

HUMAN SERVICES, DEPARTMENT of
Annual Performance Progress Report (APPR) for Fiscal Year (2007-2008)
Proposed KPM's for Biennium (2009-2011)

Original Submission Date: 2008

2007-2008 KPM #	2007-2008 Approved Key Performance Measures (KPMs)
1	PEOPLE WITH DISABILITIES IN COMMUNITY SETTINGS – The percentage of individuals with developmental disabilities who live in community settings of five or fewer.
2	SENIORS LIVING OUTSIDE OF INSTITUTIONS – The percentage of Oregon’s seniors who are living outside of institutions
3	OVRS CLOSED - EMPLOYED – The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.
4	SPD EMPLOYMENT – The percentage of Seniors and People with Disabilities (SPD) consumers participating in an employment program who are employed.
5	TANF (WELFARE) EMPLOYMENT – The percentage of Temporary Assistance to Needy Families (TANF) adults placed for whom employment is a goal.
6	TANF (WELFARE) RE-ENTRY – The percentage of Temporary Assistance to Needy Families (TANF) cases who do not return, or are off of cash assistance 18 months after exit due to employment.
7	TANF FAMILY STABILITY – The percentage of children entering foster care who had received TANF cash assistance within the prior two months.
8	TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.
9	ENHANCED CHILD CARE – The percentage of child care providers who are providing enhanced quality of care.
10	AVERAGE EARNINGS FOR SPD CLIENTS – Average monthly earnings for persons with developmental disabilities who receive Seniors and People with Disabilities (SPD) services.
11	FOOD STAMP UTILIZATION – The ratio of Oregonians receiving food stamp assistance to the number of Oregonians living in poverty.
12	DOMESTIC VIOLENCE – The percentage of women subjected to domestic violence in the past year.
13	TEEN SUICIDE – The rate of suicides among adolescents per 100,000.

2007-2008 KPM #	2007-2008 Approved Key Performance Measures (KPMs)
14	TIMELY ADOPTION – The median number of months from date of latest removal from home to finalized adoption.
15	CHILD RE-ABUSE – The percentage of abused/neglected children who were re-abused within 6 months of prior victimization.
16 a	RE-ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES – The percentage of seniors and adults with disabilities who are re-abused within 12 months of first substantiated abuse: seniors.
16 b	RE-ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES – The percentage of seniors and adults with disabilities who are re-abused within 12 months of first substantiated abuse: adults with disabilities.
16 c	RE-ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES – The percentage of seniors and adults with disabilities who are re-abused within 12 months of first substantiated abuse: developmental disabilities.
17	INTENDED PREGNANCY – The percentage of births where mothers report that the pregnancy was intended.
18	EARLY PRENATAL CARE FOR LOW INCOME WOMEN – The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy.
19	COMPLETION OF ALCOHOL AND DRUG TREATMENT – The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD.
20	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of adults employed after receiving Alcohol and Drug treatment.
21	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment.
22	8TH GRADER RISK FOR ALCOHOL AND DRUG USE – Percentage of 8th graders at high risk for alcohol and other drug use.
23	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of children whose school performance improves after receiving alcohol and drug treatment.
24 a	TOBACCO USE – Tobacco use among adults.

2007-2008 KPM #	2007-2008 Approved Key Performance Measures (KPMs)
24 b	TOBACCO USE – Tobacco use among youth.
24 c	TOBACCO USE – Tobacco use among pregnant women.
25	CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.
26	CHILD IMMUNIZATIONS – The percentage of 24 – 35 month old children served by local health departments who are adequately immunized.
27	INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.
28	HIV RATE – The annual rate of HIV infection per 100,000 persons.
29 a	ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS– The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: adults.
29 b	ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS– The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: children.
30 a	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: African Americans.
30 b	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: Native Americans.
30 c	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: Asian/Pacific Islanders.
30 d	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: d) Hispanic.
30 e	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: White.

2007-2008 KPM #	2007-2008 Approved Key Performance Measures (KPMs)
31	SAFETY NET CLINIC USE – The percentage of uninsured Oregonians served by safety net clinics.
32	MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.
33	CUSTOMER SERVICE - Percentage of customers rating their satisfaction with DHS above average or excellent: overall, timeliness, accuracy, helpfulness, expertise, availability of information.

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
NEW	<p>Title: ADEQUACY OF PRENATAL CARE FOR OHP CLIENTS - The % of pregnant OHP clients who received an adequate number of prenatal care visits while on OHP</p> <p>Rationale:</p> <p>This measure will gauge the adequacy of prenatal care while on OHP. This measure is one of two new measures that replace the Early Prenatal Care for Low Income Pregnant Women measure shared by the Public Health Office of Family Health (OFH) and DMAP (KPM#18). Both DMAP and OFH struggled with the old measure because the data sources did not align with the program efforts of each division. In addition, the original data source, the PRAMS survey, changed an income range question several times and determining the number in the household was problematic. Using the birth certificate dataset as the source did not align with DMAP's administrative data of OHP clients. DMAP and OFH agreed to discontinue sharing this measure and have each developed their own prenatal care KPM that better reflects their specific roles in improving prenatal care.</p>
NEW	<p>Title: 8TH GRADER USE OF ALCOHOL - The % of 8th graders who have used alcohol within the past 30 days</p> <p>Rationale: This is one of two measures being proposed to replace KPM #22 - 8th grader risk of alcohol and drug use. AMH proposes to track alcohol and other drug use separately. Many prevention efforts target these two issues separately, so they should be tracked in a similar manner.</p>
NEW	<p>Title: 8TH GRADER USE OF ILLICIT DRUGS - The % of 8th graders who have used illicit drugs within the past 30 days.</p> <p>Rationale: This is one of two measures being used to replace KPM #22 - 8th grader risk of alcohol and drug use. AMH proposes to track alcohol and other drug use separately. Many prevention efforts target these two issues separately, so it should be tracked in a similar manner.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
NEW	<p>Title: CHILD MENTAL HEALTH SERVICES - The % of children receiving mental health services who are suspended or expelled from school</p> <p>Rationale: This measure is specific to children/adolescents receiving mental health services and is an important measure to children/adolescents, their caregivers and stakeholders. It represents a key outcome for services.</p>
NEW	<p>Title: ADULT MENTAL HEALTH SERVICES - The % of adults receiving mental health services who report positively about the outcomes of those services.</p> <p>Rationale: This is a general measure which takes into account self-perceived improvement in domains of functional living for adults and points to issues of whether or not the services are making a difference in a person's life.</p>
NEW	<p>Title: EARLY PRENATAL CARE - The % of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women.</p> <p>Rationale: The goal of this measure is to increase access to early prenatal care for all women and reduce the disparity in access between low-income and the general population. The gap in access to prenatal care has been widening between low-income and all other births, even as prenatal care rates are stable for the whole population. The PHD, Office of Family Health (OFH) promotes early prenatal care through the Oregon MothersCare Program, Family Planning and the Preconception Health Initiative. Other state and community services and private health care providers also promote early access to prenatal care in coordination with PHD programs. This KPM will evaluate the effectiveness of the state and local system of services and programs that provide, promote and coordinate prenatal care for all pregnant women, especially for low-income and underserved women.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
NEW	<p>Title:</p> <p>HIV/AIDS - The proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment.</p> <p>Rationale: After considering DHS' stated the intent of KPMs as agency-specific outcomes that reflect program contribution to benchmarks, The HIV/STD/TB (HST) Program of the Office of Disease Prevention and Epidemiology, State Public Health Division proposes an alternative KPM that more closely reflects the performance of client- and population-based services. Specifically, HST proposes to substitute HIV/AIDS rate as a KPM (while supporting its continued use as a Progress Board Benchmark) with another program-specific outcome, "Proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment."</p> <p>Reducing the number of new HIV cases should continue to be a shared goal for all Oregonians. Its achievement is likely to be a result of collaborative effort by academia, public health, community-based organizations and individual citizens. Interviewing newly reported HIV cases to collect relevant case data for monitoring the epidemic, informing uninfected partners of cases, and referring people to appropriate care represents a large part of the work HST does to prevent disease and more directly relates to agency performance than the higher level goal of reducing the rate of new infections.</p>
NEW	<p>Title: RESTRAINT RATE - Reduction in restraint hours per thousand patient hours at Oregon State Hospital.</p> <p>Rationale: Restraint techniques never provide beneficial patient treatment, although restraint is used at times for patient safety. The goal at OSH is to minimize the use of restraint. All staff has been trained in techniques to avoid the use of restraint.</p>
NEW	<p>Title: Problem Gambling - The % of adults who gamble much less or not at all 180 days after ending problem gambling treatment.</p> <p>Rationale: This measure follows up with people who have received problem gambling treatment 180 days after the treatment ends to see if treatment had an impact.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
NEW	<p>Title: ENHANCED CHILD CARE - The % of children receiving an enhanced quality of care</p> <p>Rationale: This measure is being proposed to capture the percentage of children receiving enhanced quality of care and is a better representation of the quality of care provided to children receiving child care services through DHS.</p>
NEW	<p>Title: FOOD STAMP UTILIZATION - The ratio of Oregonians served by food stamps to the number of low-income Oregonians.</p> <p>Rationale: A data source change from the Food Stamp Management Information System and Census estimates to the Program Access Index published by Food and Nutrition Services significantly changes the ratio. PAI is one of the measures FNS uses to reward states for high performance in the administration of the food stamp program. This measure provides a consistent comparison of Oregon to other states. The PAI is a simple index of the average monthly number of food stamp participants over the course of a calendar year to the number of people with incomes below 125% of the official poverty line in each state. FNS computes average monthly participation over a calendar year - rather than the federal fiscal year - to better align the participation count with the annual poverty measure.</p>
NEW	<p>Title: ABSENCE OF REPEAT MALTREATMENT - The % of abused/neglected children who were not subsequently victimized within 6 months of prior victimization.</p> <p>Rationale: Modifying to the inverse of the 2007-09 measure to be consistent with Federal Child & Family Services Review measure.</p>
NEW	<p>Title: LENGTH OF STAY AT OSH - Reduction in overall length of stay at Oregon State Hospital</p> <p>Rationale: Reducing the length of stay at OSH demonstrates efficient and effective care, helping to move individuals to the least restrictive level of care needed. Most OSH admits are controlled by judicial decisions and discharges are dependent on bed availability in community mental health agencies.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
NEW	<p>Title: Timeliness and Permanency of Reunification and Timeliness of Adoptions</p> <p>Rationale: This KPM assesses progress, timeliness, and permanency as they relate to reunification and adoption goals for children in foster care. This KPM reflects measures that the federal government uses to assess state performance on Federal Child and Family Services Reviews. Measures imbedded within this KPM are:</p> <p>Timeliness of reunification, permanency of reunification, timeliness of adoptions of children discharged from foster care, progress toward adoption for children in foster care for 17 months or longer, and progress toward adoption of children who are legally free for adoption.</p>
NEW	<p>Title: INTEGRATED EMPLOYMENT SETTINGS - % of people with developmental disabilities who receive SPD services who are working in integrated employment settings.</p> <p>Rationale:</p> <p>People with developmental disabilities who are employed value their wage-earning capacity. People are better able to achieve a desired lifestyle. People become less financially dependent over time on long-term state and federal programs.</p>
NEW	<p>Title: DD - SUPPORT SERVICE WAIT LIST - % of eligible adults who are receiving adult support services.</p> <p>Rationale:</p> <p>Clients and client advocates of SPD believe that receiving care in a timely manner is important to a person's independence, safety and ability to contribute to their support.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
NEW	<p>Title: FOOD STAMP ACCURACY - The % of accurate food stamp payments</p> <p>Rationale: Based on LFO recommendation that the department add the program's current outcome measure reflecting accuracy in determining eligibility for benefits as a second KPM.</p>
NEW	<p>Title: ACCESS TO I&R AND I&A - Increase access to accurate and consistent Information & Referral and Information & Assistance for people who are not currently served by SPD</p> <p>Rationale: By 2025 Oregon's population of seniors will have nearly doubled. Additionally, the numbers of people with disabilities of all kinds are increasing. The expected influx of new clients will severely challenge Oregon's capacity to assure access to quality care.</p>
NEW	<p>Title: PREVENTIVE SERVICES FOR OHP YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP</p> <p>Rationale: This measure is based on line 004 of the prioritized list of health services entitled: Preventive Services for Birth for over age of 10. The Health Services Commission has recently re-prioritized the list placing prevention services at the top on lines 003 and 004 reflecting their importance for OHP clients. Basing the measure on the prioritized list connects the measure to the reimbursement and policy priorities of the Oregon Health Plan. The list guides the pricing of DMAPs reimbursement to managed care plans of which 80% of OHP clients are enrolled for physical health services.</p>
NEW	<p>Title: PREVENTIVE SERVICES FOR OHP CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP</p> <p>Rationale: This measure is based on line 003 of the prioritized list of health services entitled: Preventive Services for Birth to 10 years of age. The Health Services Commission has recently re-prioritized the list placing prevention services at the top on lines 003 and 004 reflecting their importance for OHP clients. Basing the measure on the prioritized list connects the measure to the reimbursement and policy priorities of the Oregon Health Plan. The list guides the pricing of DMAPs reimbursement to managed care plans of which 80% of OHP clients are enrolled for physical health services.</p>

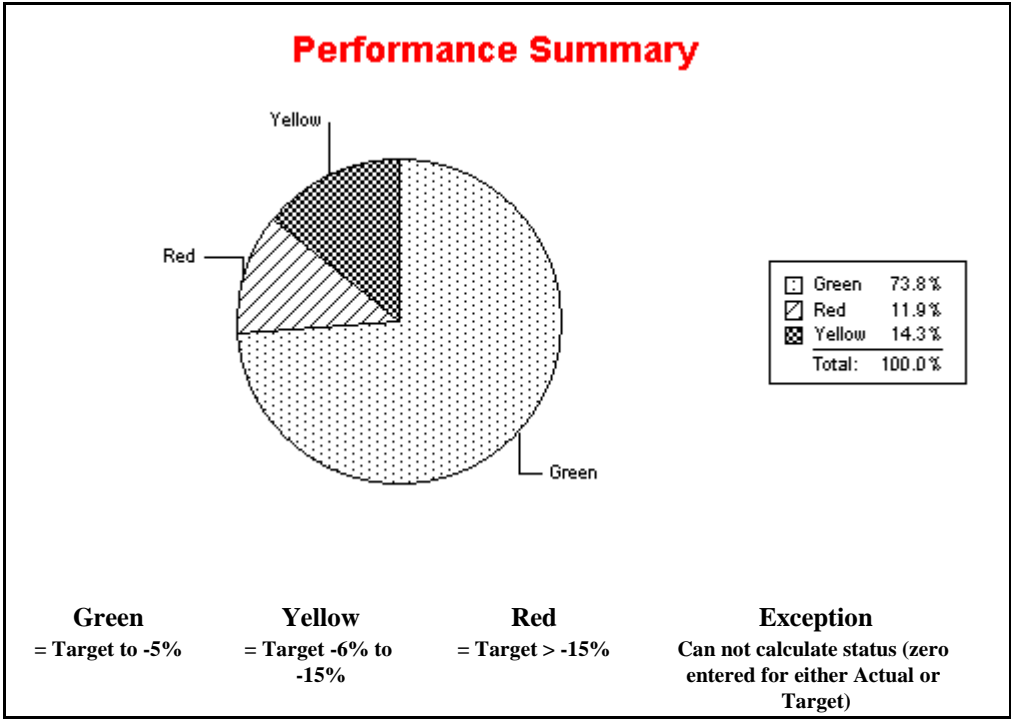
New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
NEW	<p>Title: ACS HOSPITALIZATIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients</p> <p>Rationale: Good primary care dramatically reduces the risk of hospitalization. A cornerstone of the Oregon Health Plan is emphasizing preventive services so that these admissions are less needed. Ambulatory Care Sensitive (ACS) conditions involve diagnoses where timely and effective ambulatory care (usually primary care) can help prevent or reduce the risk of hospitalization. There are three types of ACS conditions: chronic conditions, acute conditions and preventable illnesses.</p>
DELETE	<p>Title: ENHANCED CHILD CARE – The percentage of child care providers who are providing enhanced quality of care.</p> <p>Rationale: Change to "The % of children receiving an enhanced quality of care". This measure is being modified to capture the percentage of children receiving enhanced quality of care and is a better representation of their quality of care provided to children receiving child care services through DHS.</p>
DELETE	<p>Title: 8TH GRADER RISK FOR ALCOHOL AND DRUG USE – Percentage of 8th graders at high risk for alcohol and other drug use.</p> <p>Rationale: This measure is being dropped to focus on actual alcohol and drug use.</p>
DELETE	<p>Title: RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: White.</p> <p>Rationale: DHS is proposing to replace this measure with one that focuses on prevention services.</p>
DELETE	<p>Title: RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: d) Hispanic.</p> <p>Rationale: DHS is proposing to replace this measure with one that focuses on prevention services.</p>
DELETE	<p>Title: RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: Asian/Pacific Islanders.</p> <p>Rationale: DHS is proposing to replace this measure with one that focuses on prevention services.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
DELETE	<p>Title: RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: Native Americans.</p> <p>Rationale: DHS is proposing to replace this measure with one that focuses on prevention services.</p>
DELETE	<p>Title: RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: African Americans.</p> <p>Rationale: DHS is proposing to replace this measure with one that focuses on prevention services.</p>
DELETE	<p>Title: ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS– The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: children.</p> <p>Rationale: DHS is proposing to replace this measure with one that focuses on prevention services.</p>
DELETE	<p>Title: ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS– The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: adults.</p> <p>Rationale:</p> <p>DHS is proposing to replace this measure with one that focuses on prevention efforts. This measure can be broken out by race and ethnicity.</p>
DELETE	<p>Title: HIV RATE – The annual rate of HIV infection per 100,000 persons.</p> <p>Rationale: Modifying to better reflect program contributions and performance of client and population-based services.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
DELETE	<p>Title: CHILD IMMUNIZATIONS – The percentage of 24 – 35 month old children served by local health departments who are adequately immunized.</p> <p>Rationale:</p> <p>We are proposing to drop this measure and track it internally.</p>
DELETE	<p>Title: EARLY PRENATAL CARE FOR LOW INCOME WOMEN – The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy.</p> <p>Rationale: Proposed modification to focus on prenatal care in the first 3 months of pregnancy.</p>
DELETE	<p>Title: CHILD RE-ABUSE – The percentage of abused/neglected children who were re-abused within 6 months of prior victimization.</p> <p>Rationale: Modifying this measure to the inverse to be consistent with Federal Child & Family Services Review measure.</p>
DELETE	<p>Title: DOMESTIC VIOLENCE – The percentage of women subjected to domestic violence in the past year.</p> <p>Rationale: Proposing to drop this measure, to develop a more meaningful measure of DHS' impact. New measure to be proposed for 2011-13 biennium.</p>
DELETE	<p>Title: AVERAGE EARNINGS FOR SPD CLIENTS – Average monthly earnings for persons with developmental disabilities who receive Seniors and People with Disabilities (SPD) services.</p> <p>Rationale: This is not a large program within DHS and does not fit the criteria of a KPM.</p>
DELETE	<p>Title: FOOD STAMP UTILIZATION – The ratio of Oregonians receiving food stamp assistance to the number of Oregonians living in poverty.</p> <p>Rationale: A new measure is being proposed to reflect a change in the data source.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2009-2011
DELETE	<p>Title: TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.</p> <p>Rationale: DHS' role in this issue is relatively small compared to its other programs, and the measure has limited value as a measure of DHS' performance.</p>
DELETE	<p>Title: TANF (WELFARE) EMPLOYMENT – The percentage of Temporary Assistance to Needy Families (TANF) adults placed for whom employment is a goal.</p> <p>Rationale: DHS will be proposing measures that better reflect the restructured TANF program.</p>
DELETE	<p>Title: SPD EMPLOYMENT – The percentage of Seniors and People with Disabilities (SPD) consumers participating in an employment program who are employed.</p> <p>Rationale: This is not a large program within DHS and does not fit the criteria of a KPM.</p>

HUMAN SERVICES, DEPARTMENT of	I. EXECUTIVE SUMMARY
Agency Mission: Assisting people to become independent, healthy and safe.	
Contact: Cathy Iles, Administrative Services Division	Contact Phone: 503-945-5855
Alternate: Pam McVay, Finance and Policy Analysis	Alternate Phone: 503-945-5930



1. SCOPE OF REPORT

This report covers a broad array of programs throughout the Department of Human Services (DHS), such as employment, child well-being, independence of seniors, substance abuse risk and prevention, public health and many more that support the mission and goals of the agency. Of course there is no way to capture all the work of DHS with these measures, as there are more than 250 programs within the agency. The purpose of this annual performance report is to communicate the results of the work we do. While the primary audience of this report is the Oregon Legislature and other key stakeholders, it is also a communication tool for staff, other governmental agencies and the public.

