Report of the 2002-2003 Survey of RN Nursing Programs on the internet at www.nln.org (visited April 7, 2004).
[42] Daniel E. Hecker, "Occupational employment projections to 2010" *Monthly Labor Review* 124, no. 11 (2001).
[43] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2004-05 Edition,* Registered Nurses, on the Internet at http://www.bls.gov/oco/ocos083.htm (visited April 07,2004).
[44] The U.S. Department of Health and Human Services Final Report of the *2000 National Survey of Registered Nurses.*
[45] The American Nurses Association *Nursing's Agenda for the Future*, on the Internet at www.NursingWorld.org/naf (visited April 7, 2004).
[46] Texas State Auditor's Office-SCO HRAS.
[47] Bureau of Labor Statistics *Occupational Outlook Handbook, 2004-05 Edition.*
[48] Absolutely Health Care Salary Wizard on the Internet at http://absolutelyhealthcare.salary.com (visited April 7, 2004).

1321 registered nurses in the HHS Enterprise, considerable dollars would be required to implement these pay adjustments. [49]

Pharmacist Shortage

Throughout the United States, the number of pharmacists has not kept pace with the need created by employment growth and attrition. This need is projected to continue to grow faster than the average for all occupations through the year 2012 due to the increased pharmaceutical needs of a growing elderly population and increased use of medications.[50]

The weighted average annual salary for pharmacists is $76,900 in Texas.[51] In contrast, of the 75 pharmacists currently employed by HHS agencies, 30 earn less than $60,000 per year, and 39 earn less than $70,000. A request for reallocation of the pharmacist is included in the State Classification Plan for FY 2006-07.

Adult Protective Services Specialists Shortage

Currently, there are approximately 498 adult protective specialists employed by HHS agencies.[52] In FY 2003 the turnover rate was 23 percent, with turnover averaging about 24 percent over the past three years. During the next decade the significant increase in the aging population will require additional adult protective services workers, which, in turn, could further exacerbate the high turnover rate.

Vocational Rehabilitation Counselor Shortage

Currently, there are approximately 592 vocational rehabilitation counselors employed by HHS agencies.[53] The federal requirements for vocational rehabilitation counselors to have a master's degree in rehabilitation counseling and/or to be eligible to take the Certified Rehabilitation Counselor certification exam has made it increasingly difficult to fill vacancies with qualified individuals. As a result, agencies have established distance learning programs to assist current employees in obtaining the appropriate credentials. However, once counselors meet the federal standards, they tend to leave state employment for higher paying jobs with private rehabilitation or federal entities.

Epidemiologist Shortage

Currently, the 69 employed epidemiologists employed by HHS agencies are responsible for monitoring health status, diagnosing and investigating health

[49] PeopleSoft HSAS Database as of 3/10/04.
[50] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2004-05 Edition, Pharmacists, on the Internet at http://www.bls.gov/oco/ocos079.htm (visited April 07, 2004).*
[51] State Classification Office, Texas State Auditor's Office, *2003-04 Hospital and Health Care Professional, Nursing, and Allied Services Personnel Compensation Survey, p. 943.*
[52] State Auditor's Office. "Automated Applications for Risk Assessment, Planning, and Analysis." SAO web page http://www.sao.state.tx.us/Resources/AutoApps/default.cfm last accessed March 10, 2004.
[53] Ibid.

hazards, evaluating the effectiveness of health services, and monitoring and responding to health emergencies caused by bioterrorism.
Vacant positions are typically hard to fill because of the high level of education required for this profession. According to the National Assessment of Epidemiologic Capacity, 28.6 percent of epidemiologists have doctoral level training, 40 percent have masters level training, 18.4 percent have bachelor level training, and 13 percent have various other types of education qualifications.[54]

Sanitarian Shortage

Currently, the HHS Enterprise employs 121 sanitarians across the state. Historically, the challenge has and will continue to be filling vacancies in rural areas of the state. The state requirement for sanitarians to be registered and have at least 30 semester hours of science has made it increasingly difficult to fill vacancies with qualified individuals. An additional factor affecting recruitment is the need to find qualified individuals, those of whom have the ability to target inspectional duties in order to reduce food borne illnesses, including the ability to understand the risks and the specific pathogens, and their method of action in the human body.

Additionally, the HHS Enterprise routinely loses trained sanitarians to local health departments who pay on average, $5,000 more per year. Nationally, the Food and Drug Administration (FDA) and the U.S. Department of Agriculture (USDA) pay from $10,000 to $20,000 more per year.

MODIFICATIONS TO CORE HHS FUNCTIONS

A core HHS function that may soon be greatly modified is the determination of eligibility for HHS benefits. As directed by HB 2292, the HHSC must determine whether eligibility-determination call centers are cost effective, and who should staff them (state and/or private sector employees). Because this core function is currently being performed by a large portion of HHS employees (7,489 employees),[55] this decision, if adopted, may result in significant reductions-in-force, and the increased use of technology and streamlined processes to increase productivity.

[54] National Assessment of Epidemiologic Capacity, 6.
[55] PeopleSoft HSAS Database as of 3/10/04.

ANALYSIS OF CURRENT AND PROJECTED GAPS IN THE HHS WORKFORCE

A review of the current and future workforce has indicated gaps in areas related to infrastructure, recruitment, retention, and employee development.

INFRASTRUCTURE GAPS

At present, HHS agencies are transitioning to consolidated and streamlined organizational structures. The transformation of these organizational structures necessitates a corresponding development and adjustment of communication channels for agency leadership and program management. Due to this changing environment, there is currently only tentative communication and limited working relationships between HHS HR and management within the newly formed HHS agencies. As management's commitment to workforce planning process is critical to its success, complete communication channels and collaborative working relationships must be instituted for these groups.

Additionally, the future composition of the HHS workforce has not yet been determined. The exact number and types of staff that will be needed in the new and streamlined organizational structures are not yet known. There are numerous changes that must be made to HHS Enterprise programs and services to achieve cost savings, efficiencies, and a streamlined system of service delivery.

Finally, the HHS infrastructure needed to support workforce planning is not yet completely in place. Though the development of an overall infrastructure, policies, and procedures has begun with the adoption of common HR policies, many other needed policies and procedures have not yet been finalized.

RECRUITMENT GAPS

Currently, the HHS agencies do not attract enough qualified applicants for critical and/or difficult to fill jobs. Current data indicate that the HHS Enterprise will continue to experience difficulties in filling difficult to fill and critical shortage positions, such as pharmacist, epidemiologist, vocational rehabilitation counselor, sanitarian, protective services, direct care, nursing, pharmacy, and similar occupations.

To compete in the future, the HHS Enterprise will need to develop and implement aggressive recruitment activities and strategies

RETENTION GAPS

Within the HHS Enterprise there is high rate of attrition among younger employees, less tenured employees, and employees performing stressful jobs.

To compete in the future, the HHS Enterprise will need to focus on the development and implementation of employee retention strategies and competitive compensation and benefit programs.

EMPLOYEE DEVELOPMENT GAPS

Currently, the HHS administrative training program does not conduct training needs assessments and/or provide training opportunities for all HHS employees. To develop and improve employee competencies, the HHS Enterprise will need to determine the competencies needed for future and current job responsibilities. Once competencies are defined, employees' skills will need to be assessed and appropriate training provided.

Additionally, key staff members are leaving HHS agencies. The large number of employees retiring or seeking employment elsewhere is a growing problem for the HHS Enterprise. The HHS Enterprise does not currently have a plan in place to address this issue.

STRATEGIES FOR ADDRESSING HHS WORKFORCE GAPS

The HHS agencies are transitioning to new consolidated and streamlined organizational structures. Only upon the completion of this transition will it be possible to fully implement workforce strategies that address the needs of the HHS Enterprise and the individual HHS agencies.