2. THE OREGON CONTEXT

DHS helps achieve Oregon's goals: Quality jobs for all Oregonians; Safe, caring and engaged communities; and Healthy, sustainable surroundings. The 33 DHS Key Performance Measures support nearly 20 Oregon Benchmarks: #14 – Workers at 150% or more of poverty; #39 – Teen pregnancy; #40 – Prenatal care; #42 – Immunizations; #43 – HIV diagnosis; #44 – Adult non-smokers; #45 – Preventable death; #46 – Perceived health status; #48 – Available child care; #49 – Teen substance abuse; #50 – Child abuse or neglect; #51 – Elder abuse; #52 – Alcohol/Tobacco during pregnancy; #53 – Poverty; #57 – Hunger; #58 – Independent seniors; #59 – Working disabled; #60 – Disabled living in poverty. More information about Oregon Benchmarks and state partners can be accessed at http://www.oregon.gov/DAS/OPB/2005report/obm_list.shtml.

3. PERFORMANCE SUMMARY

We are making progress on nearly half (15) of our Key Performance Measures. Seven measures are not showing the desired level of results, and progress on the remaining 11 is unclear at this point.

4. CHALLENGES

Poor economic conditions and unemployment appear to have an influence on many of our measures. Cuts in funding and limited resources (such as staff and providers) have an impact on whether or not we can achieve our desired results. While some funding was restored during the 2007 legislative session, it will take some time to show the impact on our outcomes.

Other challenges include the fact that the work of DHS is complex and requires coordinated efforts to see an impact in the results. It's not uncommon for clients to have multiple barriers to face. They may have drug or alcohol abuse issues, involvement with law enforcement, be victims of domestic violence, or be unemployed. Many of our outcomes are about human behavior changes, such as teen pregnancy and alcohol and drug abuse, which makes it challenging to achieve the desired results.

It continues to be a challenge to connect the daily work of the agency to intermediate and high level outcomes. However, doing so will enable us to prioritize and clarify the results of what we do (effectiveness) and the importance of efficient processes, thereby creating a culture throughout DHS by which all managers and staff rigorously use performance measures and other metrics for decision-making, managing the daily work and driving improvements throughout the agency. More effective communication with the public and stakeholders of the value of DHS services is desired as we attempt to educate others about our role as good stewards of public resources.

5. RESOURCES AND EFFICIENCY

2007-09 Total Fund Budget by Division

This section provides overall budget and staffing resource information for DHS and the major program areas. More detailed program budget and

expenditure information is available online at <http://www.oregon.gov/DHS/aboutdhs/budget/index.shtml>

Division, % Funds, Total Funds (in millions)

CAF – Children, Adults and Families Division, 21%, \$2,528

DMAP – Division of Medical Assistance Programs, 40.1%, \$4,819

AMH – Addictions and Mental Health Division, 6.4%, \$766

PHD – Public Health Division, 4.2%, \$500

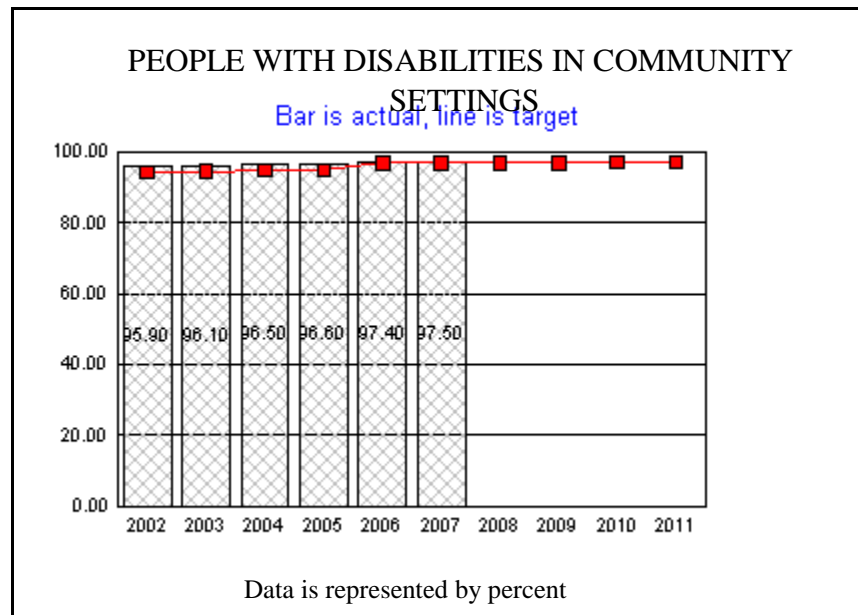
SPD – Seniors and People with Disabilities Division, 23.6%, \$2,836

ASD – Administrative Services Division, 4.0%, \$485

Capital Improvement/Construction, .7%, \$83

TOTAL FUNDS = \$12,017

KPM #1	PEOPLE WITH DISABILITIES IN COMMUNITY SETTINGS – The percentage of individuals with developmental disabilities who live in community settings of five or fewer.	2002
Goal	People are living as independently as possible.	
Oregon Context	DHS high-level outcome – Increase the percentage of Oregonians with a lasting developmental, mental and/or physical disability who could live on their own with adequate support.	
Data Source	Client Process Monitoring System (CPMS)	
Owner	Seniors and People with Disabilities, Trish Johnson, (503) 945-6445	



1. OUR STRATEGY

SPD provides alternatives to services previously provided in large congregate care settings. Critical partners include County Developmental Disabilities Programs, Oregon’s network of private service provider entities, and a variety of advocacy/stakeholder organizations.

2. ABOUT THE TARGETS

SPD provides opportunities to individuals with developmental disabilities to become better integrated with their local communities. By making it possible for people with developmental disabilities to live in small community settings, a reduction in maladaptive behaviors related to institutionalization has been seen, giving people a chance to experience living in environments that approximate those experienced by all other Oregon citizens. Additionally people with developmental disabilities can take advantage of everyday community life and involvement and take advantage of the opportunities this offers.

3. HOW WE ARE DOING

DHS has met or exceeded its target for the past six years.

4. HOW WE COMPARE

No national data is available for comparison for 2007.

5. FACTORS AFFECTING RESULTS

SPD, through the continued implementation of the Staley Settlement Agreement and development of Family Support and other in-home type services continues momentum in providing small community-based or family setting services to people with developmental disabilities. Continued implementation of Crisis diversion assists in keeping people from ICF/MR (Intermediate Care Facility for the Mentally Retarded) placement. PASRR- the Pre-Admission Screening Resident Review is a screening tool which is used to prevent the placement of individuals with mental illness or mental retardation / developmental disabilities (MR/DD) in a nursing facility unless their medical needs clearly indicate they require the level of care provided by a nursing facility. When placement into a nursing facility is ruled out, smaller, community based settings are explored. In-home support services and establishment of the Housing Trust Fund also support this measure.

SPD reviews the programs with people greater than five persons to determine their ability to fill vacancies in the program. Agencies are required to offer vacancies to individuals determined to be in crisis and in need of residential services. If the larger size program cannot meet the need due to low staff to high client ratio, programmatic changes may be required.

6. WHAT NEEDS TO BE DONE

SPD needs to preserve policy and funding structures that contribute to the maintenance and / or improvement of efforts for providing in-home

services to persons with developmental disabilities, and continued attention to the impact of aging family caregivers and their needs.

Next steps may include a focus on quality of life issues, particularly for those clients under age 18, and review of larger group homes with respect to their ability to meet the needs of the community.

7. ABOUT THE DATA

Reporting cycle is calendar year.

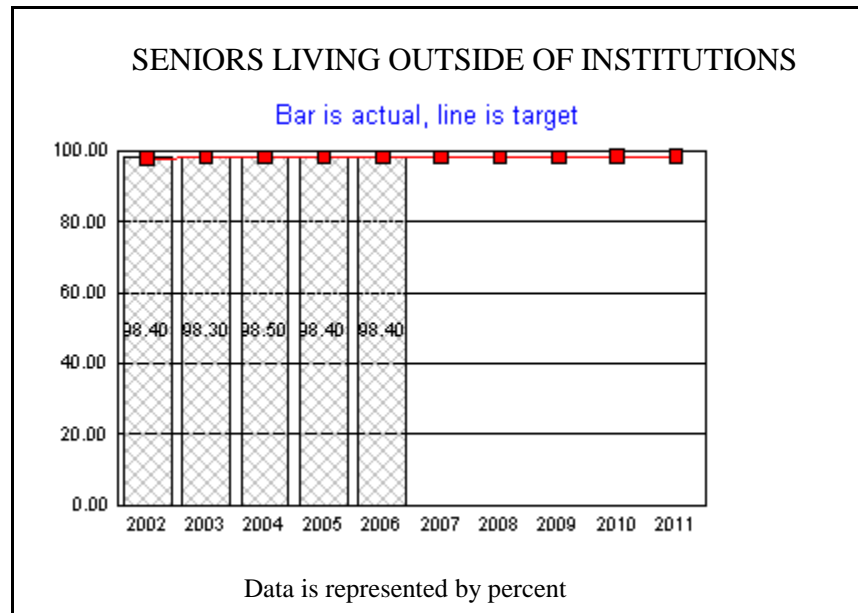
Data comes from the following sources:

- Client Processing Monitoring System (CPMS) - count of people receiving Case Management (Service Element 48)
- University of Minnesota Survey Count - CPMS aggregation of residents living in settings 7 or greater
- Eastern Oregon Training Center report # MPOP030-01 "Mental Health Division" Population Bulletin Data – count of residents at EOTC.

Data in CPMS is dependent on submission from counties and providers. While reports are delivered to counties and providers to provide them opportunities to correct and update data in CPMS, data is not always maintained in the system. Caseload count data is reviewed monthly.

University of Minnesota Survey Count data is only available as an aggregation of residents living in settings 7 or greater.

KPM #2	SENIORS LIVING OUTSIDE OF INSTITUTIONS – The percentage of Oregon’s seniors who are living outside of institutions	2002
Goal	Independence – People are living as independently as possible.	
Oregon Context	DHS high-level outcome – Independent seniors	
Data Source	Oregon Office of Health Policy and Research and Portland State University Population Research Center	
Owner	Seniors and People with Disabilities, Trish Johnson, (503) 945-6445	



1. OUR STRATEGY

This performance measure links to the DHS goal – “People are living as independently as possible.” This measure also links to Oregon Benchmark #58 and the DHS high-level outcome “Percent of seniors (over 65) living independently.” This measure concerns seniors and where they live. Institutionalization of people age 65 and older has historically been used as a marker of the degree to which seniors are living independently and has

been extensively tracked. A nursing facility is an institution; people who live in their own homes, in the homes of family, or in community based care settings, adult foster homes, assisted living facilities, and residential care facilities are considered to be living independently. DHS strategy continues to emphasize maintaining seniors in their home communities, outside of institutions, to the maximum extent possible.

2. ABOUT THE TARGETS

This measure is used by SPD to track its performance at helping seniors to age in their own communities. SPD recognizes that some people must be served in institutional settings, but some institutionalized individuals could receive services in other less restrictive settings if they were available. Oregon continues to be the nation's leader in identifying and establishing community based options to institutional care, and as a result, the values of choice, dignity, and independence for Oregon's senior and disabled citizens continue to be the focus of all agency activities.

3. HOW WE ARE DOING

Recognizing that institutional care is appropriate in certain circumstances for some individuals, and generally for short periods of time, this performance measure demonstrates a track record of maintaining an institutionalization rate of less than 3%, the best in the nation. The overwhelming majority of Oregon's seniors are exercising their right to choose the most independent living situation possible.

4. HOW WE COMPARE

DHS continues to maintain the lowest overall institutionalization rate of seniors of the 50 states.

5. FACTORS AFFECTING RESULTS

Hospitals continue to discharge patients "sicker and quicker". In many cases, hospital preference on discharge of a senior who needs additional care is a nursing facility. While institutional care may be appropriate for certain individuals for short periods of time, DHS must continue to aggressively ensure that seniors are appropriately discharged from nursing facilities.

6. WHAT NEEDS TO BE DONE

DHS should continue to develop community resources to address the needs of seniors who may not be able to live fully independently, but need not live in an institution. DHS was awarded a Money Follows the Person grant by the Centers for Medicare and Medicaid Services and has begun to help people move from nursing facilities to community settings. DHS has also increased activities to divert or relocate clients from nursing facilities to community settings. These steps will enable DHS to allow seniors and people with disabilities to remain in their communities after living in nursing

facilities.

7. ABOUT THE DATA

The OOHPR data for 2007 will not be available until February 2009. This measure will be updated at that time.

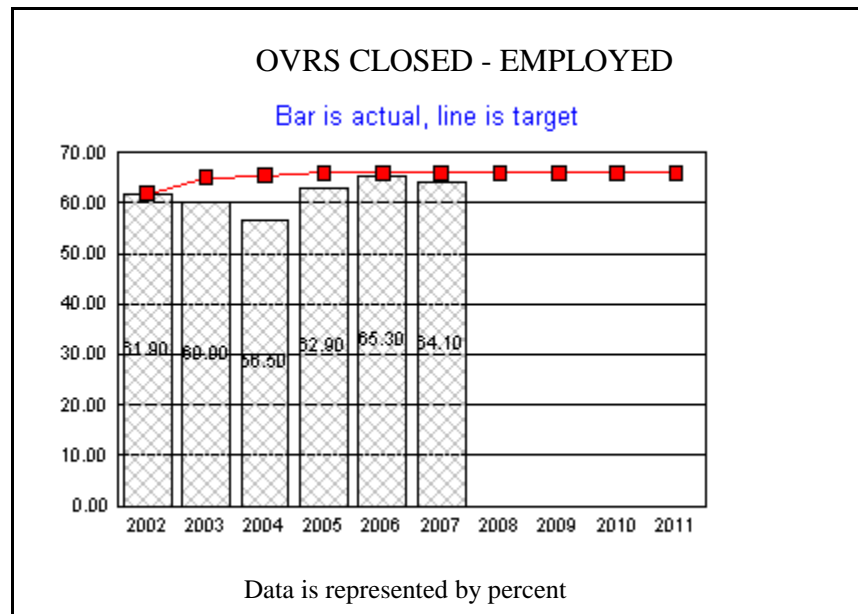
Reporting cycle is calendar year.

Data comes from the following sources:

- Oregon Office of Health Policy and Research (OOHPR) Nursing Facilities Survey
- Portland State University Population Research Center 2006 Oregon Population Report (https://stage.www.pdx.edu/media/p/o/PopRpt06_fnl7.pdf)

This Key Performance Measure was included in the Department's first performance audit during the summer of 2008. The DHS Internal Audit group certified that this key performance measure falls within the category of verified. The performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #3	OVRS CLOSED - EMPLOYED – The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.	1997
Goal	Goal Independence – People are living as independently as possible.	
Oregon Context	Percentage of individuals receiving services who had employment outcomes during the state fiscal year.	
Data Source	Office of Vocational Rehabilitation Services Core Performance Status Summary Report	
Owner	Owner Budget and Performance Unit, David Ritacco, 503-945-6720	



1. OUR STRATEGY

Obtaining and maintaining suitable

Employment is consistent with the Department’s goal of assisting people to live independently. This outcome measure shows how successful DHS and its partners are at helping people with disabilities become employed in local communities. Based on a Harris Survey of Americans with

Disabilities, “Two out of three unemployed people with disabilities would prefer to be working.” During State Fiscal Year 2007, VR clients who closed with employment earned an average wage of \$10.36 an hour and worked an average of 30 hours per week.

2. ABOUT THE TARGETS

This target, often internally referred to as the success rate, reports the percentage of vocational rehabilitation clients who have received services and maintained suitable employment for a minimum of 90 consecutive days and who have exited the program. A higher percentage indicates a better performance regarding this measure.

3. HOW WE ARE DOING

The Vocational Rehabilitation (VR) program continues to show excellent performance. VR has exceeded the Federal target of 55.8% over the past eight years. However, over the past 5 years, VR has not met the internal targets that have been set.

4. HOW WE COMPARE

All 50 states have a state run general VR program. The State of Oregon’s VR program is required to meet or exceed a national performance level of 55.8 percent. As such, this percentage is considered a minimum acceptable number. The State of Oregon’s VR program has exceeded this level every year since State Fiscal Year 2000.

5. FACTORS AFFECTING RESULTS

The State of Oregon unemployment rate affects the VR success rate. If there is a down turn in Oregon’s economy the VR placement rate drops. The variance in the measure is significantly influenced by factors outside the program’s control. The Oregon VR program provides vocational services to meet the needs of placing people with disabilities in jobs consistent with industry standards.

6. WHAT NEEDS TO BE DONE

The VR program will continue to conduct program monitoring and implement any necessary program improvements based on the data analysis.

7. ABOUT THE DATA

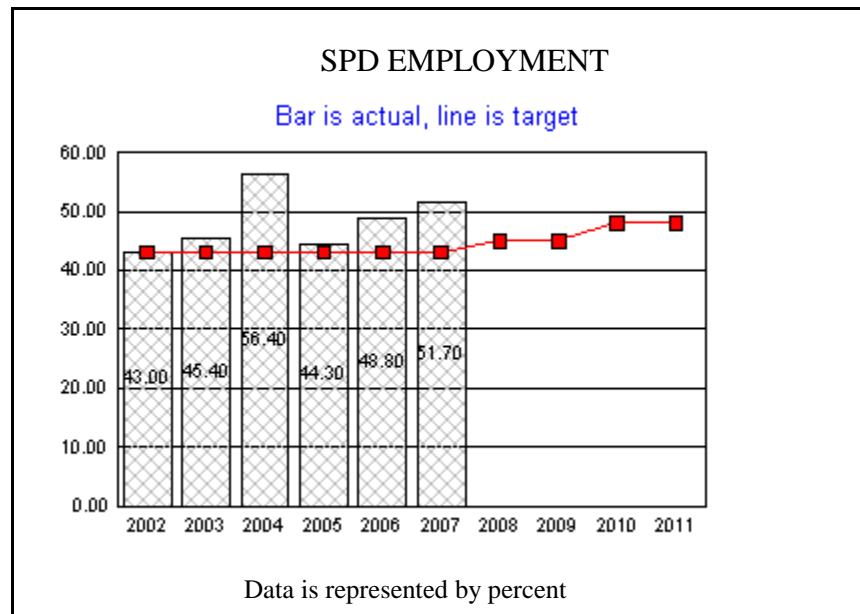
Reporting cycle - fiscal year. The success rate calculation is based on dividing the number of clients who exited the VR program in employment by

the number of clients who exited the VR program after receiving services, multiplied by 100.

VR relies on a state and federal relationship. Federal funding requires a state match of 21.3 percent and this has worked well for over 80 years but under the current appropriations, the VR program can meet the needs of only a small percentage of people with disabilities who live in Oregon. The VR program continues to look at state population distributions and have relocated staff to meet the increased demands in specific areas.

This Key Performance Measure was included in the Department's first performance audit during the summer of 2008. The DHS Internal Audit group certified that this key performance measure falls within the category of verified. The performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #4	SPD EMPLOYMENT – The percentage of Seniors and People with Disabilities (SPD) consumers participating in an employment program who are employed.	2002
Goal	People are living as independently as possible.	
Oregon Context	DHS high-level outcome – Oregonians with disabilities living in poverty	
Data Source	Oregon ACCESS, Orca2, Client Maintenance System (CMS) and Client Process Monitoring System (CPMS)	
Owner	Seniors and People with Disabilities, Trish Johnson, (503) 945-6445	



1. OUR STRATEGY

Seniors and People with Disabilities (SPD) continues to provide some employment programs and policies to help people address barriers in the workplace and afford them the opportunity to contribute to their household’s income, contribute to the cost of their care, and engage in community activities.

The Employed Persons with Disabilities (EPD) program was designed to enable people who have disabilities to work while still maintaining their Medicaid Coverage. Loss of Medicaid coverage, including personal attendant services has been identified as a major barrier to those persons with a disabling condition who desire employment.

SPD, Office of DD Services, has funds available that individuals may use for extra supports to achieve and maintain employment. In an effort to increase supported employment outcomes, the Office of DD Services has joined the State Employment Leadership Network (SELN). SELN is a 13-state collaborative sharing effective policies, strategies and technical assistance. 2007 was a planning year. Some impact of SELN recommended activities should be seen in 2007 and beyond.

2. ABOUT THE TARGETS

The Legislative Fiscal Office raised the targets for 2008 and 2009 from 43.0% to 45.0%. However, SPD has exceeded the 2006 and 2007 targets of 43.0%. The average percentage over the past three years is 48%. SPD may not be able to continue to achieve this level as the present employment market and tight human service budgets represent a threat to the employment of individuals receiving services from SPD. Achieving our target of 45% will represent significant efforts by SPD in light of the downward trend in employment of people with disabilities. Our hope is that we in fact exceed targeted levels and is reflected in our proposed targets for 2010 and 2011 of 48.0%.

3. HOW WE ARE DOING

DHS has met its target since 2002; however, a discrepancy was found in 2004 in how the data for this measure has been accessed in the past, resulting in prior year's performance reporting including only a portion of the people served. In 2005, this process was further refined as noted. Even with the adjustments to more accurately reflect the outcomes, SPD is maintaining at present levels.