Before traditional recruitment, retention, and employee development strategies can be implemented, the HHS Enterprise must do the following:

- Establish a complete network of collaborative working relationships with managers.
- Determine where the HHS workforce will be located.
- Identify the organizational functions that will be performed by state employees.
- Determine what job skills critical to the successful functioning of the HHS Enterprise and the individual HHS agencies.

The goals presented in the following strategies section reflect these priorities.

HHS HR intends to take a lead role in developing and implementing the strategies proposed in the workforce plan and will work with HHS agencies during this process. The timing of this implementation is dependent upon the completion of the HHS agencies transformation into new consolidated and streamlined organizational structures. After the transition is complete, the HHS workforce planning staff will work with the individual HHS agencies to develop and implement strategies that address their emerging needs.

The implementation of the workforce plan may also be affected by the potential outsourcing of HHS HR. After issuing a Request for Proposals for HR services, the HHSC announced in June 2004 a tentative contract award to Convergys to provide human resources, timekeeping and payroll services for health and human services agencies. It is anticipated that the contract negotiation period will be completed in mid-July. Depending on the results of this potential outsourcing, the role of HHS HR will likely change.

TRANSITION AND INFRASTRUCTURE STRATEGIES

COMMUNICATION AND WORKING RELATIONSHIPS

Gap	HHS HR has tentative communication and limited working relationships with leadership and program management of the HHS agencies.
Goal	Establish collaborative working relationships between HHS HR staff and leadership and program management of the individual HHS agencies.
Rationale	Gaining management's commitment to the workforce planning process is critical to developing an effective workforce plan. Due to the current uncertainties, HHS HR has taken the lead in developing this workforce plan. However, management support must be obtained before any plan can be implemented.
Strategies	♦ Obtain support from senior leaders in the HHS Enterprise. ♦ Communicate benefits of workforce planning to program managers. ♦ Involve leaders, managers, and employees in future workforce planning processes. ♦ Solicit continuous feedback for improving and modifying the workforce planning process.

WORKFORCE COMPOSITION

Gap	The future composition of the HHS workforce has not yet been determined.
Goal	Confirm the location of HHS staff, organizational structures, lines of authority, and job skill requirements.
Rationale	The consolidation of programs and outsourcing may result in a realignment of existing jobs, requiring employees to acquire new skills. Future skill needs may be different from those currently projected or previously reported in workforce plans. To address workforce skill needs, it is important to first know what the remaining job functions will require. The first step in that process is to identify the remaining staff and assess the requirements of the remaining jobs.
Strategies	♦ Determine the number and location of HHS staff. ♦ Determine what jobs have been outsourced and what assignments/jobs remain. ♦ Determine skills and competency levels required for the remaining jobs. ♦ Determine the availability of staff with required competencies. ♦ Identify jobs where succession planning is appropriate.

HHS INFRASTRUCTURE

Gap	The HHS infrastructure needed to support workforce planning at the Enterprise level is still being defined and developed.
Goal	Establish the policies, procedures and infrastructure required to support the HHS Enterprise workforce planning efforts and strategies.
Rationale	Through the review of research and prior workforce planning efforts it is possible to glean a great deal of information regarding successful workforce planning strategies. Even though the current level of communication between HHS HR leadership and HHS agency management has been limited, the review of demographic data and questionnaires has provided some guidance to HHS HR regarding the workforce planning needs of HHS agencies. The most commonly identified need is for the infrastructure, policies, and procedures to support the implementation of workforce planning strategies. HHS HR will need to take the lead in developing the overall infrastructure, policies, and procedures, and then working with leadership and management of the HHS agencies to customize workforce strategies for each agency.
Strategies	♦ Consult with Financial Services and management staff to design and fund a compensation program that will attract, retain, and reward employees. Compensation strategies for some HHS agencies might include the use of: o promotions; o merit raises, including one-time merit awards; o retention bonuses; and o hiring above step one in selected positions. ♦ Explore development and implementation of a career ladder system, in compliance with HB 2292, to help counter criticism regarding the lack of advancement opportunities and impact of management/supervisory restrictions. ♦ Seek legislative approval for increasing the pay of employees in hazardous duty positions. Texas Department of Criminal Justice (TCDJ) policies, the Schedule C pay schedule, and legislation could serve as a model. ♦ Identify available HHS programmatic and administrative training resources (funds, trainers, etc.).