4. HOW WE COMPARE

DHS has not compared this performance measure to other standards; however, as the measure is reconsidered, national standards for comparable programs and services will be sought for comparison.

When comparing employment data from the EPD program with other buy-in programs in the nation, Oregon has the fourth highest average earnings and are in the top ten in enrollment per capita.

Many state DD Programs are challenged with lower than desired performance. The Office of DD Services' participation in SELN will allow comparison of Oregon DD Programs to other states in 2008 and beyond.

5. FACTORS AFFECTING RESULTS

SPD clients require unique assistance in obtaining employment to help people live more independently by removing or reducing the barriers that make it difficult to obtain and maintain employment.

Additionally, as SPD continues to refine the data elements and sources, the outcomes will become more reflective of the actual results.

6. WHAT NEEDS TO BE DONE

SELN has assisted OR in completion of an analysis and strategic plan for DD Supported Employment for 2008-2011.

7. ABOUT THE DATA

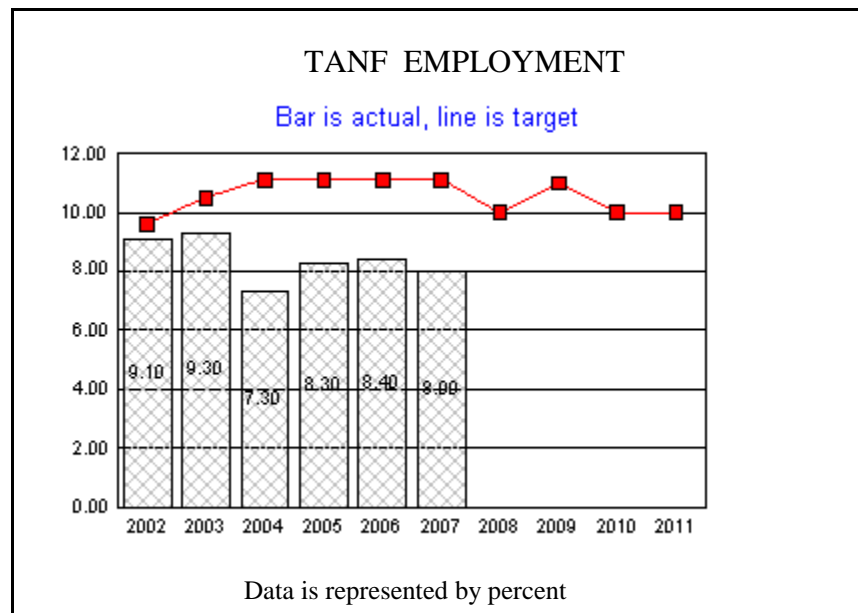
Reporting cycle is calendar year.

Data comes from the following sources:

- Client Processing Monitoring System (CPMS)
- Express Payment and Recovery System (eXPRS)
- Client Maintenance System (CMS)
- Oregon ACCESS
- Orca2

Data in CPMS is dependent on submission from counties and providers. While reports are delivered to counties and providers to provide them opportunities to correct and update data in CPMS, data is not always maintained in the system.

KPM #5	TANF (WELFARE) EMPLOYMENT – The percentage of Temporary Assistance to Needy Families (TANF) adults placed for whom employment is a goal.	1991
Goal	People are able to support themselves and their families.	
Oregon Context	This measure links to the DHS goal, “People are able to support themselves and their families.” It also links to Oregon Benchmark #14 and the DHS high-level outcome; “Percentage of covered Oregon workers with earnings of 150% or more of the poverty level for a family of four.”	
Data Source	Placement and Number of Mandatory JOBS Participants are pulled from the CAF Branch and Service Delivery Area Data monthly reports and totaled for the reporting period. The percent is determined by dividing Placements by the # of TANF recipients who are mandatory to participate in the JOBS program.	
Owner	Children, Adults and Families Division – Office of Self-Sufficiency, Xochitl Esparza, Interim TANF Manager, (503) 945-6122	



1. OUR STRATEGY

One of the department's goals is to assist families to support themselves. Finding and maintaining employment is critical to this goal. This indicator shows how successful DHS and its partners have been at helping people in the Temporary Assistance for Needy Families (TANF) program become employed. Most of these placements are 30 or more hours per week and result in families earning their way off monthly cash assistance. For most economically disadvantaged families, employment is the best avenue available for a better life.

2. ABOUT THE TARGETS

The 2002 placement target of 9.6% was a middle point between the 2000 and 2001 actual performance. The placement target gradually increased between 2002 through 2004 to a target level of 11.1%. Tighter definitions of "countable placements" were instituted in July 2003, although the target level was not adjusted. The Legislative Fiscal Office (LFO) recommended re-setting the target for 2008 to 10.0% to reflect the current performance and increased investments in the TANF/JOBS program.

3. HOW WE ARE DOING

2007 decreased by 0.4% from 2006. 8% of work-eligible JOBS participants report having secured new work each month. For clients, this represents either the first job, a return to the workforce, or a new job that allows them to earn enough to completely leave cash assistance. While it is hoped that JOBS clients will secure employment in the highest paying jobs possible, many times these first jobs pay minimum or near-minimum wages. It is believed that the best way for most individuals to become employed in higher wage jobs in the future is to build their experience and resumes over time. This is best explained by the phrase "First job, better job, career." This program helps clients enter or re-enter the workforce. In doing so, they can start up the ladder to a long-term career in the workplace.

4. HOW WE COMPARE

We are not aware of any public or private industry standards that would be a relevant comparison.

5. FACTORS AFFECTING RESULTS

The agency changed from using recorded placements to the counts of verified placements effective July 2007. This had an impact on the results of the calculation, and more accurately reflects the outcome of the agency's efforts, as it is a stricter standard. The economic picture has declined and the unemployment rate has continued to worsen.

Over the last decade the characteristics of TANF clients have dramatically shifted. Those able to get a job are able to do so relatively quickly. The sustained population left is more likely to have multiple barriers that need to be addressed. Given these factors, the target for 2008 has been lowered to 10% placed each month. This new target will reflect new investments in the TANF/JOBS program to better address clients needs. These new investments will provide additional assessment/evaluation services, additional employment and training opportunities, and new program elements such as Post-TANF employment support and State Family Pre-SSI/SSDI services for families applying for federal disability benefits. Additional case management supports, child abuse prevention services and administrative supports should also improve program outcomes.

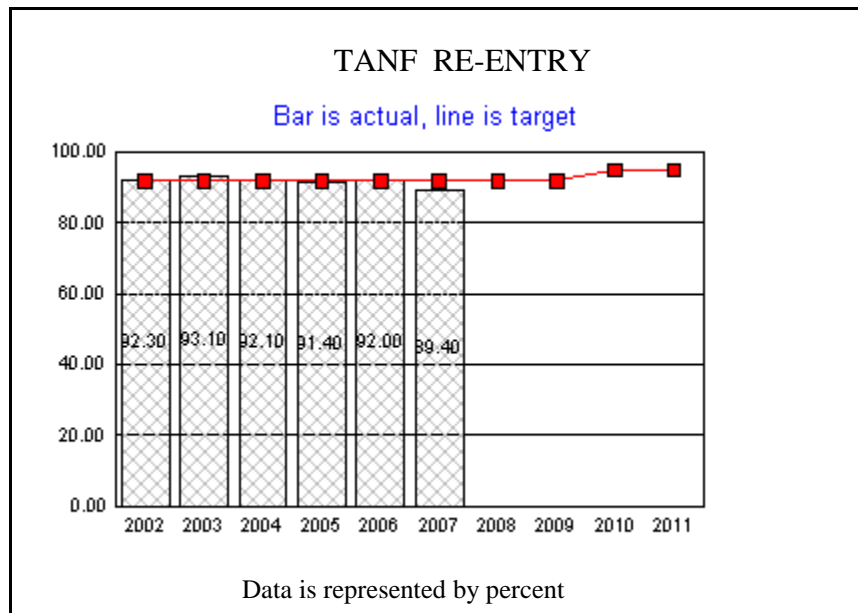
6. WHAT NEEDS TO BE DONE

We will closely monitor the implementation of the new TANF/JOBS program design to ensure the expected increased outcomes from the investments mentioned above are achieved. This monitoring will provide data on possible further program modifications. Further study of this measure is also needed to ensure it accurately reflects the TANF/JOBS program's new design. This measure may be modified in the coming years.

7. ABOUT THE DATA

Reporting cycle – calendar year. The data represented is run on a monthly basis, but reported annually. Reports are issued on a monthly basis and reviewed for potential anomalies and to identify trends in performance. The data is sent to program managers and interested parties. The methodology was changed effective July 2007 from using recorded placements to using verified placements (a more accurate count).

KPM #6	TANF (WELFARE) RE-ENTRY – The percentage of Temporary Assistance to Needy Families (TANF) cases who do not return, or are off of cash assistance 18 months after exit due to employment.	1991
Goal	People are able to support themselves and their families.	
Oregon Context	This performance links to the DHS goal, “People are able to support themselves and their families.” It also links to Oregon Benchmark #14 and the DHS high-level outcome; “Percentage of covered Oregon workers with earnings of 150% or more of the poverty level for a family of four.”	
Data Source	JAS/TRACS system placement data and Client Maintenance system public assistance data is used to determine the TANF clients who left TANF due to employment and did not return to case assistance ore were still off case assistance 18 months after case closed.	
Owner	Children, Adults and Families Division - Office of Self Sufficiency, Xochitl Esparza, Interim TANF Manager, (503) 945-6122	



1. OUR STRATEGY

One of the goals of the Temporary Assistance for Needy Families (TANF) JOBS program is to help clients find and keep employment. The longer clients can maintain employment, the higher their wages will be. DHS wants the TANF JOBS program outcomes to reduce incidences of returning to assistance. The department's strategies are focused on family stability and as part of this; we strive to give clients the tools they need to be successful in the workplace.

Our partners include other state agencies such as the Employment Department and Community Colleges and Workforce Development. We also work closely with county –based services, JOBS program providers, and community social service partners.

2. ABOUT THE TARGETS

Our objective is to increase the number of former TANF clients who do not require future TANF cash assistance. DHS used the 1991 performance data to develop a baseline. The target was determined by adding 1% to the baseline performance. The target has remained at a high rate. Our goal is to maintain the high level of success in this area. Due to new investments in the TANF/JOBS program, specifically the new Post-TANF employment support program, the performance for this measure should begin increasing in 2009. The target for this measure increases to over 95% by 2010. This performance measure may be modified in the coming years to better reflect the new TANF/JOBS program design.

3. HOW WE ARE DOING

89.4 of TANF clients that left public cash assistance due to employment between January 2007 and December 2007 were not receiving cash assistance 18 months later. This continues to indicate that a larger majority of TANF clients that leave the program due to employment are having relative success in the workplace, or have found other resources to maintain their own and their family's financial independence. The full impact of the October 2007 TANF redesign will take some time to be realized. While the new program investments were projected to increase the performance of this measure, the effects of the current economy reflect increased need for TANF services.

4. HOW WE COMPARE

There are no relevant public or private industry standards that directly compare to this measure.

5. FACTORS AFFECTING RESULTS

This measure may be affected by several things, including the status of the labor market and industry, the effectiveness of the JOBS program that

determines, coordinates, and provides services to assist TANF clients find and retain employment, and offer strategies to enhance wage gain efforts. As mentioned above, the new Post-TANF program, which will offer on-going cash payments to eligible former TANF recipients and applicants who enter employment, will increase the performance on this measure. Investments in improved assessment/evaluation services, case management and employment and training services should better prepare clients to maintain employment once they leave the program. Changes in TANF Related Medical policy beginning in October 2008 allowing more families to qualify for Extended Medical Assistance may also increase performance in the coming years. The full impact of the October 2007 TANF redesign will take some time to be realized. While the new program investments were projected to increase the performance of this measure, the effects of the current economy reflect increased need for TANF services.

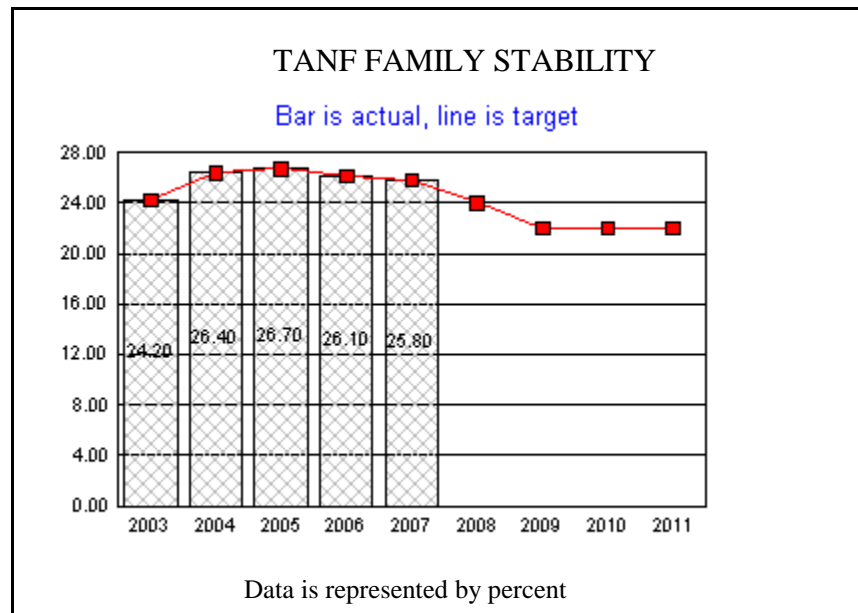
6. WHAT NEEDS TO BE DONE

We will closely monitor the implementation of the new TANF/JOBS program design for expected increased outcomes from the investments mentioned above. This monitoring will provide data on possible further program modifications. Further study of this measure is also needed to ensure it accurately reflects the TANF/JOBS program's new design. This measure may be modified in the coming years.

7. ABOUT THE DATA

Reporting cycle – calendar year. The methodology and criteria used to obtain the data is adjusted as program changes occur, to ensure the validity of the data. Recidivism and Placement reports are issued separately, on a monthly basis and studied for any potential anomalies, as well as to identify trends in performance. The data is sent to program managers and interested parties.

KPM #7	TANF FAMILY STABILITY – The percentage of children entering foster care who had received TANF cash assistance within the prior two months.	2007
Goal	People are safe	
Oregon Context	Oregon Benchmark #51 - Number of children per 1,000 persons under 18, who are: a) neglected/abused, b) at substantial risk of being neglected/abused.	
Data Source	Cumulative Federal Fiscal report cycle using AFCARS quarterly is used to identify the number of children entering foster care and Client Maintenance System to identify whether those children were from a household that received TANF cash assistance within the prior two months (referred to as TANF children). The number of TANF children is divided by the total number of children entering foster care for the federal fiscal year to arrive at the percent of children entering foster care who had received TANF cash assistance within the prior two months.	
Owner	Children, Adults and Families Division – Office of Self Sufficiency, Xochitl Esparza Interim TANF Manager 503-945-6122	



1. OUR STRATEGY

Develop and enhance TANF related programs and activities designed to strengthen and support families by addressing risk factors related to child abuse. This is accomplished through the expansion of family stability services through the Family Support and Connections program, increased financial support for families potentially eligible for SSI or SSDI, and on-going efforts around supporting families in accessing domestic violence and drug/alcohol related services. These new and on-going efforts combined will improve family stability by addressing risk factors related to child abuse and thus will contribute to fewer TANF children needing foster care placements.

2. ABOUT THE TARGETS

Targets are based on the 2003 through 2006 outcomes reported for this performance measure. The goal for this measure will be to decrease the number of children that enter foster care within two months of receiving TANF by 15 percent by the end of the 2007-09 biennium.

3. HOW WE ARE DOING

This is a new key performance measure and will be measured by a decrease in the number of TANF children entering the foster care system. Although the percentage has moved slightly, the number of TANF children entering foster care has significantly reduced. The reduction in the number of TANF children entering foster care is not accurately reflected in a percentage when both the denominator and numerator are changing at different rates.

4. HOW WE COMPARE

There is no other state measuring this data, nor is there an industry standard. Oregon is unique in its approach to this population.

5. FACTORS AFFECTING RESULTS

Program results can be impacted by:

1. Multiple child abuse risk factors present in families including alcohol or drug use, parental involvement with law enforcement, domestic violence, unemployment. Often, there are several of these factors in families of child abuse/neglect victims.
2. Voluntary parental participation in family strengthening programs and activities
3. Continuation of access to community based services that support family stability
4. Continuation of Federal, State and leveraged funding for direct services

The addition, investments made by the 2007 Oregon Legislature in the Family Support and Connections program, the State Family Pre-SSI/SSDI program, and the Post TANF program, will further support achievement of the targets for this measure in 2007-2009.

6. WHAT NEEDS TO BE DONE

DHS should continue to seek resources that meet the needs of families being served through the TANF program.

Enhance and strengthen partnerships with community partners that provide family-centered, preventative, and comprehensive services for children and families.

Provide training to staff on the correlations between child abuse risk factors and family stability efforts

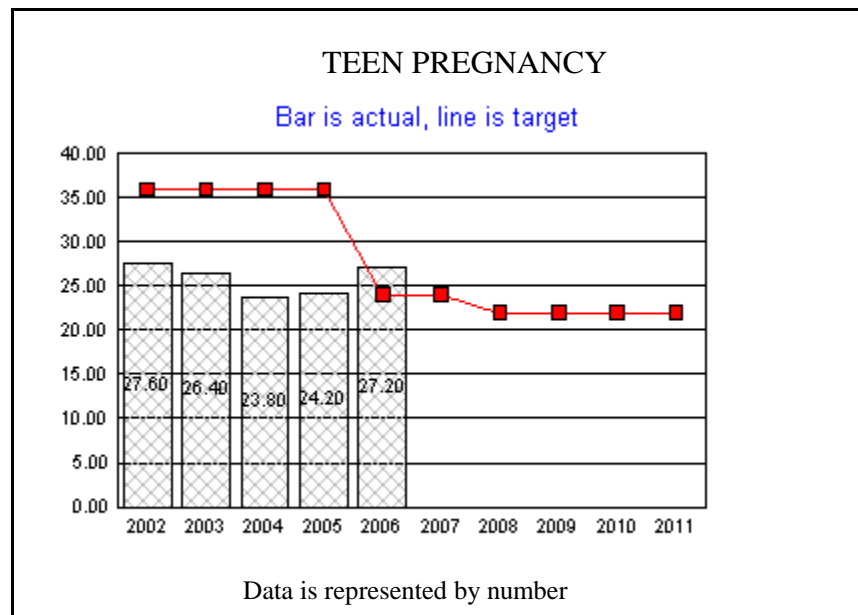
Continue to monitor data and trends related to family stability, child abuse and foster care utilization.

7. ABOUT THE DATA

Reporting Cycle - Federal fiscal year. Regarding the Data: The utilization of a percent is problematic. As the number of children in foster care decreases it appears the measure is moving in the wrong direction, which may not accurately reflect the true outcome of investments in this program. Absolute numbers will be tracked and reported as an internal outcome measure, which will provide the perspective for the requested change to percentage.

This Key Performance Measure was included in the Department's first performance audit during the summer of 2008. The DHS Internal Audit group certified that this key performance measure falls within the category of verified. The performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #8	TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.	2000
Goal	Self-Sufficient – People are able to support themselves and their families.	
Oregon Context	This performance measure links to the DHS goal, “People are able to support themselves and their families.” This measure also links to Oregon Benchmark #39 and the DHS high-level outcome, “Pregnancy rate per 1,000 females ages 15-17.”	
Data Source	DHS Health Services and PSU Center for Population and Census estimates....Based on births and induced terminations and population estimates provided by the Center for Population and Census.	
Owner	Children, Adults and Families Division, Belit Stockfleth (503) 947-5389	



1. OUR STRATEGY

The Governor approved a proposal for a new permanent, statewide Teen Pregnancy Prevention and Adolescent Sexual Health Partnership (TPP/SHP) to create a new strategic action plan for Oregon. The partnership includes the following:

- DHS/Children, Adults and Families Division (CAF)
- Commission on Children and Families
- Oregon Teen Pregnancy Task Force
- DHS/Office of Family Health
- Planned Parenthood Health Services of SW Oregon
- DHS/HIV Program
- Multnomah County Health Department, Adolescent Health Promotion
- Jackson County Health and Human Services
- Benton County Health Department
- Oregon Department of Education

2. ABOUT THE TARGETS

Teen pregnancy is still a major problem. Continuing to reduce the rate of teen pregnancy is a good investment. Oregon uses the 15-17 year-old category for its teen pregnancy KPM. This age group of females is usually still in high school and is targeted for intervention and education programs along with their male peers.

The number of pregnancies and population is small in many counties in Oregon. An aggregate rate was calculated for the 5 year period from 1998 to 2002. Five years of pregnancies were divided by 5 years of population data. This allowed for stabilization of rates in smaller counties. Aggregation allowed analysis of the smaller population areas of the state using rates and average number of pregnancies.

3. HOW WE ARE DOING

The State's teen pregnancy rate has consistently been lower than the national rate and the State has made great progress in reducing it even further over the past decade. Among 15-17 year-olds in Oregon, the pregnancy rate rose from 24.2 in 2005 to 27.2 in 2006.

4. HOW WE COMPARE

The most recent national teen pregnancy information available is for 2002, this is due to the delay in the reporting from states across the country. The national teen pregnancy rate was 42.3 for 2002 and the Oregon teen pregnancy rate for 2002 was 27.6.

5. FACTORS AFFECTING RESULTS

When dealing with teen pregnancy and prevention we will always be working with data that is at least 1 year behind. The factors affecting teen pregnancy that need to be addressed are not factors that can be changed quickly, because the factors that contribute to change in pregnancy trends are human behaviors - behavior changes that contribute to adolescents making healthy choices about sexuality.

6. WHAT NEEDS TO BE DONE

We will continue to use new and existing data that examine our statistics, trends, demographics and behavioral factors related to adolescent sexual health.

We have learned that successful strategies to reduce teen pregnancy must:

- Be long-term
- Be comprehensive
- Reach young people before they are sexually active and continue after they begin sexual activity
- Consider underlying risks and contributing factors, such as poverty and sexual abuse
- Utilize culturally sensitive approaches

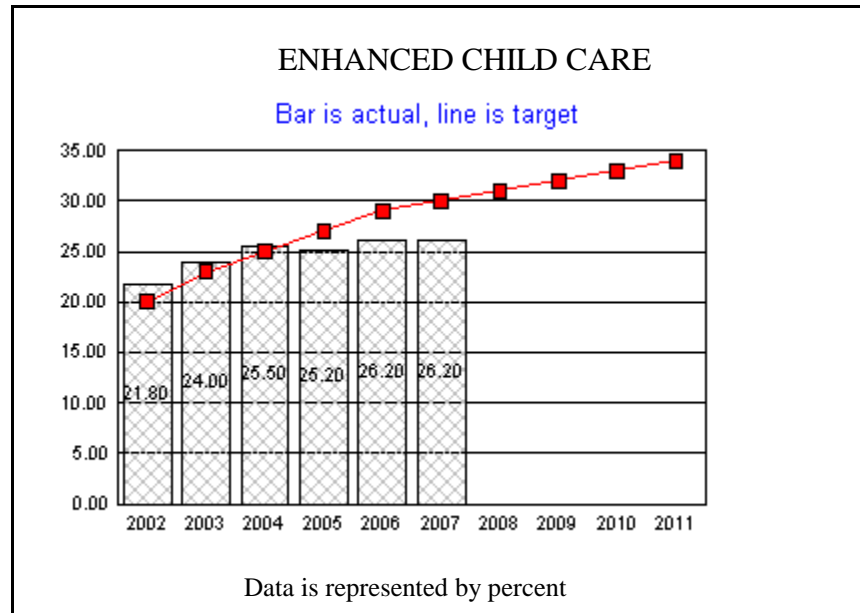
7. ABOUT THE DATA

Reporting cycle - calendar year. The data are generally 1 ½ to 2 years behind. The data, which are collected locally and out-of-state, cannot be pulled until the end of the full year. The data used here reflects the prevalence of pregnancy among teens aged 15-17.

Oregon data for 2006 is located here <http://www.dhs.state.or.us/dhs/ph/chs/data/arpt/06v1/section4.shtml>

National pregnancy data is found at <http://www.guttmacher.org/pubs/2006/09/12/USTPstats.pdf>

KPM #9	ENHANCED CHILD CARE – The percentage of child care providers who are providing enhanced quality of care.	2000
Goal	People are able to support themselves and their families.	
Oregon Context	This performance measure links to the DHS goal, “People are able to support themselves and their families.” With respect to children in care this measure links to the DHS goals, “People are healthy” and “People are safe.”	
Data Source	DHS Provider Pay system. Percent of child care providers paid through DHS Provider Pay system receiving the 7% enhanced rate.	
Owner	Children Adults and Families Division, Rhonda Prodinski (503) 945-6108	



1. OUR STRATEGY

To improve the quality of care available to subsidized families, DHS provides an incentive of 7% above the standard rate for license-exempt providers who meet the same basic training requirements that are required of licensed family providers.

DHS partners with Child Care Resource & Referral Agencies (CCR&R) and the Oregon Registry. The CCR&Rs assist with provider training that

is required to qualify for the DHS enhanced rate. The Oregon Registry documents provider training and encourages trained providers to care for families on the DHS subsidy. DHS, the CCR&Rs, and the Oregon Registry team together to publicize the enhanced rate.

2. ABOUT THE TARGETS

The targets were set based on an anticipated - and desired - increase in the numbers of providers who meet the training standards required to become licensed. These training standards promote child safety and well-being and enhance the quality of child care which encourages a more stable provider base. Stability in care arrangements promotes healthy child development and helps parents remain employed.

3. HOW WE ARE DOING

There was a steady increase in the percentage of providers receiving the enhanced rate from 2000 through 2004. This measure was consistently above target until 2005. The general trend in 2005 showed a decrease and was below target. Although 2006 remains below target it shows an increase over 2005. 2007 remains steady with no increase or decrease.

4. HOW WE COMPARE

Although a number of states have a tiered reimbursement system for child care providers, requirements vary too widely to draw meaningful comparisons.

5. FACTORS AFFECTING RESULTS

The large majority of providers who qualify for the enhanced rate are licensed. Since 1997, DHS maximum rates have fallen far below what most licensed providers charge. The result is that fewer licensed providers are willing to care for children whose parents receive a DHS subsidy. This has made it difficult to remain on target. However, the 2007 Legislature authorized significant rate increases that took effect October 1, 2007. This is expected to give parents increased access to licensed providers. In addition the Legislature authorized significant funding for outreach and training for license-exempt providers. The combination of more parents selecting licensed providers and increased investment in exempt provider training should result in a steady increase in the percentage of providers earning the enhanced rate.

6. WHAT NEEDS TO BE DONE

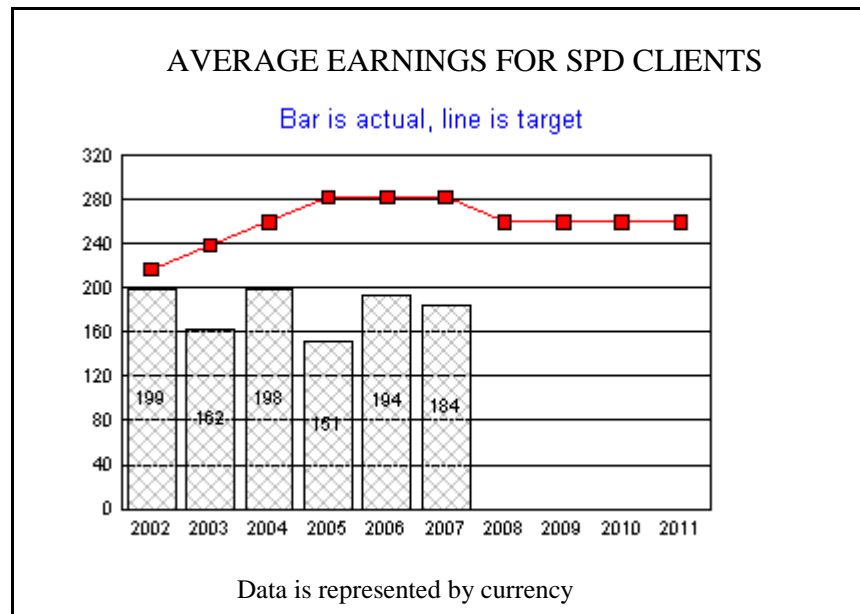
Efforts to inform parents and providers of the importance of quality child care and training must continue. Exempt providers are now represented by SEIU. DHS, Child Care Resource and Referral agencies and SEIU will be working together to promote the enhanced rate and help exempt

providers access the training required to earn the enhanced rate.

7. ABOUT THE DATA

Reporting cycle - calendar year. This measure is reported as a percentage. The data are taken from the DHS Provider Pay system and compares the number of providers earning the enhanced rate to the total number of active providers in the system. As a result, the number is very reliable. Any variance caused by possible coding errors would be too small to be statistically significant.

KPM #10	AVERAGE EARNINGS FOR SPD CLIENTS – Average monthly earnings for persons with developmental disabilities who receive Seniors and People with Disabilities (SPD) services.	1997
Goal	People are able to support themselves and their families.	
Oregon Context	Percent of Oregonians with lasting, significant disabilities living in households with incomes below the federal poverty level.	
Data Source	SPD Employment Outcomes System tracking those who receive SPD – Developmental Disability Employment services.	
Owner	Seniors and People with Disabilities, Trish Johnson, (503) 945-6445	



1. OUR STRATEGY

SPD will expand competitive employment opportunities for people with developmental disabilities. SPD is currently engaging providers (including private businesses) and other key stakeholders in discussions about strategies to create more employment opportunities for people with developmental disabilities. The agency is using grant and other resources to support this effort. Through this same effort the agency is looking at

methods to collect employment related data on clients served that is not included in currently available data sources.

2. ABOUT THE TARGETS

The 2008 and 2009 targets have been lowered. The population reported in the Employment Outcomes System (currently the only data source for measuring this outcome) has changed since many people whose employment services were previously reported in this system are no longer included in this data. The remaining population being reported via EOS is more complex in their support needs and their earnings data are generally lower.

3. HOW WE ARE DOING

SPD has not met the target since 2001.

4. HOW WE COMPARE

There is no current available data to make this comparison. However, communications with other states and national organizations indicate the lack of progress in obtaining competitive employment for persons with developmental disabilities is a nationwide concern. This concern has led to several new initiatives to address this concern. Most notable are initiatives by the Centers for Medicare and Medicaid Services (CMS) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS) Supported Employment Leadership Network (SELN). SPD is participating in both of these initiatives. SELN has assisted Oregon in completion of an analysis and strategic plan for DD Supported Employment for 2008-2011.

5. FACTORS AFFECTING RESULTS

The recent economic factors in recent years have had a negative impact on the opportunities for competitive employment for people with developmental disabilities. Paid employment opportunities have diminished and the stability/capacity of provider organizations that work to develop employment opportunities has been compromised. As mentioned above, the implementation in recent years of the Staley Settlement Agreement has changed the available data since several hundred people with developmental disabilities previously included in the data have changed their service arrangements and are no longer part of the data pool. Correspondingly, there are no data systems to collect wage information for people served under this new type of service arrangement.

6. WHAT NEEDS TO BE DONE

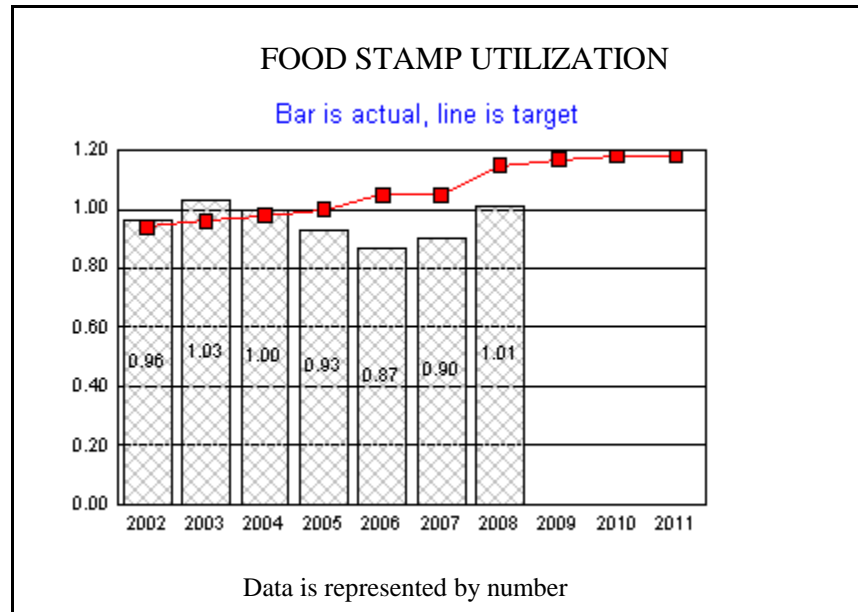
Efforts will continue towards developing strategies for training and collaboration, and creating new employment opportunities. A more critical review of the available outcome data and performance measurement issues will continue in order to align agency performance with meaningful targets. Key to these continuing efforts is SPD's participation in the national initiatives identified in response #4. With other DHS and community partners, SPD is participating in a 4-year CMS Medicaid Infrastructure Grant designed to increase competitive employment opportunities for people with disabilities. SPD is also participating along with 13 other states in the Supported Employment Leadership Network created by NASDDDS.

7. ABOUT THE DATA

Reporting cycle is fiscal year.

Data source is the Employment Outcomes Survey (EOS), September Report Executive Summary. Data collected is only for people with developmental disabilities who are living and working in state licensed and certified programs. EOS is a bi-annual snapshot of earnings as reported from surveys of employment providers of adults with developmental disabilities who are employed or are alternately employed. Historically, data used for this performance measure comes only from September EOS reports.

KPM #11	FOOD STAMP UTILIZATION – The ratio of Oregonians receiving food stamp assistance to the number of Oregonians living in poverty.	2001
Goal	People are able to support themselves and their families.	
Oregon Context	This performance measure links to the DHS goal, “People are able to support themselves and their families.” This measure also links to Oregon Benchmark #58 and the DHS high-level outcome, “Percent of Oregon households that are food insecure as a percentage of the US.”	
Data Source	Food Stamp Management Information System and Census estimates.	
Owner	Children, Adults and Families Division, Belit Stockfleth (503) 947-5389	



1. OUR STRATEGY

Our strategy is to continue our outreach efforts, improve and increase access and continue a focus on customer service. Outreach and education

efforts will continue to focus on the most vulnerable populations (children and elderly) and the most under-served (the elderly).

2. ABOUT THE TARGETS

It is possible for more than 100% of people living in poverty to receive food stamps; food stamp income eligibility extends to 185% of the federal poverty level. Fewer households at higher income levels complete the application process because of their relatively low benefit level. This makes the targets chosen a challenging but attainable goal.

3. HOW WE ARE DOING

Between December 2007 and December 2008, the Oregon food stamp case load increased by 15.5% (233,340 households in 12/07 to 269,623 households in 12/08).

4. HOW WE COMPARE

Oregon received \$1.9 million for being one of the top five states in food stamp participation for FY 2007. Food & Nutrition Services (FNS) ranking is based on the number of potential eligibles compared to the number receiving benefits. Under this ranking Oregon's participation rate for 2006 was 85% while the national average was 67%.

5. FACTORS AFFECTING RESULTS

Nationwide, the elderly are recognized as the most under-served population. Oregon has pursued and received a federal grant that will allow us to create a simplified on-line application process and expand outreach efforts to identify and neutralize barriers to food stamp participation.

While caseload has increased significantly in the last several years there was a period of time the federal Small Area Income and Poverty Estimates (SAIPE) increased more than caseload. The SAIPE has decreased over the past 2 years and our caseload continued to increase results in an

overall increase in the ratio.

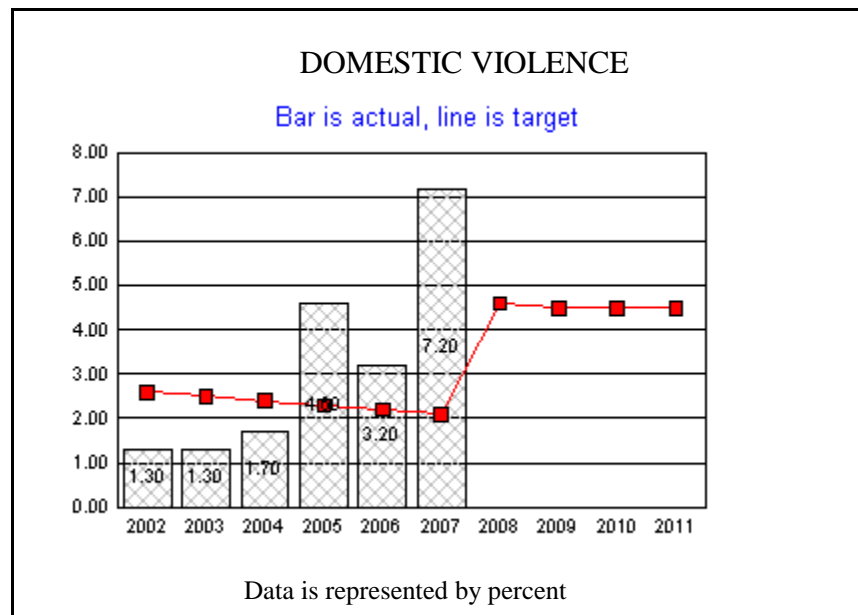
6. WHAT NEEDS TO BE DONE

Oregon continues efforts in outreach and customer service to reach more Oregonians; including working to increase population segments who are underserved.

7. ABOUT THE DATA

Reporting cycle - federal fiscal year. The Food Stamp Management Information system is compared to Census estimates of Oregonians living at or below the federal poverty level. The data has been adjusted to accurately reflect the US Census Bureau's Small Area Income and Poverty Estimates (SAIPE) numbers.

KPM #12	DOMESTIC VIOLENCE – The percentage of women subjected to domestic violence in the past year.	2002
Goal	Safe & Healthy – People are safe. People are healthy.	
Oregon Context	This performance measure links to the DHS goals, “People are safe” and “People are healthy.” This measure also links to Oregon Benchmark #45 and the DHS high-level outcomes, “Premature death: years of life lost before age 70”, and “Decrease domestic violence.”	
Data Source	Office of Disease Prevention & Epidemiology survey and database.	
Owner	Public Health Division, Lisa Millet (971) 673-1111	



1. OUR STRATEGY

DHS provides financial support to families who are fleeing or need to stay free from domestic violence. DHS is one of the state agencies that pass state and Federal Funds to domestic violence service providers across the state. The DHS DV Council has developed “Quality Assurance

Standards for DV Intervention and Prevention” as an effort to standardize DV related policies and practices across the department. DHS provides training in coordination with DV service providers to staff on the dynamics of domestic violence as well as DV related policies. DHS Human Resources workplace domestic violence policies (DHS-060-032) have been in place since 2004. DHS participated on a DAS work group which developed DV workplace policies (DAS 50.010.04) for all state agencies based on the Governor's Executive Order 07-17. DHS supports a coordinated community response and staff participate on statewide and local DV related committees, councils and task forces. DHS is represented on the AG’s Batterer Intervention Standards Advisory Committee as well as state and federal funding advisory committees.

2. ABOUT THE TARGETS

Progress in reducing domestic violence will be reflected in decreasing incidence rates over time.

3. HOW WE ARE DOING

Trend data are interrupted in 2005 by the introduction of a new risk behavior module in the Behavioral Risk Factor Surveillance Survey. The new module includes a series of new questions on interpersonal violence. Data for 2006 show an increase due to the new question module. The percentage increased in 2007 to 7.2%.

In 2005, the state published a cost report on violence against women that estimates that the cost of intimate partner violence exceeds \$50 million per year, nearly \$35 million of which is for direct medical and mental health care services. Health care expenditures represent more than two thirds of all costs related to domestic violence. The state increased slightly the funding for local services for victims in the 2007 legislative session.

4. HOW WE COMPARE

As yet there are no data that provide a way to measure Oregon’s progress in response to violence or prevention efforts. There is no evaluation conducted of funds spent on response and there are no funds spent on primary prevention. Other states are also introducing primary prevention plans and Oregon will be able to compare progress in implementing primary prevention with other states in the future.

5. FACTORS AFFECTING RESULTS

The state funds for response to DV are inadequate to meet the need. In addition, the state has not invested in any primary prevention activities, evaluation, public health data system, or research to address this problem.

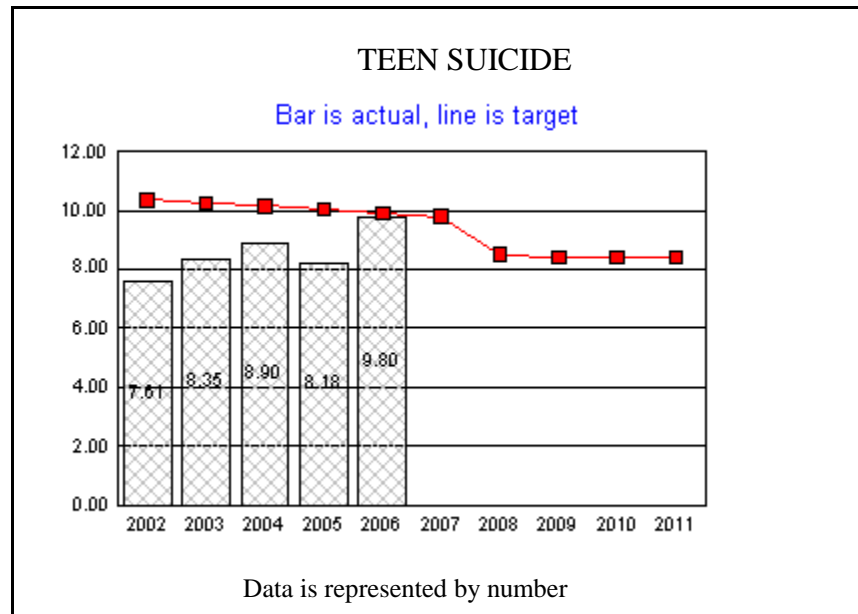
6. WHAT NEEDS TO BE DONE

The state needs funds to implement prevention activities as a means to reducing the incidence of violence. Responding alone will not reduce violence. The state needs to implement evaluation of existing response programs. A public health data system is necessary to better understand the incidence and prevalence of the problem.