	♦ Develop an on-line version of a training needs assessment instrument and implement an annual assessment. ♦ Create/contract for an administrative training program. ♦ Develop and implement a succession planning program for management and leadership. ♦ Create an on-line system to implement/track competency training and succession planning. ♦ Develop the capability to provide computer based training. ♦ Develop strategies for identifying and cross-training employees affected by outsourcing or reductions-in-force. ♦ Revise policies and procedures to require employee development plans for all employees, except those in 'terminal jobs.' ♦ Develop a manager/supervisory/leadership training program designed to improve on-the-job training, coaching, recognition, and supervision provided to employees. ♦ Develop an HHS internship program to attract future employees in difficult to fill job classes. ♦ Update antiquated, lengthy, and time consuming hiring practices. ♦ Establish flexible work schedules conducive to retaining staff, including the use of o telecommuting, o job sharing, o part time jobs for nurses, and o flex hours ♦ Conduct parity studies of jobs classified similarly to address disparity among individuals with the same job but different responsibilities and/or FLSA designations. ♦ Develop an HHS Wellness Program to promote organizational satisfaction, reduce employee stress, and reduce turnover. ♦ Create an HHS system that will target recruitment needs and track recruitment efforts to determine the most efficient techniques and effective use of HHS funds. ♦ Develop an HHS employee recognition program. ♦ Adjust policies and procedures to attract the retiree population for difficult to fill shortage occupations and contingent workforce opportunities.

AGENCY STRATEGIES FOR HHS ENTERPRISE

RECRUITMENT STRATEGIES

Gap	HHS agencies do not attract enough qualified applicants for critical and/or difficult to fill jobs.
Goal	Establish efficient and effective recruiting initiatives to attract an abundance of qualified applicants.
Rationale	If HHS agencies are to recruit the right workers in the right jobs at the right time, the agencies must recognize there is a competitive market for good workers and take appropriate actions.
Strategies	♦ Implement an HHS internship program to attract future employees in hard to fill job classes. ♦ Identify and cross-train employees who are designated for reductions-in-force. ♦ Build processes to coordinate work between managers and HHS HR recruitment staff to create customized recruitment strategies based on managers' affirmative action goals, current/future program priorities, and specific job vacancies. ♦ Increase recruitment efforts for 'critical' occupations, such as: o Nurses; o Pharmacists; o Vocational Rehabilitation Counselors; o Epidemiologist; and o Sanitarians. ♦ Provide tools to assist understanding of hiring process. ♦ Prepare and implement diversity recruitment plans to attract applicants from untapped ethnic and gender groups. ♦ Use aggressive recruiting efforts, such as extensive internet recruiting, attendance at technical job fairs, and same day hiring at job fairs. ♦ Develop media presentations to assist in recruiting efforts. ♦ Post jobs using the full salary range to provide applicants with more competitive salaries. ♦ Rehire skilled retirees.