7. ABOUT THE DATA

Reporting cycle - calendar year. The new DV module will provide a standard set of questions that Oregon and other states will use to measure self-reported violence. In years to come Oregon will be able to compare data with other states. Comparisons are not possible. Limitations of the data include the assumption that these estimates are under-reporting the problem. Self reported survey data should be combined with death and hospitalization data as well as service data from the response system (law enforcement and shelters) to provide an estimate of the overall problem.

KPM #13	TEEN SUICIDE – The rate of suicides among adolescents per 100,000.	2002
Goal	People are safe. People are healthy.	
Oregon Context	Preventable death	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Death Certificates) and Portland State University, Population Research Center (Population Estimates)	
Owner	Public Health Division, Office of Disease Prevention & Epidemiology, Injury Prevention & Epidemiology Program, Lisa Millet 971-673-1059	



1. OUR STRATEGY

The agency strategy is to encourage local organizations and agencies to integrate best practices and evidence based practices in suicide prevention

practices into existing infrastructure in schools, non-profit organizations and agencies. In addition, the agency is leveraging resources from federal agencies and foundations to support building projects. Projects include public health surveillance, development of interventions that will reduce risk factors and increase protective factors identified by data in individuals, families, communities and on the societal level, evaluate projects, and disseminate results broadly.

2. ABOUT THE TARGETS

Reducing suicides among youth will occur over time. The long-range target of reducing deaths is dependent upon:

- developing resources to fund prevention activities
- increasing awareness of the problem
- increasing community readiness to adopt suicide prevention strategies
- increasing the number of people working with youth who can intervene in suicidal behavior
- supporting parents in learning to monitor moods and communicate with youth
- teaching youth to take suicide talk seriously and report it to an adult
- establishing procedures and policies in schools
- providing health education on depression and suicide to youth and families
- providing bereavement support in communities
- enhancing crisis response
- increasing the number of school based health centers with enhanced ability to provide behavioral health services
- providing teens with problem solving and coping skills
- reducing the stigma associated with behavioral health care and with suicide
- improving screening and assessment that can identify youth at risk in all settings where youth are typically assessed
- providing training for professionals in health, behavioral health, and social services on suicide

Oregon's suicide rate among youth has been higher than the nation for over a decade. The rates in Oregon are comparable to rates in other Western states.

3. HOW WE ARE DOING

There are more activities being implemented in Oregon than ever before as a result of funding received from the Substance Abuse and Mental Health Services Administration. The state is piloting a new data form for the Adolescent Suicide Attempt Reporting System. This form will include

personal identifiers that will allow health departments to conduct community assessment activities to define access to care issues and inform prevention planning. The state is also working to expand the growth of a suicide intervention skills training program known as QPR across Oregon. School districts are being recruited in three regions to implement a comprehensive school based program known as RESPONSE. Funding for a state-wide conference has been requested through the Substance Abuse and Mental Health Services Administration as part of the Garrett Lee Smith Memorial Act grant. Eight colleges and universities are implementing suicide prevention on campuses as part of GLSMA funding to colleges. The Native American Rehabilitation Association is implementing a program known as No More Broken Feathers among tribes in the state. The Confederated Tribes of Warm Springs has implemented a program known as Native Hope. School Based Health Centers are receiving support to serve students on campuses funded to provide enhanced mental health services. The Applied Suicide Intervention Skills Training program is being offered in three regions of the state. The state is forming a statewide coalition to address suicide prevention. The Governor's Wrap Around Project is defining how the state can increase mental health services for children and youth in Oregon. The Healthy Kids Learn Better Coordinated School Health program has funded eight school based mental health enhancements in schools.

4. HOW WE COMPARE

The state rate of 8.2 per 100,000 (2005) is greater than the national rate of 7.1 per 100,000 (2005 national comparison data; 2006 national data not available at the time of this writing).

5. FACTORS AFFECTING RESULTS

There are not enough staff and resources to implement statewide efforts. While some communities have been able to develop prevention activities, there are big regions of the state where no efforts have been implemented. Funding for efforts is dependent on special grants and foundation awards. Access to behavioral health care and stigma about that care are barriers to intervention with youth and families in acute crisis. Lack of awareness about the problem of depression and suicide among youth is a barrier to engaging communities in investing in prevention strategies.

6. WHAT NEEDS TO BE DONE

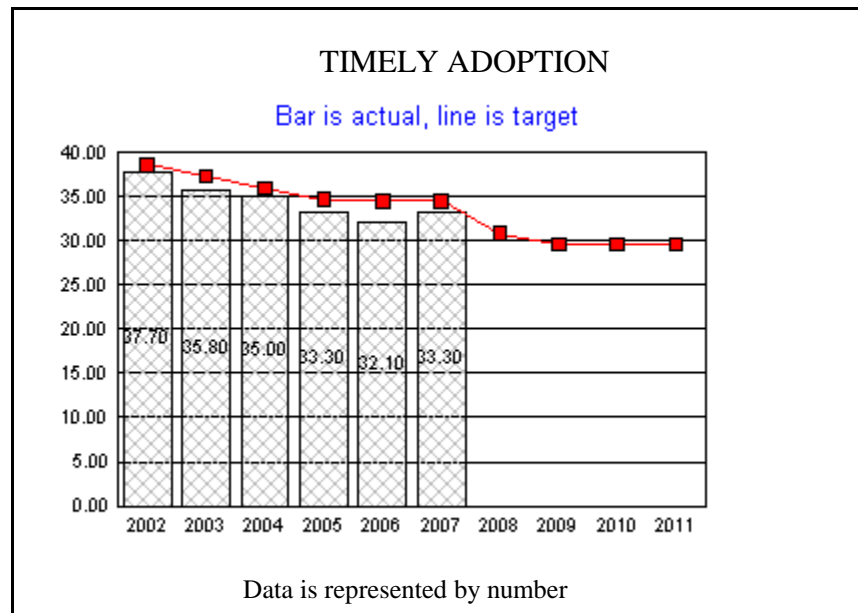
The state will work to learn lessons from the implementation of a three-year federal grant that will enable communities to hire staff and implement a multifaceted suicide prevention program. Evaluation of these efforts will provide information on how to broaden those efforts.

7. ABOUT THE DATA

Reporting cycle – calendar year. The data are provided by the Center for Health Statistics death certificate database. The data include youth aged

10-24 years of age. Some suicides may be excluded as local medical examiners may hesitate to rule a death a suicide due to stigma. Deaths are verified in two ways: through Oregon's Child Fatality Review system and through Oregon's Violence Death Reporting System.

KPM #14	TIMELY ADOPTION – The median number of months from date of latest removal from home to finalized adoption.	1997
Goal	People are safe.	
Oregon Context	This performance measure links to the DHS goal, “People are safe.” It also links to the DHS high-level outcome “Increase the percentage of children living in safe, nurturing families.” This measure focuses on timely achievement of adoption for children in foster care who are unable to return home.	
Data Source	AFCARS (Federal Adoption and Foster Care Analysis and Reporting System) table, which is derived from the State Child Welfare IIS data system.	
Owner	Children Adults and Families Division, Angela Cause, (503) 947-5358	



1. OUR STRATEGY

Increased monitoring and support of cases and families as they move through the process to finalization. While children need and deserve timely

permanency, the processes to terminate parental rights and establish a legal and emotional relationship with a new (adoptive) family is complex and time consuming. This process is being accomplished with due care given to protecting the civil rights of the biological family while at the same time assuring, as much as possible using good social work practice, that the child's new (adoptive) family will truly be permanent. This further promotes the agency goal of "people are safe."

2. ABOUT THE TARGETS

Oregon continues to exceed the target for median time to adoption for Federal Fiscal Years 2002 through 2007, however, the median months to adoption increased slightly from Federal Fiscal Year 2006 to 2007. The data demonstrate that Oregon continues to make steady progress toward reducing the time to achieve adoption.

3. HOW WE ARE DOING

Although 2007 reflects a slight increase in the length of time to achieve permanency via adoption Oregon continues to be well within the targeted standard. The agency maintains ongoing training to staff, as well as the review and modifications of policies and practices in order to sustain and even further reduce the time to permanency for children. The continual effort to streamline processes, procedures and paperwork to expedite the timeliest achievement of adoption for every child in need of this service is a primary focus. The agency has engaged and solicited input from community partners to help advance timeliness throughout the adoption process. The agency is committed to continuous quality improvement in its practices, which lead up to and result in termination of parental rights and adoption.

4. HOW WE COMPARE

The agency's performance on the median time to adoption has exceeded the targets for 2002 through 2007. Oregon's median time to achieve adoption is slightly higher than the national median of 32.4 months.

5. FACTORS AFFECTING RESULTS

Throughout 2003, the agency convened committees to study and revise the administrative rules relating to adoption, streamlining processes and paperwork, as well as inserting prescribed timeframes for the completion of many of the steps toward terminating parental rights and achieving adoption. The new administrative rules went into effect in January 2004, and by March 2004, child welfare staff and community partners in all Oregon counties were trained on these changes. The agency continued to identify and address barriers that impede timeliness to adoption throughout 2006 and 2007.

The 2007 Federal Child and Family Service Review (CFSR) stressed again essential areas impacting timeliness to adoption. Concurrent planning continues to necessitate attention. While the agency has implemented policies to direct practice regarding what activities constitute “concurrent planning,” there remains inconsistent effective statewide performance. Concurrent planning includes not only the identification of an alternate permanency plan for foster children whose permanency goal is “return home;” it also includes the achievement of concrete activities toward achieving the alternate permanency plan. Adoption and guardianship are the acceptable alternative plans, with adoption being the most preferred. Assessing, determining and executing the most appropriate alternative plan is essential to the department’s ability to achieve the adoption performance measure.

6. WHAT NEEDS TO BE DONE

Oregon has made steady progress toward reducing the time to achieve adoption for children in its care and custody who are unable to live safely and permanently with their families of origin. Nonetheless, the department needs to further examine its practices through its performance and continue to streamline and adjust them to further reduce the timeliness. The CFSR resulted in the need to develop action steps to be included in an agency Program Improvement Plan. The agency convened several meetings with community stakeholders to readdress the issue of timeliness to adoption. Particular attention was given to ways to improve concurrent planning. The intended outcome is to strengthen understanding and execution of concurrent planning by the agency as well as those community stakeholders who support the process, i.e. Courts and CRB.

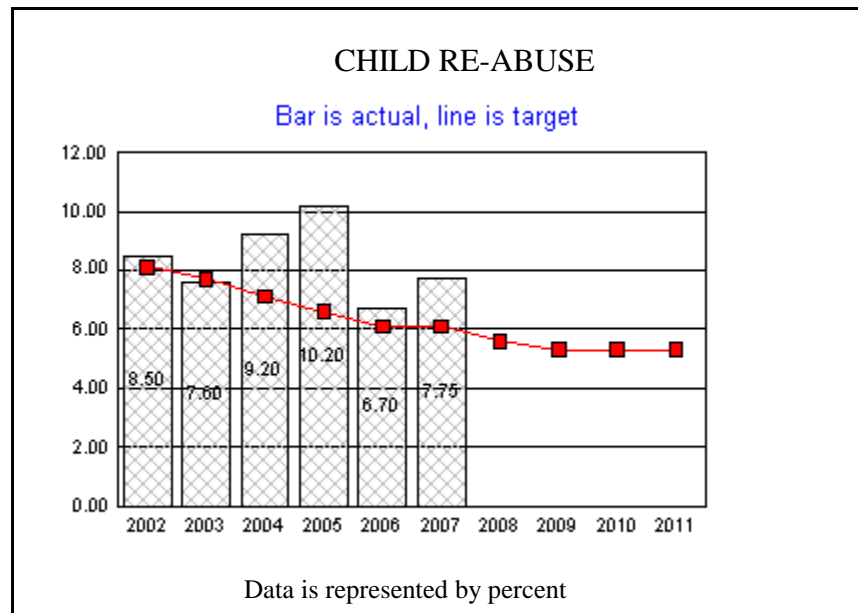
7. ABOUT THE DATA

Reporting cycle: federal fiscal year

Definition: Permanency Composite 2: Timeliness of Adoptions, Component A: Timeliness of adoptions of children discharged from foster care, Measure C2 - 2: Exits to adoption, median length of stay: Of all children who were discharged from foster care (FC) to a finalized adoption in the year shown, what was the median length of stay in FC (in months) from the date of latest removal from home to the date of discharge to adoption? [national median = 32.4 months, 25th Percentile = 27.3 months (lower score is preferable in this measure)]

Data Source: AFCARS (Federal Adoption and Foster Care Analysis and Reporting System) table, which is derived from the State Child Welfare IIS data system. The AFCARS table contains specific data elements reported per federal guidelines.

KPM #15	CHILD RE-ABUSE – The percentage of abused/neglected children who were re-abused within 6 months of prior victimization.	1997
Goal	People are safe.	
Oregon Context	This performance measure links to the DHS goal, “People are safe.” It also links to Oregon Benchmark #50 and the DHS high-level outcome, “Number of children per 1,000 persons under 18, who are: a) neglected/abused, b) at a substantial risk of being neglected/abused.” This measure concerns children who are victims in founded cases of abuse. The term “founded” means that there is reasonable cause to believe that child abuse or neglect has occurred.	
Data Source	State Child Welfare IIS data system.	
Owner	Child Protective Services Program, Children Adults and Families Division, Stacey Ayers, (503) 945-6696	



1. OUR STRATEGY

The state Child Welfare Program is currently working with the National Resource Center for Child Protective Services (NRCCPS) to develop and implement a comprehensive Safety Intervention Model. This model was implemented in March 2007. The Safety Intervention Model includes all actions and decisions required throughout the life of a case to:

- Define Child Welfare as the “safety expert” and assure that all child welfare staff receive training in child safety interventions.
- Assess allegations of child abuse in a timely manner and provide a comprehensive protective capacity assessment of caregivers when abuse has been identified.
- Develop focused service plans in families impacted by issues of abuse and create change goals to increase protective capacity and restore safety for children.
- The Safety Intervention System will include specific statewide training and policy/procedure development to reconfirm the safety of children in their own homes or in out of home care throughout the life of the case. Active safety monitoring will enhance safety of children and decrease the potential of reabuse.
- Implementation of the Oregon Safety Model has shifted our practice from an incident based model of practice to a comprehensive safety assessment model of practice. Workers identify all safety threats the child has been and is exposed to, not just the safety threats identified in the report of abuse and neglect. The CPS workers address all identified safety threats with appropriate specific services to ameliorate those threats.

2. ABOUT THE TARGETS

The 2006 and 2007 targets were based on the national standard set by Health and Human Services, Administration for Children and Families. The decrease in the target for 2008 and 2009 is due to the change in the national standard, which is $\leq 5.4\%$, the 75th percentile of all the states’ repeat maltreatment rates (i.e. 75% of states have a repeat maltreatment rate LOWER than 5.4%). The target of 5.3 is carried through 2010 and 2011.

3. HOW WE ARE DOING

Oregon’s child repeat maltreatment rate increased by 1% during Federal Fiscal Year 2007.

4. HOW WE COMPARE

Oregon’s children are reabused at a rate that is higher than the national median of 6.7% established in 2004.

5. FACTORS AFFECTING RESULTS

The major factors affecting families of abused and neglected children are drug/alcohol abuse, parental involvement with law enforcement, domestic violence and unemployment. Often, there are several of these factors in families of child abuse/neglect victims. The addition of resources from the 2007 Legislature, in the child welfare staffing improvement package and the legal representation package, will further support achievement of the targets for this measure in the future.

6. WHAT NEEDS TO BE DONE

Oregon is implementing a Safety Intervention model to improve safety intervention and service provision to families impacted by child abuse and neglect. The Safety Intervention System will include specific statewide training, and policy/procedure development to reconfirm the safety of children in their own homes or in out of home care throughout the life of the case. Active safety monitoring will enhance safety of children and decrease potential of reabuse.

Oregon recently hired thirteen staff to provide intensive training regarding the safety model. These trainers are currently out in offices and plan to have training completed by June of 2009. This training includes the importance of the comprehensive assessment model of practice.

As gaps in practice are identified, solutions will be implemented to further assist staff in fully understanding the concept of a comprehensive assessment model of practice. Oregon recently convened a workgroup to evaluate whether policies/procedures give workers adequate guidance in completing comprehensive assessments of teen parents.

7. ABOUT THE DATA

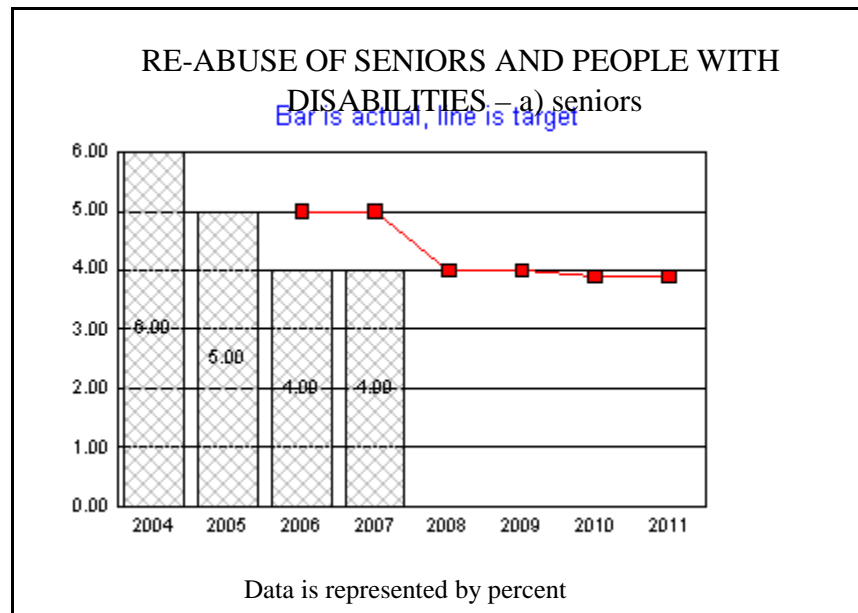
Reporting cycle: federal fiscal year

Definition: Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect. Of all children who were victims of a substantiated maltreatment allegation during the first 6 months of the year, the percent who were victims of another substantiated maltreatment allegation within the 6 months following that maltreatment incident.

Data Source: State Child Welfare IIS data system.

This Key Performance Measure was included in the Department's first performance audit during the summer of 2008. The DHS Internal Audit group certified that this key performance measure falls within the category of verified. The performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #16a	RE-ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES – The percentage of seniors and adults with disabilities who are re-abused within 12 months of first substantiated abuse: seniors.	2002
Goal	People are safe.	
Oregon Context	Elder abuse	
Data Source	Office of Licencing and Quality of Care Adult Protective Services and Office of Investigation and Training	
Owner	Seniors and People with Disabilities, Trish Johnson, (503) 945-6445	



1. OUR STRATEGY

Seniors and adults with disabilities: Increase public awareness, strengthen collaboration with community partners, strengthen and increase Protective Service Training.

2. ABOUT THE TARGETS

All targets for 2008 and 2009 were changed from 5.0 to 4.0 at the request of the Legislative Fiscal Office (LFO). (In the re-abuse graphs, lower is better.)

Seniors and adults with disabilities: In order to measure success in reducing re-abuse, in the community, SPD in agreement with the legislature selected the target of 5% for tracking victims who have been reabused within 12 months of the first reported abuse incident. The primary strategy is to assist the victim in moving from the abusive living situation or to remove the abuser from the situation. The underlying ethical value for the Seniors and Adults with Disabilities' protective service model is to balance our obligation to protect older adults and adults with disabilities with their rights to self-determination. Independent adults can make decisions about their own life and the course of action to be taken in abuse situations. This individual decision-making is factored into our reabuse rate.

Performance to target comparison could be affected by a number of variables.

This includes but is not limited to the following for Seniors and Adults with Disabilities:

- Right to self-determination;
- Limited resources including local community, state, and federal resources;
- Additional training and development needed for APS Specialist's;
- Response of the criminal justice system;
- Development and understanding of intra-agency functions;
- Self-neglect: The re-abuse data figures include those clients that are categorized under self-neglect. This may be result of an individual's right to self-determination that results in re-abuse, and may not be due to any of the other potential contributory factors.

3. HOW WE ARE DOING

Seniors and adults with disabilities: Since our Department currently meets or is below the current target of 5% for the percentage of seniors, adults with disabilities who are re-abused within 12 months, it appears that we are meeting the goals of our intervention model described above. However, reabuse in the community can be difficult to lower due to the individual's right to make decisions about their own life and the course of action. Additionally, as public awareness of the signs of abuse increases so do the number of abuse reports received by the department resulting in more investigations and interventions. The department wants to encourage individuals to report as suspected abuse.

Strategies to improve the department's performance include:

- On-going Adult Protective Service training including fundamentals of and advanced training for experienced APS workers.
- Continuation of public education efforts;
- Technical Assistance to field offices;
- Basic Adult Protective Service Specialist functions such as screening, consultation, triage, assessment, investigation, intervention, documentation

and risk management;

- Collaboration with community partners;
- Continuation of intra-agency relationships/training with other agencies that serve Adult Protective Service clients such as those with mental illness, developmental disabilities, and the Office of Investigations and Training.

4. HOW WE COMPARE

Seniors and adults with disabilities: There is no national data on re-abuse.

5. FACTORS AFFECTING RESULTS

Seniors and adults with disabilities: Performance to target comparison could be affected by a number of variables. This includes but is not limited to the following for Seniors and Adults with Disabilities:

- Right to self-determination;
- Limited resources including state, federal, and community-type(s);
- Additional training and development needed for APS Specialist's;
- Response of the criminal justice system;
- Development and understanding of intra-agency functions;
- Self-neglect: The re-abuse data figures include those clients that are categorized under self-neglect. This could be interpreted to mean that it may be an individual's right to self-determination that results in re-abuse, and may not be due to any of the other potential contributory factors.

6. WHAT NEEDS TO BE DONE

Seniors and adults with disabilities:

- Continue to develop data tracking systems for baseline figures needed for comparison;
- Continue Department activities related to this measure;
- Address the variances and see if any reductions can be made in order to achieve the Department's goals;
- Gather data from public/private industry sources for comparison;
- Respond to legislative request to direct efforts at maintaining to 5%.

7. ABOUT THE DATA

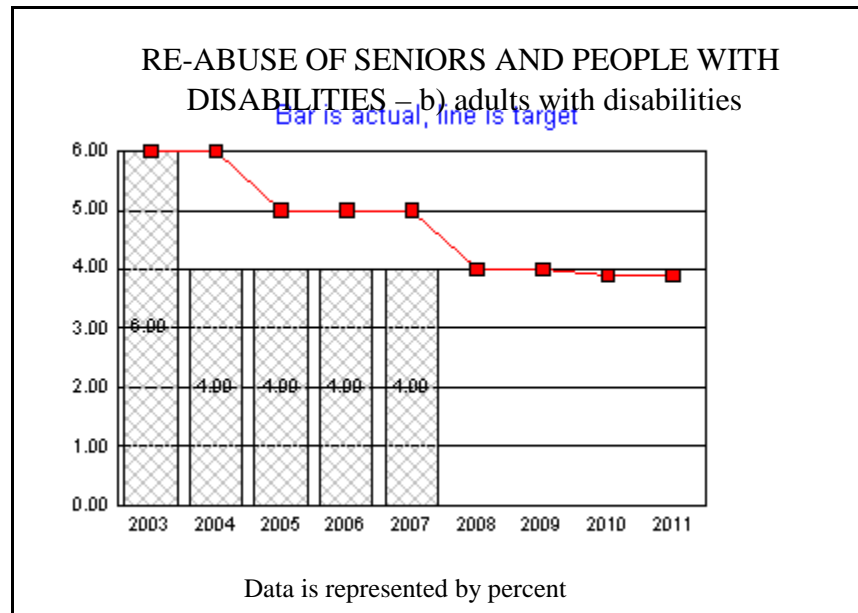
Reporting cycle is Calendar Year.

Seniors and Adults with Disabilities – Data is maintained by the Office of Licensing and Quality of Care, Quality Assessment and Monitoring Unit. Original data source is Oregon ACCESS. Since Lane County does not use Oregon Access, abuse data is sent in via paper forms and then appended to the abuse data. Oregon ACCESS has system edits the help prevent duplication in data. Reports are checked for duplication.

Additional and Disaggregated Data:

Data for Seniors and Adults with Disabilities can be obtained by contacting the Office of Licencing & Quality of Care Adult Protective Services.

KPM #16b	RE-ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES – The percentage of seniors and adults with disabilities who are re-abused within 12 months of first substantiated abuse: adults with disabilities.	2002
Goal	People are safe.	
Oregon Context	Elder abuse	
Data Source	Office of Licencing and Quality of Care Adult Protective Services and Office of Investigation and Training	
Owner	Seniors and People with Disabilities, Trish Johnson, (503) 945-6445	



1. OUR STRATEGY

Seniors and adults with disabilities: Increase public awareness, strengthen collaboration with community partners, strengthen and increase Protective Service Training.

2. ABOUT THE TARGETS

All targets for 2008 and 2009 were changed from 5.0 to 4.0 at the request of the Legislative Fiscal Office (LFO). (In the re-abuse graphs, lower is better.)

Seniors and adults with disabilities: In order to measure success in reducing re-abuse, in the community, SPD in agreement with the legislature selected the target of 5% for tracking victims who have been reabused within 12 months of the first reported abuse incident. The primary strategy is to assist the victim in moving from the abusive living situation or to remove the abuser from the situation. The underlying ethical value for the Seniors and Adults with Disabilities' protective service model is to balance our obligation to protect older adults and adults with disabilities with their rights to self-determination. Independent adults can make decisions about their own life and the course of action to be taken in abuse situations. This individual decision-making is factored into our reabuse rate.

Performance to target comparison could be affected by a number of variables.

This includes but is not limited to the following for Seniors and Adults with Disabilities:

- Right to self-determination;
- Limited resources including local community, state, and federal resources;
- Additional training and development needed for APS Specialist's;
- Response of the criminal justice system;
- Development and understanding of intra-agency functions;
- Self-neglect: The re-abuse data figures include those clients that are categorized under self-neglect. This may be result of an individual's right to self-determination that results in re-abuse, and may not be due to any of the other potential contributory factors.

3. HOW WE ARE DOING

Seniors and adults with disabilities: Since our Department currently meets or is below the current benchmark of 5% for the percentage of seniors, adults with disabilities who are re-abused within 12 months, it appears that we are meeting the goals of our intervention model described above. However, reabuse in the community can be difficult to lower due to the individual's right to make decisions about their own life and the course of action. Additionally, as public awareness of the signs of abuse increases so do the number of abuse reports received by the department resulting in more investigations and interventions. The department wants to encourage individuals to report as suspected abuse.

Strategies to improve the department's performance include:

- On-going Adult Protective Service training including fundamentals of and advanced training for experienced APS workers.
- Continuation of public education efforts;
- Technical Assistance to field offices;
- Basic Adult Protective Service Specialist functions such as screening, consultation, triage, assessment, investigation, intervention, documentation

and risk management;

- Collaboration with community partners;
- Continuation of intra-agency relationships/training with other agencies that serve Adult Protective Service clients such as those with mental illness, developmental disabilities, and the Office of Investigations and Training.

4. HOW WE COMPARE

Seniors and adults with disabilities: There is no national data on re-abuse.

5. FACTORS AFFECTING RESULTS

Seniors and adults with disabilities: Performance to target comparison could be affected by a number of variables. This includes but is not limited to the following for Seniors and Adults with Disabilities:

- Right to self-determination;
- Limited resources including state, federal, and community-type(s);
- Additional training and development needed for APS Specialist's;
- Response of the criminal justice system;
- Development and understanding of intra-agency functions;
- Self-neglect: The re-abuse data figures include those clients that are categorized under self-neglect. This could be interpreted to mean that it may be an individual's right to self-determination that results in re-abuse, and may not be due to any of the other potential contributory factors.

6. WHAT NEEDS TO BE DONE

Seniors and adults with disabilities:

- Continue to develop data tracking systems for baseline figures needed for comparison;
- Continue Department activities related to this measure;
- Address the variances and see if any reductions can be made in order to achieve the Department's goals;
- Gather data from public/private industry sources for comparison;
- Respond to legislative request to direct efforts at maintaining to 5%.

7. ABOUT THE DATA

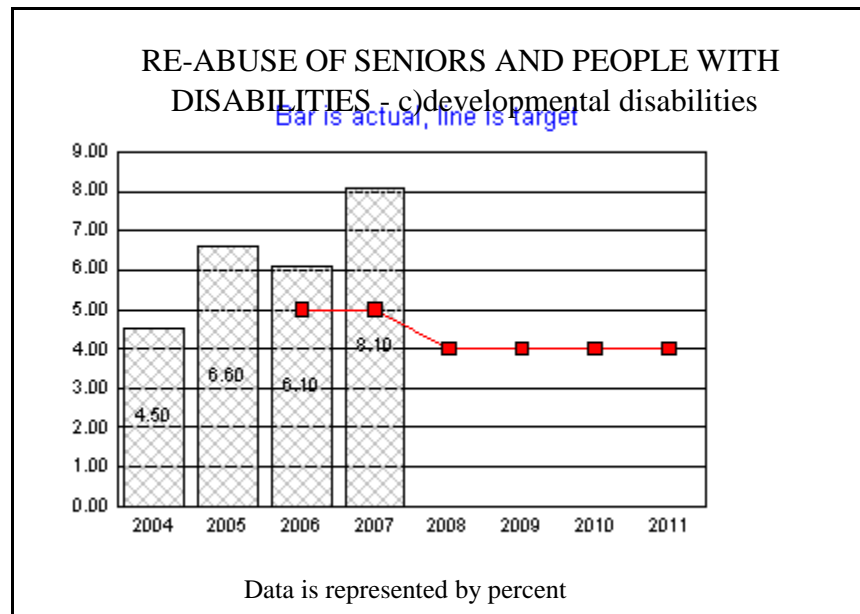
Reporting cycle is Calendar Year.

Seniors and Adults with Disabilities – Data is maintained by the Office of Licensing and Quality of Care, Quality Assessment and Monitoring Unit. Original data source is Oregon ACCESS. Since Lane County does not use Oregon Access, abuse data is sent in via paper forms and then appended to the abuse data. Oregon ACCESS has system edits the help prevent duplication in data. Reports are checked for duplication.

Additional and Disaggregated Data:

Data for Seniors and Adults with Disabilities can be obtained by contacting the Office of Licencing & Quality of Care Adult Protective Services.

KPM #16c	RE-ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES – The percentage of seniors and adults with disabilities who are re-abused within 12 months of first substantiated abuse: developmental disabilities.	2002
Goal	People are safe.	
Oregon Context	Elder abuse	
Data Source	Office of Licencing and Quality of Care Adult Protective Services and Office of Investigation and Training	
Owner	Seniors and People with Disabilities, Trish Johnson, (503) 945-6445	



1. OUR STRATEGY

Developmental disabilities: Increase training for local protective service investigators and collaboration with brokerages who serve people with developmental disabilities in their own home. Initiate a Prevention Initiative with a focus on clients, their family, providers and the community at large.

2. ABOUT THE TARGETS

All targets for 2008 and 2009 were changed from 5.0 to 4.0 at the request of the Legislative Fiscal Office (LFO). (In the re-abuse graphs, lower is better.)

Developmental Disabilities: In order to measure success in reducing re-abuse in the community, SPD, in agreement with the legislature, selected the target of 5% for tracking victims who have been reabused within 12 months of the first reported abuse incident. The primary strategy is to remove the abuser from the situation, provide the provider with tools that help them prevent abuse and reabuse, and/or assist the victim in moving from the abusive living situation.

Performance to target comparison could be affected by a number of variables.

This includes but is not limited to the following for Children and Adults with Developmental Disabilities:

An overall increase in people with developmental disabilities receiving some, at a minimum, case management services;

Increased awareness of the definitions of abuse;

Greater numbers of people with developmental disabilities becoming eligible for services due to the Staley settlement and having previously unidentified abusive situations discovered;

Limited resources including local community, state, and federal resources;

Development and understanding of intra-agency functions;

Self-neglect: The re-abuse data figures include those clients that are categorized under self-neglect. This may be result of an individual's right to self-determination that results in reabuse, and may not be due to any of the other potential contributory factors.

3. HOW WE ARE DOING

Developmental disabilities: Analysis of the 2007 abuse and neglect data include type of abuse, setting and review of individual allegations. The total number of clients being served for whom mandatory reports are made have increased, including an increase in individuals in the Staley Settlement services, Adult Support Services. The reabuse rate has risen from 6.6% (54 people) to 8.1% (78 people). Overall the numbers of substantiated abuse and neglect reports have ranged from 866 in 2004 to 966 in 2007. The serious types of abuse (sexual and physical) have remained relatively low with significant increases in financial exploitation.

Strategies to improve performance on these measures include initiation of a prevention initiative which will increase training to providers consumers advocates and the public; leadership of an initiative to address sexual abuse of persons with developmental disabilities that is sponsored by the Attorney General's Sexual Assault Task Force.

4. HOW WE COMPARE

Developmental disabilities: There are no national prevalence/incidence studies for abuse of individuals with developmental disabilities.

5. FACTORS AFFECTING RESULTS

Developmental disabilities: For people with developmental disabilities, primarily due to their cognitive limitations, there is a pronounced level of vulnerability resulting in an inability to report along with the inability to protect themselves. Factors affecting performance to target include high turnover of staff in licensed and certified programs; right to self determination; response of the criminal justice system; lack of services knowledgeable and able to respond and support developmentally disabled victims of abuse (e.g. domestic violence shelters, counseling resources).

6. WHAT NEEDS TO BE DONE

Developmental disabilities: Additional training for protective service investigators and brokerage staff who are serving people in their own homes. Research and collaboration with community response systems including domestic violence and sexual assault. Increase county APS office access to resources to experts such as forensic nurses and psychologists. Initiate program focusing on prevention of abuse such as the Attorney General's Sexual Assault Task Force Developmental Disability Initiative and inclusion of clients, their family and the community at large.

7. ABOUT THE DATA

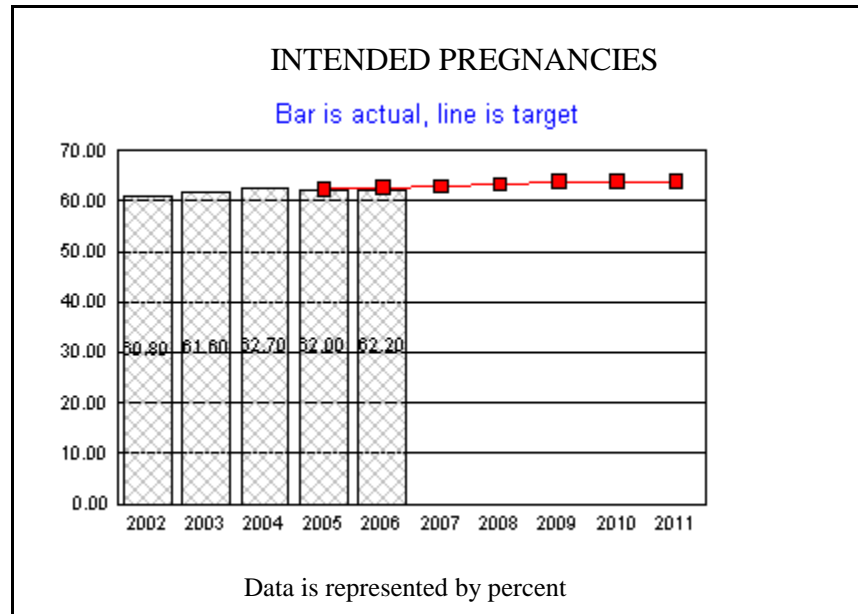
Reporting cycle is Calendar Year.

Developmental Disabilities – Data is maintained by the Office of Investigation and Training (OIT). The data source is the DD and MH Abuse Database, which reflects the investigation reports submitted to OIT by county and state DD and MH abuse investigators. Several quality assurance checks are conducted before final reports are generated from the database. The data for performance measure was checked for duplication.

Additional and Disaggregated Data:

Data for People with Developmental Disabilities can be obtained by contacting the Office of Investigation and Training.

KPM #17	INTENDED PREGNANCY – The percentage of births where mothers report that the pregnancy was intended.	2006
Goal	People are healthy.	
Oregon Context	Teen pregnancy	
Data Source	Public Health Division, Office of Family Health, Pregnancy Risk Assessment Monitoring System (PRAMS) survey	
Owner	Public Health Division, Office of Family Health, Reproductive Health Program, Lisa Angus (971) 673-0358	



1. OUR STRATEGY

Through a network of approximately 160 county health department clinics, private providers, and other local agencies, the state Reproductive Health program provides contraceptive services and supplies to enable all individuals to plan and space their pregnancies as desired.

2. ABOUT THE TARGETS

Modest targets have been set based on national trends in unintended pregnancy and teen pregnancy (see note above), limited program budget, and the complex nature of pregnancy intent.

3. HOW WE ARE DOING

The trend over the last five years indicates that intended pregnancies are increasing, as desired. Estimates fluctuate a little from year to year but always within the margin of error for this survey-based measure.

4. HOW WE COMPARE

The Healthy People 2010 Objective related to intended pregnancy (Objective 9-1) sets an ambitious goal of increasing the national proportion of pregnancies that are intended to 70%. Oregon currently falls short of this goal, as do most other states.

5. FACTORS AFFECTING RESULTS

Federal decisions about funding allocation and program eligibility have a substantial influence on the reach of public family planning programs and those programs' success in promoting intended pregnancy. Title X—the federal grant program devoted to family planning and reproductive health care—has been flat-funded for several years, which translates to a decrease in funding when adjusted for inflation and the rising cost of providing medical care. Oregon's Medicaid family planning waiver, FPEP, experienced almost a 30% decline in visits when federal citizenship documentation requirements were implemented in 2006. Finally, because pregnancy intent is influenced by an often complex mix of feelings about pregnancy, childbearing, intimate relationships and other issues, there is a limit to what state-level programs can do to increase the proportion of pregnancies that are intended. Comprehensive access to high-quality family planning services should be considered a necessary, but not sufficient, step toward achieving significant increases in intended pregnancy.

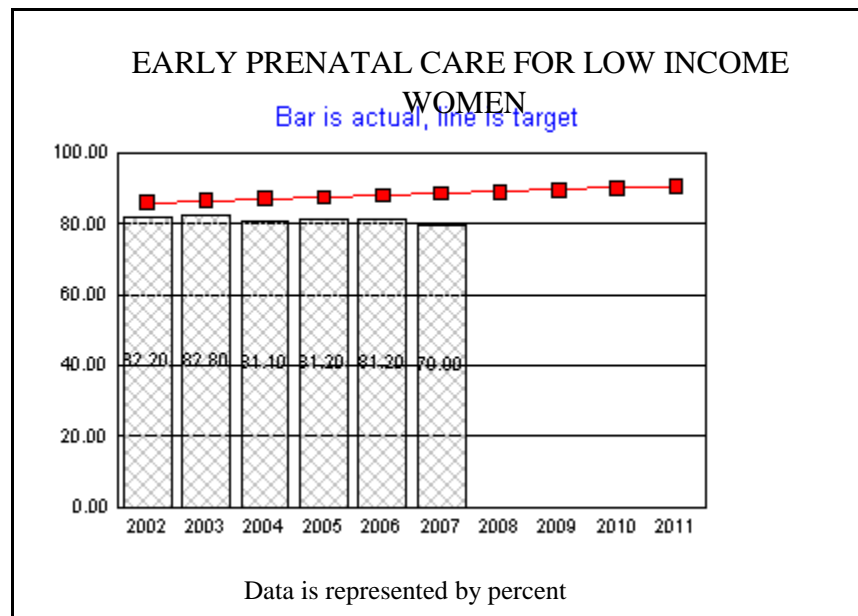
6. WHAT NEEDS TO BE DONE

Current family planning activities should continue and every effort should be made to expand or at least maintain current levels of access to free or low-cost contraceptive services for low-income individuals.

7. ABOUT THE DATA

The reporting cycle for these data is the calendar year. The foremost strength of the data is that they directly reflect women's own reports of pregnancy intent; the population-based design and high response rate of the PRAMS survey are also strengths. The primary limitation of the data is that the complexity women's feelings about pregnancy and childbearing can make pregnancy intent difficult to measure accurately. There is also a considerable time lag in data availability because file processing takes place at the Centers for Disease Control and Prevention.

KPM #18	EARLY PRENATAL CARE FOR LOW INCOME WOMEN – The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy.	2002
Goal	People are healthy.	
Oregon Context	Prenatal care	
Data Source	Oregon DHS, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Birth Certificates)	
Owner	Public Health Division, Office of Family Health, Ruth Helsley 971-673-0345 / Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

Office of Family Health (OFH) is continuing to provide funding and technical support for Oregon MothersCare (OMC), a program that collaborates with Division of Medical Assistance Programs (DMAP), the agency that administers the Oregon Health Plan (OHP), to assist pregnant women in

entering early prenatal care. OFH also promotes SafeNet, the toll-free hotline for referrals to local prenatal services.