RETENTION STRATEGIES

Gap	There is high rate of attrition for younger employees, less tenured employees, and employees performing stressful jobs.
Goal	Create an environment whereby employees and applicants will view their HHS agency as an employer of choice, thereby increasing the average employee service tenure and significantly reducing the turnover rates for select positions.
Rationale	Due to limited funding, excellence goes unrewarded, and mediocre job performance carries few consequences. If HHS agencies are to retain good employees, then employees need to be treated well and rewarded for outstanding job performance. HHS HR will concentrate on improving the use of financial incentives, internal communications, and employee recognition.
Strategies	♦ Obtain funding and implement a compensation program intended to attract, retain, and reward employees, and make salaries more competitive. Compensation strategies for some HHS agencies might include the use of: o promotions; o merit raises, including one-time merit awards; o retention bonuses; and o hiring above step one in selected positions or within a range. ♦ Develop strategies to address early turnover, including provide realistic picture of job during interview process. ♦ Survey employees to identify the reasons for turnover to make SAO Exit Survey Report more 'informational.' ♦ Grant administrative leave for outstanding performance. ♦ Establish flexible work schedules to retain staff and meet the needs of HHS agencies, including the use of: o Telecommuting; o job sharing; o part time jobs for nurses; and o flex hours. ♦ Audit HHS agency positions and create career ladders, where job duties are clearly differentiated within job series, to counter the lack of advancement opportunities and the impact of management/supervisory restrictions.

	♦ Implement manager/supervisory training programs to ensure that new employees receive better on-the-job training, coaching, recognition, and supervision. ♦ Develop peer mentoring programs to ensure that employees receive adequate support from lead workers. ♦ Implement an HHS employee recognition program to ensure that employees know that their work is valued and appreciated. ♦ Implement an HHS Wellness Program to promote organizational satisfaction, reduce employee stress, and reduce turnover. ♦ Allow employees to use educational leave, stipends, and scholarships to prepare employees for future employment in 'critical' or 'hard to fill positions'. ♦ Conduct parity studies of similar positions and FLSA designations, then pay comparable salaries for employees performing the same type of jobs. ♦ Seek hazardous duty pay for employees who handle difficult clients or who are routinely placed in hazardous conditions. ♦ Implement strategies to hire 'soon to be qualified' individuals - even if they have not completed required certifications. ♦ Develop employee mentoring and 'new hire' socialization programs. ♦ Explore opportunities for job rotation, sabbaticals, job sharing, etc. for employees in extremely difficult and stressful jobs. ♦ Extend practice allowing rehired retirees to return to "critical" former occupations as regular employees at a rate of up to 94 percent of their previous base salary. MHMR currently allows exceptions for: o Direct care staff (includes MHMR services series employees); o Case Workers; o Nurses; o Pharmacists; o Physicians; o Psychologists; and o Therapists.

EMPLOYEE DEVELOPMENT STRATEGIES

Gap	The current HHS administrative training program does not conduct training needs assessments and/or provide training opportunities for all HHS employees. Programmatic training is not consistently being provided across the HHS agencies.
Goal	Develop competent managers, supervisors, and employees.
Rationale	The HHS Enterprise does not effectively access employee competence. The HHS Enterprise must assess employees' training needs, and then provide training for employees to develop and maintain the competencies needed for their current and future job responsibilities.
Strategies	♦ Implement annual on-line training needs assessments. ♦ Implement a Distance Learning program. ♦ Provide computer based training opportunities ♦ Allow out of state travel for employees working in 'specialized' jobs. ♦ Provide 'Administrative' training on the following: o change management; o project management; o contract management; o supervisory/management/leadership; o technical training; o customer service; o research; o data analysis; o communication/interpersonal skills; and o technology. ♦ Provide programmatic and job specific training. ♦ Allow employees to use educational leave, stipends, and scholarships.

SUCCESSION PLANNING

Gap	Key staff members are leaving HHS agencies. The large number of employees retiring or seeking employment elsewhere is a growing problem for the HHS Enterprise.
Goal	Create a succession planning program to prepare staff to take over key positions and to modify the performance evaluation system to require professional development plans.
Rationale	The training and development of current employees to fill key positions is critical to the future success of the agencies. In response to this problem, the HHS Enterprise should develop a systematic process for maintaining continuity in leadership and service quality within the organization by creating pools of staff qualified for advancement to positions of greater responsibility. The program could have two tracks: (1) a certification track designed to prepare selected staff for succession into the highest levels of responsibility, and (2) a self-directed track designed for employees at any level who are interested in professional development.
Strategies	♦ Implement a succession planning program. ♦ Require employee development plans to be developed for all supervisors and employees.