Other strategies include the following: DMAP expedites applications for OHP received from pregnant women; DMAP regularly sends its contracted managed health care plans data from which the plan can identify pregnant women--plans use this information to make timely contact and help arrange the first prenatal visit; and DMAP places regular messages on the monthly medical card emphasizing the importance of initiating early prenatal care.

2. ABOUT THE TARGETS

The state target for 2007 is 88.7%. There was a slight decline in '01 and '04 and '07. The numbers remained stable from '04-'06. The National Title V Performance Measure and the Healthy People 2010 target is 90% of all infants born to pregnant women received prenatal care in the first trimester.

3. HOW WE ARE DOING

The OMC program expanded from five sites serving fewer than 1,000 low-income women in 2000 to 27 sites that served more than 5,300 unduplicated women in 2007 with over 30,000 referrals to prenatal care and other services. Putting these numbers in context, OMC is only able to serve around one quarter of women who had their deliveries paid for by OHP per birth certificate data. Oregon remains just under 80% of women receiving early prenatal care as defined by this KPM. This KPM remains relatively flat over all measurement years with at most a smaller than three percentage point change.

4. HOW WE COMPARE

This measure of low income women entering prenatal care by the end of the fourth month is unique to Oregon and so can not be compared to other states. Although this measure is for women entering prenatal care by the end of the fourth month, a comparison between OMC clients (where 88% of clients apply for OHP) and OHP clients in general might be helpful. In 2007, approximately 79% of women receiving services through OMC during their first trimester entered prenatal care during the first trimester. This includes women who are low-income but ineligible for Oregon Health Plan (OHP) coverage. Among OHP clients, (self-identified on the birth certificate) overall, the percent of first trimester care is consistently slightly less than 70%. Several important caveats concerning birth certificate data and program requirements are that 1) OHP identified as a delivery payment source is under reported compared to DMAP's claims data and 2) for a portion of the women (non-citizens) OHP pays for their delivery but not for their prenatal care.

5. FACTORS AFFECTING RESULTS

There has continued to be a consistent rise in the number of Hispanic births in Oregon, from 17.4% in '01 to 20.7 % in 2007. Investment in the Oregon Mothers Care (OMC) program expansion results in increased outreach to pregnant Hispanic women. When low-income women who are not already covered by Medicaid become pregnant they must apply for OHP after they find out they're pregnant. It is possible that some of them do not know immediately that they can now qualify because they are pregnant, especially if they were recently told they were ineligible for OHP due to income. Although OHP applications from pregnant women are expedited, Oregon is not one of the thirty states that have Medicaid presumptive eligibility for pregnant women. Presumptive eligibility allows pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed.

The most recent factors affecting the results are dramatic decreases in local resources and subsequent decreases in infrastructure to support the OMC program at the local level. In addition, due to inadequate reimbursement of OHP providers, especially ob/gyn physicians, there can be difficulty in linking women with a provider who will accept OHP patients causing delays that result in women initiating prenatal care after the 4 month mark of this KPM.

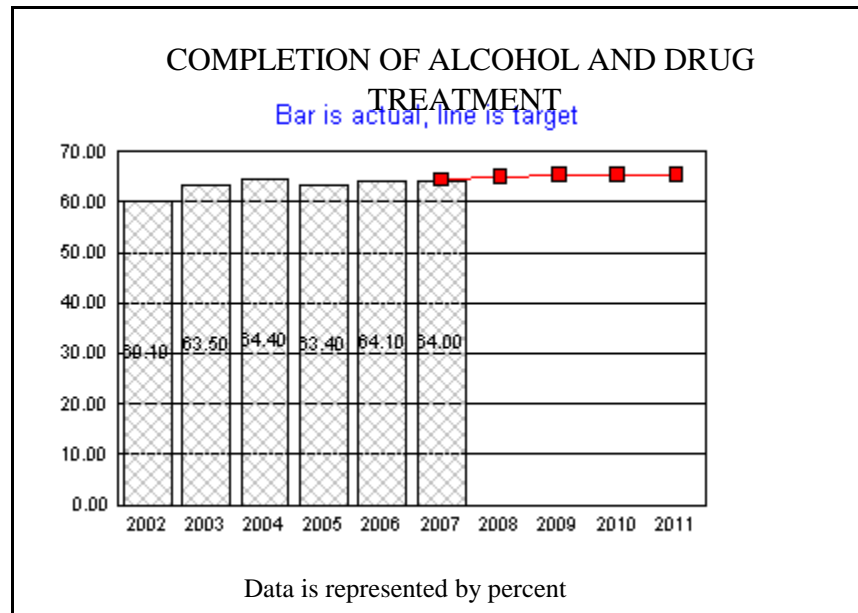
6. WHAT NEEDS TO BE DONE

Trends will continue to be tracked, comparing low-income Medicaid and non-Medicaid women for the entire state as well as by county and will likely use several measures including birth certificate data and perhaps birth record data linked to Medicaid-DMAP data. In addition, moving forward this shared OFH/DMAP measure will be uncoupled. And the measure parameters will be revised from the first 4 months of pregnancy to the first 3 months of pregnancy. This will align the measure with the Title V Performance Measure and the Healthy People 2010 indicator. In addition, DMAP has developed its own adequacy of prenatal care measure based on DMAP data rather than using birth certificate data.

7. ABOUT THE DATA

Birth certificate data were used to calculate early prenatal care during months 1 through 4. Income data not available; OHP/Medicaid as a source of payment was used as a surrogate for "low income." OHP identified as a delivery payment source tends to be under reported on the birth certificate compared to DMAP's claims data.

KPM #19	COMPLETION OF ALCOHOL AND DRUG TREATMENT – The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD.	2002
Goal	People are healthy	
Oregon Context	Teen substance abuse, alcohol/tobacco use during pregnancy, alcohol/drug abuse	
Data Source	Addictions and Mental Health Division, Client Process Monitoring System database	
Owner	Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

Completion of treatment services leads to better outcomes for the client.

2. ABOUT THE TARGETS

The higher the completion rate the better.

3. HOW WE ARE DOING

The completion rate for clients has been steadily increasing for the past seven years. The Division is working with providers to continue this trend through a quality improvement process and by incorporating this measure into performance based contracting.

4. HOW WE COMPARE

Nationally the completion rate was 51% in 2003, according to reports available from the Substance Abuse and Mental Health Services Administration Office of Applied Studies.

5. FACTORS AFFECTING RESULTS

There are a number of factors affecting this measure including referral source (legal referrals are more likely to complete), type of service being delivered (residential compared to outpatient completion), and the quality of services (varies by provider and by type of service delivered). Methadone clients and clients receiving detoxification services are not included in this measure, as it is inappropriate for this type of measure.

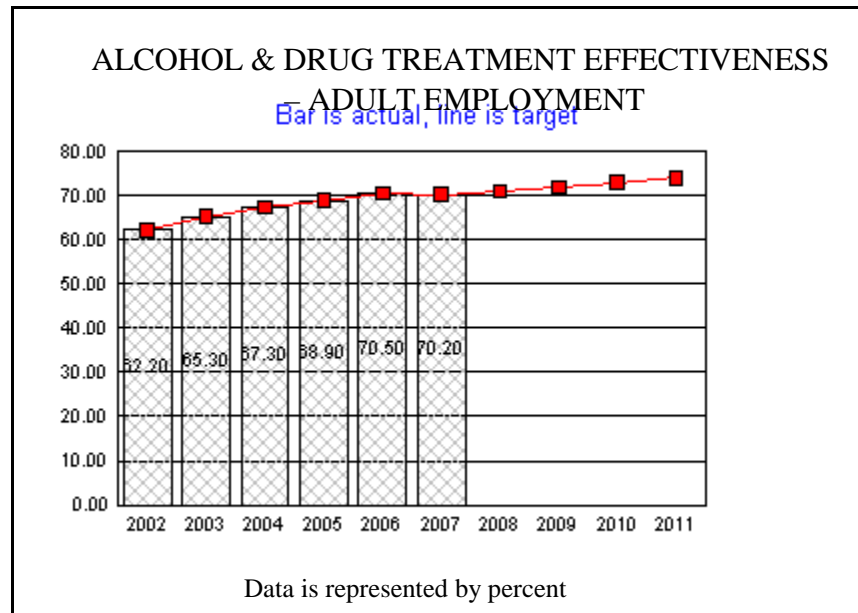
6. WHAT NEEDS TO BE DONE

The Division will continue quality improvement and process improvement efforts to improve completion rates.

7. ABOUT THE DATA

Data is extracted from the Division's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. The Division produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate/accurate data are submitted to the CPMS.

KPM #20	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of adults employed after receiving Alcohol and Drug treatment.	2007
Goal	Independence- People are living as independently as possible	
Oregon Context	Employed by end of treatment	
Data Source	Client Process Monitoring System (CPMS)	
Owner	Addictions and Mental Health Division, Karen Wheeler, 503-945-6191	



1. OUR STRATEGY

Oregon’s AMH strategy relates to the Oregon Business Plan initiative to increase access to treatment and intervention services for Oregon workers who have alcohol and drug problem but no insurance.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

It appears that more clients each year are employed after receiving treatment.

4. HOW WE COMPARE

Oregon has a higher rate of employment at discharge than the national rate.

5. FACTORS AFFECTING RESULTS

Factors such as limited treatment capacity, lack of insurance for treatment, limited transportation, and young children requiring care contribute are major barriers to obtaining treatment.

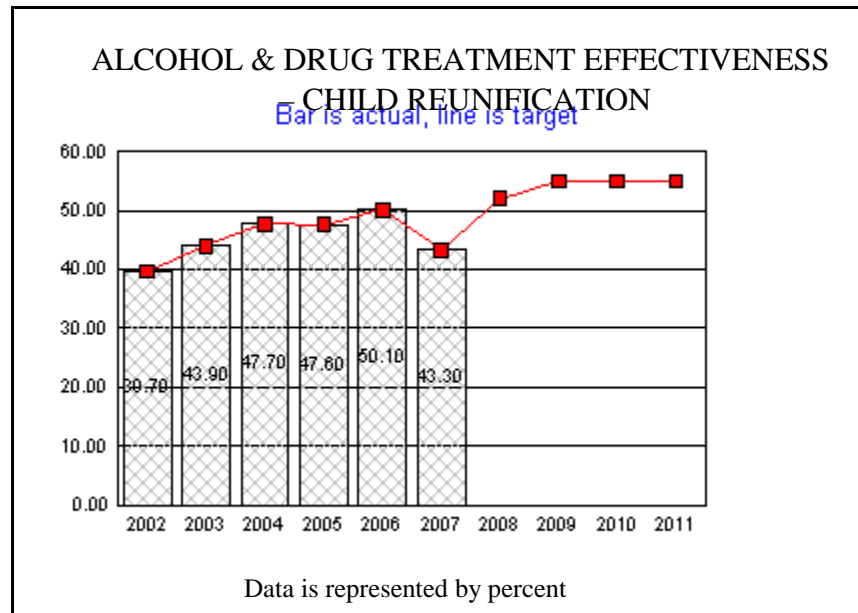
6. WHAT NEEDS TO BE DONE

Increase funding in treatment, more emphasis on co-occurring disorder treatment, additional case management services, and recovery management services.

7. ABOUT THE DATA

Data is extracted from AMH's Client Processing Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. AMH produces reports on this data regularly and trains providers throughout the state to insure that appropriate/accurate data is submitted to the CPMS.

KPM #21	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment.	2007
Goal	Healthy- People are healthy.	
Oregon Context	Prevent out-of-home placement	
Data Source	Client Process Monitoring System (CPMS)	
Owner	Addictions and Mental Health, Karen Wheeler, 503-945-6191	



1. OUR STRATEGY

To deliver services promoting family reunification.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

The trend up until 2007 showed that more parents were reuniting with their children. In 2007, the rate decreased. Whether or not this represents a new trend down or a temporary drop in an overall upward trend will have to be examined in the coming year.

4. HOW WE COMPARE

We do not have any national data to compare.

5. FACTORS AFFECTING RESULTS

Because of limited capacity in publicly funded alcohol and drug treatment, fewer parents receive the treatment they need to overcome addiction and reunite with their children.

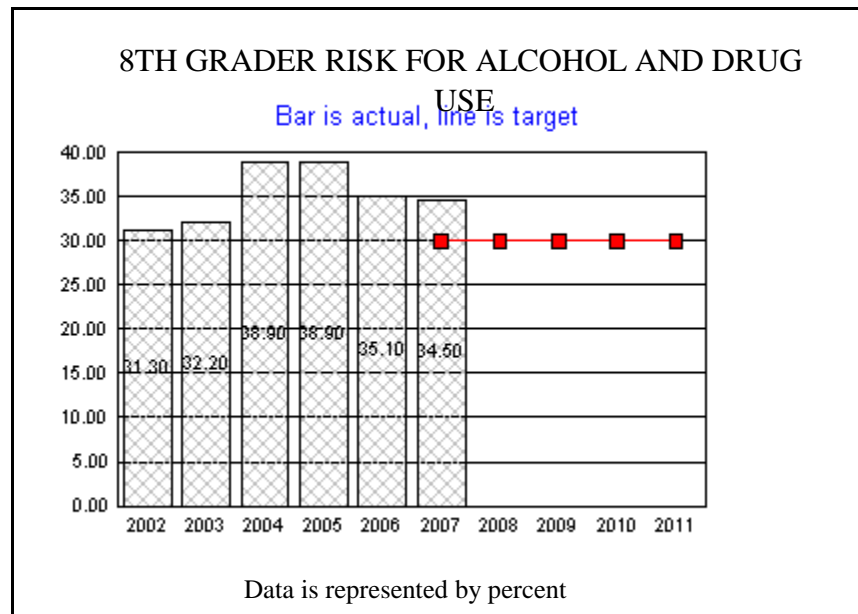
6. WHAT NEEDS TO BE DONE

Increase capacity for alcohol and drug treatment, increase family therapy, more emphasis placed on co-occurring disorder treatment, additional case management services, recovery management services, and additional wrap-around-services for the entire family.

7. ABOUT THE DATA

Data is extracted from AMH's Client Processing Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. AMH produces reports on this data regularly and trains providers throughout the state to insure that appropriate/accurate data is submitted to the CPMS.

KPM #22	8TH GRADER RISK FOR ALCOHOL AND DRUG USE – Percentage of 8th graders at high risk for alcohol and other drug use.	2002
Goal	People are healthy	
Oregon Context	Teen substance abuse	
Data Source	Addictions and Mental Health Division/Office of Disease Prevention & Epidemiology, Oregon Health Teens Survey	
Owner	Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

Addictions and Mental Health Division (AMH) uses a comprehensive approach to addressing underage drinking issues and intervening when underage drinking has occurred. This includes a variety of community and county level programs funded with state and federal dollars.

AMH currently funds a statewide public education effort, which focuses primarily on radio and television advertising. Youth written and produced

spots target messages to parents encouraging them to provide clear messages to youth regarding underage drinking, family expectations, and not providing alcohol to those under 21.

AMH has contracted with Girls, Inc. of NW Oregon to provide a program focused specifically on preventing alcohol and drug use among young girls. Using the Friendly PEERsuasion program, six sites will receive extensive training and technical assistance to implement this evidence-based prevention program. Target areas have been determined by utilizing data from the Oregon Healthy Teens survey.

All of the nine Tribes receive funds to address underage drinking through a variety of strategies.

In addition, a number of counties in the state currently receive funding to provide underage drinking prevention activities locally. These include minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy, and efforts directed at social policies related to underage drinking. AMH will continue to provide community grants to implement programs to reduce underage drinking on the local level, utilizing Oregon Healthy Teens Survey data.

2. ABOUT THE TARGETS

The lower the rate the better.

3. HOW WE ARE DOING

The percent of 8th graders at risk of alcohol or drug use declined in 2007, but still exceeds the target.

4. HOW WE COMPARE

This measure addresses drug and alcohol use. Most other states separate the issues. For example looking at alcohol, Oregon does not compare favorably to Washington. In 2006, only 15.4% of Washington 8th graders reported using alcohol in the past 30 days, while 31.9% of Oregon 8th graders did.

5. FACTORS AFFECTING RESULTS

Perceptions of youth to being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use have a tremendous effect on youth use. Youth whose parents feel that alcohol use is a “rite of passage” or that “kids will be kids” have much higher rates of drinking than those whose parents are clear that youth should not drink. Unfortunately, all too many Oregon parents still provide youth with a “safe” place to drink by providing the alcohol, taking away car keys so they don’t drive, or both. These mixed

messages give youth the impression that it's okay to drink, as long as they don't drive.

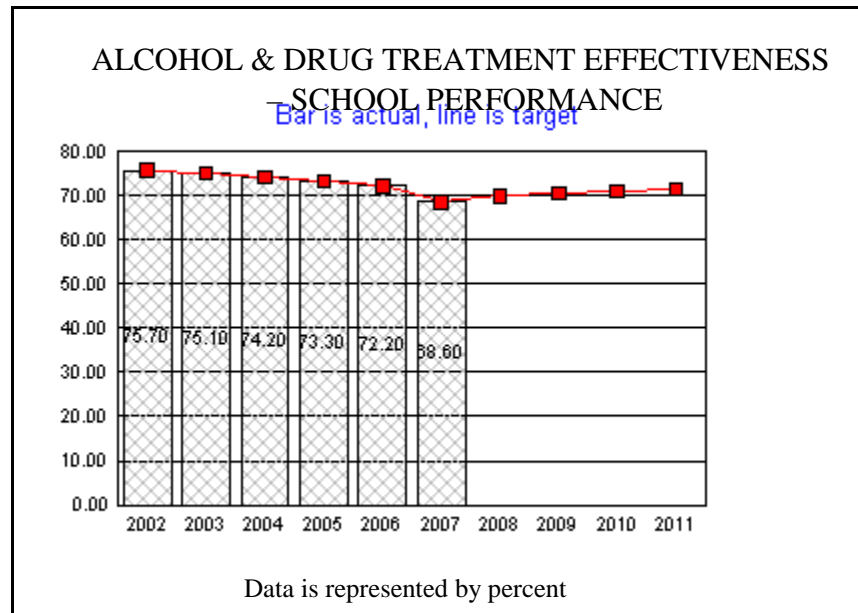
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol and other drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. In addition, continued and consistent enforcement of current laws across the state would provide a constant message that Oregon does not tolerate underage drinking. Statewide media should continue to provide messages to parents that it's against the law to provide alcohol to minors, as well as the importance of having well-defined expectations of their children regarding alcohol use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey. The survey is administered annually to 8th and 11th graders across the state.

KPM #23	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of children whose school performance improves after receiving alcohol and drug treatment.	2007
Goal	People are healthy	
Oregon Context	Alcohol and Drug Treatment Effectiveness	
Data Source	Addictions and Mental Health Division, Client Process Monitoring System database	
Owner	Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

To deliver services promoting healthy youth by focusing on a holistic approach to treatment.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

Not as well as expected, each year since 2002 the trend appears to be reduced and school performance has been reduced.

4. HOW WE COMPARE

This measure looks at academic performance; most national data available only track improvement in attendance. This makes comparison data at a state level difficult. Using past performance as a measure indicates that performance on this outcome needs to be improved.

5. FACTORS AFFECTING RESULTS

Factors such as limited treatment capacity, less case management, and reduction in number of youth in Oregon that are finishing school contribute to this trend.

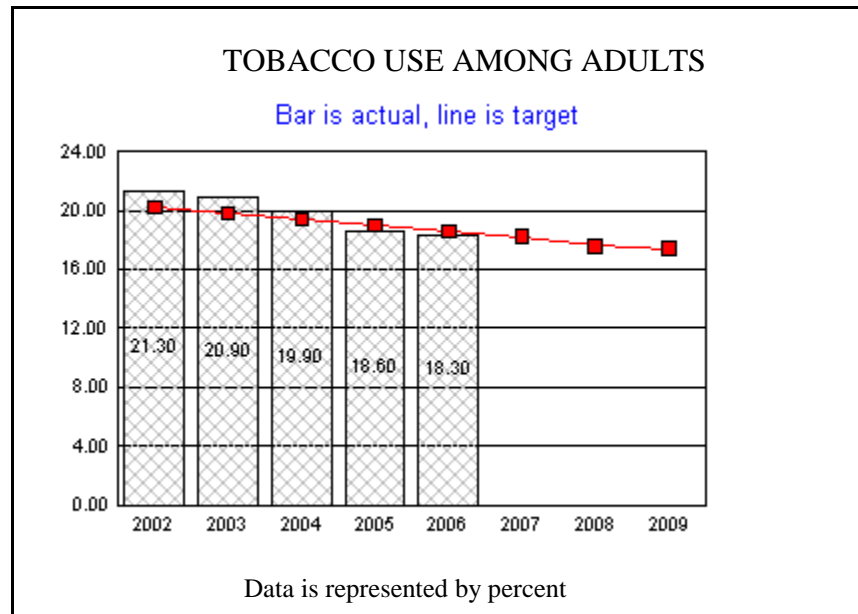
6. WHAT NEEDS TO BE DONE

Increase funding in treatment, more emphasis place on youth specific co-occurring disorder treatment, additional case management services, recovery management services, and additional wrap-around-services.

7. ABOUT THE DATA

Data is extracted from AMH's Client Processing Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. AMH produces reports on this data regularly and trains providers throughout the state to insure that appropriate/accurate data is submitted to the CPMS.

KPM #24a	TOBACCO USE – Tobacco use among adults.	2002
Goal	People are healthy.	
Oregon Context	Adult non-smokers, Preventable death, Teen substance abuse, Alcohol / tobacco use during pregnancy	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099.	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a

statewide public awareness and education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman's use of tobacco during pregnancy is associated with serious, at times fatal health problems for the child, ranging from low birth weight and premature births, to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality - contributing substantially toward the DHS goal "People are healthy" in both the short-term and long-term.

3. HOW WE ARE DOING

In 2006, the prevalence of smoking in Oregon was 18.3% for the general adult population, 8.7% among 8th grade adolescents, and 12.3% among pregnant women. From 2007, data are only available for 8th graders, and their smoking prevalence is 9.0%. For the general population of adults and for 8th graders, these measures were slightly better than targeted levels, while for pregnant women, this figure was slightly worse than the target. Although all measures are lower than their 2000 values, there does not appear to be a trend of declining smoking prevalence among 8th graders and among pregnant women.

4. HOW WE COMPARE

For adult smoking prevalence, the Healthy People 2010 target for this performance measure is 12%. By dedicating substantial resources to tobacco prevention, Oregon may meet this target by 2010.

Healthy People 2010 has a target of 16% for the smoking rate among high school students. The Department's performance measure is for 8th graders, but the 11th grade-smoking rate is currently 16.1% in Oregon. If this success continues, Oregon's 11th grade smoking rates should meet the 16% target for 2010.

The performance measure of tobacco use during pregnancy has generally met or exceeded targeted levels in prior years, but is worse than target for 2006. Oregon's prevalence of smoking during pregnancy has historically been higher than the national rate, although national data for 2006 are not

currently available.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended annual investment for tobacco prevention is \$11.60 per capita, or \$43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than \$2 billion lost to medical care and lost productivity annually in Oregon. Despite the recommendation, Oregon currently receives \$2.13 per capita for tobacco prevention from all funding sources. For most of the 2001-2003 biennium, the TPEP received approximately \$2.87 per capita per year. However, in April 2003, the Legislature stopped funding TPEP for the remainder of the biennium. Although TPEP funding was restored during the 2007 Legislative Session to the level approved by the voters in 1996, Oregon today spends less than one-fifth of the CDC recommended annual investment on tobacco prevention. After funding decreased in 2003, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased – for the first time since the program was first implemented.

6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for a comprehensive tobacco control program would need to be increased substantially. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

7. ABOUT THE DATA

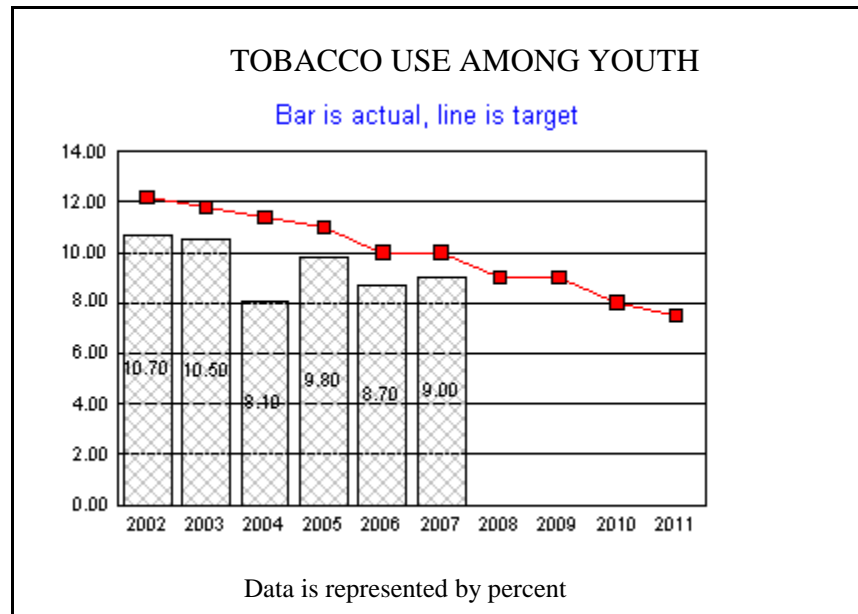
Reporting cycle – calendar year. The smoking prevalence among adult Oregonians estimate comes from the Oregon Behavioral Risk Factor Surveillance System, a telephone-administered survey of adults that examines health related behaviors. Responses to both of the following questions determine smoking status: “Have you smoked at least 100 cigarettes in your entire life?” (yes) and “Do you now smoke everyday, some days, or not at all?” (every day, or some days). Data depicted are weighted as appropriate, but not age-adjusted. A more comprehensive and accurate weighting formula has been developed by CDC, and will be available to apply to these data beginning in 2007. Oregon's tobacco prevalence estimates are anticipated to increase by 3.3 percentage points when the new weighting is applied to the data. Thus, it is difficult to set targets accurately. In the absence of more information, we have elected to extend the 2009 target into 2010 and 2011, with 3.3 percent added.

Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. Disadvantages associated with BRFSS include its reliance upon telephone landlines, which are increasingly less common among younger age groups, people with low income, and certain racial and ethnic populations. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.

Smoking prevalence among 8th graders in Oregon is on an annual reporting cycle, computed once per calendar year. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper survey administered to students at school. Responses to the following question determine smoking status: "During the past 30 days, on how many days did you smoke cigarettes?" (1-30). This measure depicts data from 8th graders (data are also collected on 11th graders). Data are weighted as appropriate. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.

Smoking prevalence among pregnant women is on an annual reporting cycle, computed once per calendar year. These data come from the birth certificates issued to all newborns in Oregon, which include parental demographic information, conditions of the newborn, and medical factors during the pregnancy (including mothers' smoking status). Responses to the following checkbox question determine smoking status: "Tobacco use during pregnancy" (yes). Unknown responses are subtracted from the denominator to replicate national calculations. Beginning in 2008, data comparable to 2002-2007 will no longer be available. TPEP will need to recalibrate targets for 2008, and subsequent years, after several years of data using the new birth certificate question format have been collected.. Advantages of these data are that they represent a census of information (that is, all births) and are not prone to sampling error, as are surveys. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.

KPM #24b	TOBACCO USE – Tobacco use among youth.	2002
Goal	People are healthy.	
Oregon Context	Adult non-smokers, Preventable death, Teen substance abuse, Alcohol / tobacco use during pregnancy	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099.	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a

statewide public awareness and education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman's use of tobacco during pregnancy is associated with serious, at times fatal health problems for the child, ranging from low birth weight and premature births, to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality - contributing substantially toward the DHS goal "People are healthy" in both the short-term and long-term.

3. HOW WE ARE DOING

In 2006, the prevalence of smoking in Oregon was 18.3% for the general adult population, 8.7% among 8th grade adolescents, and 12.3% among pregnant women. From 2007, data are only available for 8th graders, and their smoking prevalence is 9.0%. For the general population of adults and for 8th graders, these measures were slightly better than targeted levels, while for pregnant women, this figure was slightly worse than the target. Although all measures are lower than their 2000 values, there does not appear to be a trend of declining smoking prevalence among 8th graders and among pregnant women.

4. HOW WE COMPARE

For adult smoking prevalence, the Healthy People 2010 target for this performance measure is 12%. By dedicating substantial resources to tobacco prevention, Oregon may meet this target by 2010.

Healthy People 2010 has a target of 16% for the smoking rate among high school students. The Department's performance measure is for 8th graders, but the 11th grade-smoking rate is currently 16.1% in Oregon. If this success continues, Oregon's 11th grade smoking rates should meet the 16% target for 2010.

The performance measure of tobacco use during pregnancy has generally met or exceeded targeted levels in prior years, but is worse than target for 2006. Oregon's prevalence of smoking during pregnancy has historically been higher than the national rate, although national data for 2006 are not

currently available.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended annual investment for tobacco prevention is \$11.60 per capita, or \$43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than \$2 billion lost to medical care and lost productivity annually in Oregon. Despite the recommendation, Oregon currently receives \$2.13 per capita for tobacco prevention from all funding sources. For most of the 2001-2003 biennium, the TPEP received approximately \$2.87 per capita per year. However, in April 2003, the Legislature stopped funding TPEP for the remainder of the biennium. Although TPEP funding was restored during the 2007 Legislative Session to the level approved by the voters in 1996, Oregon today spends less than one-fifth of the CDC recommended annual investment on tobacco prevention. After funding decreased in 2003, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased – for the first time since the program was first implemented.

6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for a comprehensive tobacco control program would need to be increased substantially. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

7. ABOUT THE DATA

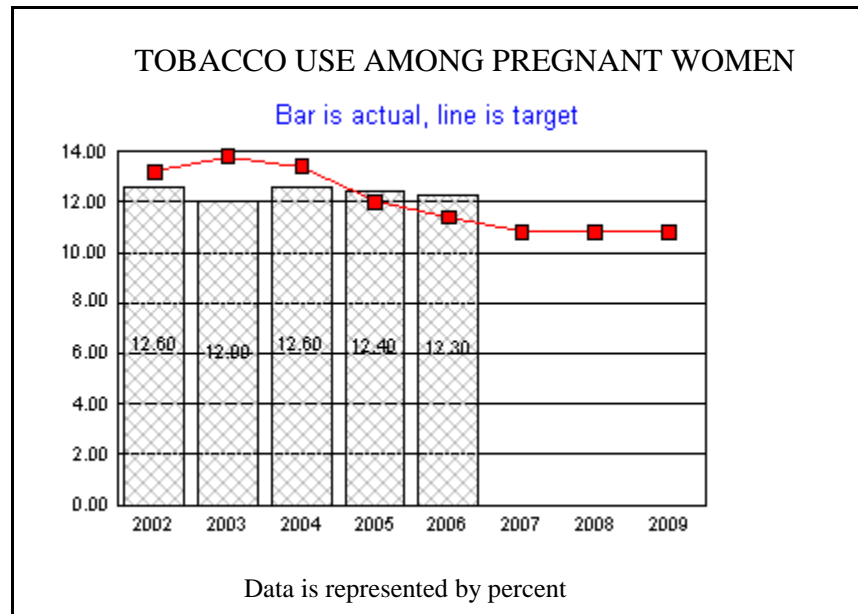
Reporting cycle – calendar year. The smoking prevalence among adult Oregonians estimate comes from the Oregon Behavioral Risk Factor Surveillance System, a telephone-administered survey of adults that examines health related behaviors. Responses to both of the following questions determine smoking status: “Have you smoked at least 100 cigarettes in your entire life?” (yes) and “Do you now smoke everyday, some days, or not at all?” (every day, or some days). Data depicted are weighted as appropriate, but not age-adjusted. A more comprehensive and accurate weighting formula has been developed by CDC, and will be available to apply to these data beginning in 2007. Oregon's tobacco prevalence estimates are anticipated to increase by 3.3 percentage points when the new weighting is applied to the data. Thus, it is difficult to set targets accurately. In the absence of more information, we have elected to extend the 2009 target into 2010 and 2011, with 3.3 percent added.

Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. Disadvantages associated with BRFSS include its reliance upon telephone landlines, which are increasingly less common among younger age groups, people with low income, and certain racial and ethnic populations. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.

Smoking prevalence among 8th graders in Oregon is on an annual reporting cycle, computed once per calendar year. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper survey administered to students at school. Responses to the following question determine smoking status: "During the past 30 days, on how many days did you smoke cigarettes?" (1-30). This measure depicts data from 8th graders (data are also collected on 11th graders). Data are weighted as appropriate. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.

Smoking prevalence among pregnant women is on an annual reporting cycle, computed once per calendar year. These data come from the birth certificates issued to all newborns in Oregon, which include parental demographic information, conditions of the newborn, and medical factors during the pregnancy (including mothers' smoking status). Responses to the following checkbox question determine smoking status: "Tobacco use during pregnancy" (yes). Unknown responses are subtracted from the denominator to replicate national calculations. Beginning in 2008, data comparable to 2002-2007 will no longer be available. TPEP will need to recalibrate targets for 2008, and subsequent years, after several years of data using the new birth certificate question format have been collected.. Advantages of these data are that they represent a census of information (that is, all births) and are not prone to sampling error, as are surveys. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.

KPM #24c	TOBACCO USE – Tobacco use among pregnant women.	2002
Goal	People are healthy.	
Oregon Context	Adult non-smokers, Preventable death, Teen substance abuse, Alcohol / tobacco use during pregnancy	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099.	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a

statewide public awareness and education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman's use of tobacco during pregnancy is associated with serious, at times fatal health problems for the child, ranging from low birth weight and premature births, to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality - contributing substantially toward the DHS goal "People are healthy" in both the short-term and long-term.

To report tobacco use among adults, a more comprehensive and accurate weighting formula has been developed by CDC, and will be available to apply to these data beginning in 2007. Oregon's tobacco prevalence estimates are anticipated to increase by 3.3 percentage points when the new weighting is applied to the data. Thus, it is difficult to set targets accurately. In the absence of more information, we have elected to extend the 2009 target into 2010 and 2011, with 3.3 percent added. See full explanation under question 7 - About the Data.

For tobacco use among pregnant women, TPEP will need to recalibrate targets for 2008, and subsequent years, after several years of data using the new birth certificate question format have been collected. See full explanation under question 7 - About the Data.

3. HOW WE ARE DOING

In 2006, the prevalence of smoking in Oregon was 18.3% for the general adult population, 8.7% among 8th grade adolescents, and 12.3% among pregnant women. From 2007, data are only available for 8th graders, and their smoking prevalence is 9.0%. For the general population of adults and for 8th graders, these measures were slightly better than targeted levels, while for pregnant women, this figure was slightly worse than the target. Although all measures are lower than their 2000 values, there does not appear to be a trend of declining smoking prevalence among 8th graders and among pregnant women.

4. HOW WE COMPARE

For adult smoking prevalence, the Healthy People 2010 target for this performance measure is 12%. By dedicating substantial resources to tobacco

prevention, Oregon may meet this target by 2010.

Healthy People 2010 has a target of 16% for the smoking rate among high school students. The Department's performance measure is for 8th graders, but the 11th grade-smoking rate is currently 16.1% in Oregon. If this success continues, Oregon's 11th grade smoking rates should meet the 16% target for 2010.

The performance measure of tobacco use during pregnancy has generally met or exceeded targeted levels in prior years, but is worse than target for 2006. Oregon's prevalence of smoking during pregnancy has historically been higher than the national rate, although national data for 2006 are not currently available.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended annual investment for tobacco prevention is \$11.60 per capita, or \$43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than \$2 billion lost to medical care and lost productivity annually in Oregon. Despite the recommendation, Oregon currently receives \$2.13 per capita for tobacco prevention from all funding sources. For most of the 2001-2003 biennium, the TPEP received approximately \$2.87 per capita per year. However, in April 2003, the Legislature stopped funding TPEP for the remainder of the biennium. Although TPEP funding was restored during the 2007 Legislative Session to the level approved by the voters in 1996, Oregon today spends less than one-fifth of the CDC recommended annual investment on tobacco prevention. After funding decreased in 2003, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased – for the first time since the program was first implemented.

6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for a comprehensive tobacco control program would need to be increased substantially. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

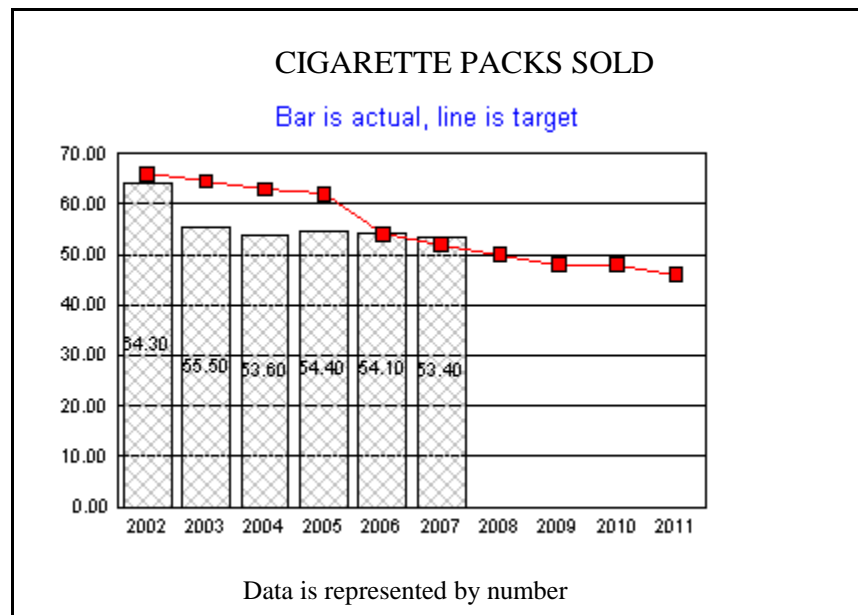
7. ABOUT THE DATA

Reporting cycle – calendar year. The smoking prevalence among adult Oregonians estimate comes from the Oregon Behavioral Risk Factor Surveillance System, a telephone-administered survey of adults that examines health related behaviors. Responses to both of the following questions determine smoking status: “Have you smoked at least 100 cigarettes in your entire life?” (yes) and “Do you now smoke everyday, some days, or not at all?” (every day, or some days). Data depicted are weighted as appropriate, but not age-adjusted. A more comprehensive and accurate weighting formula has been developed by CDC, and will be available to apply to these data beginning in 2007. Oregon’s tobacco prevalence estimates are anticipated to increase by 3.3 percentage points when the new weighting is applied to the data. Thus, it is difficult to set targets accurately. In the absence of more information, we have elected to extend the 2009 target into 2010 and 2011, with 3.3 percent added. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. Disadvantages associated with BRFSS include its reliance upon telephone landlines, which are increasingly less common among younger age groups, people with low income, and certain racial and ethnic populations. Additional years of data are available via our website by downloading the latest version of Oregon’s annual data report, Tobacco Facts.

Smoking prevalence among 8th graders in Oregon is on an annual reporting cycle, computed once per calendar year. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper survey administered to students at school. Responses to the following question determine smoking status: “During the past 30 days, on how many days did you smoke cigarettes?” (1-30). This measure depicts data from 8th graders (data are also collected on 11th graders). Data are weighted as appropriate. Additional years of data are available via our website by downloading the latest version of Oregon’s annual data report, Tobacco Facts.

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KPM #25	CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.	2002
Goal	People are healthy.	
Oregon Context	Adult non-smokers, Preventable death, Teen substance abuse, Alcohol / tobacco use during pregnancy	
Data Source	Oregon Department of Revenue (Cigarette Tax Receipts); Portland State University, Population Research Center (Population Estimates)	
Owner	Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099.	



1. OUR STRATEGY

One of the main goals of the Tobacco Prevention and Education Program (TPEP) is to reduce tobacco use by adults. This goal is accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and

education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing per capita cigarette consumption – it takes a comprehensive approach to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco or reducing the amount smoked has significant health benefits. Reductions in the number of cigarette packs sold per capita results from two distinct phenomena: an increase in former smokers, and a decrease in the quantity of cigarettes smoked among continuing smokers. It is clear that reducing the per capita packs of cigarettes sold will lead to substantial improvement in people's health, both in the short-term and long-term.

3. HOW WE ARE DOING

In 2007, the number of cigarette packs sold in Oregon was 53.4 packs per capita. This measure is higher than the desired target for 2007, and for the fourth year in a row has remained level. These data points are of concern because they represent a deviation from the previous, desirable trend.

4. HOW WE COMPARE

In 1997, prior to the TPEP's inception, Oregon had greater per capita sales of cigarette packs than the rest of the country (92.1 – Oregon, 87.2 – U.S.). In 2005, conversely, U.S. per capita sales of cigarette packs was 61.6. The current difference between Oregon and the U.S. represents a much steeper decline in per capita cigarette sales in Oregon, on average, than in the rest of the country. Nonetheless, Oregon's per capita pack sales in 2005 (54.4) were nearly double those of Washington (35.8) and California (33.1), our neighboring states that have dedicated significant resources to tobacco prevention activities.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended annual investment for tobacco prevention is \$11.60 per capita, or \$43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than \$2 billion lost to medical care and lost productivity annually in Oregon. Despite the recommendation, Oregon currently receives \$2.13 per capita for tobacco prevention from all funding sources. For most of the 2001-2003

biennium, the TPEP received approximately \$2.87 per capita per year. However, in April 2003, the Legislature stopped funding TPEP for the remainder of the biennium. Although TPEP funding was restored during the 2007 Legislative Session to the level approved by the voters in 1996, Oregon today spends less than one-fifth of the CDC recommended annual investment on tobacco prevention. After funding decreased in 2003, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased – for the first time since the program was first implemented.

6. WHAT NEEDS TO BE DONE

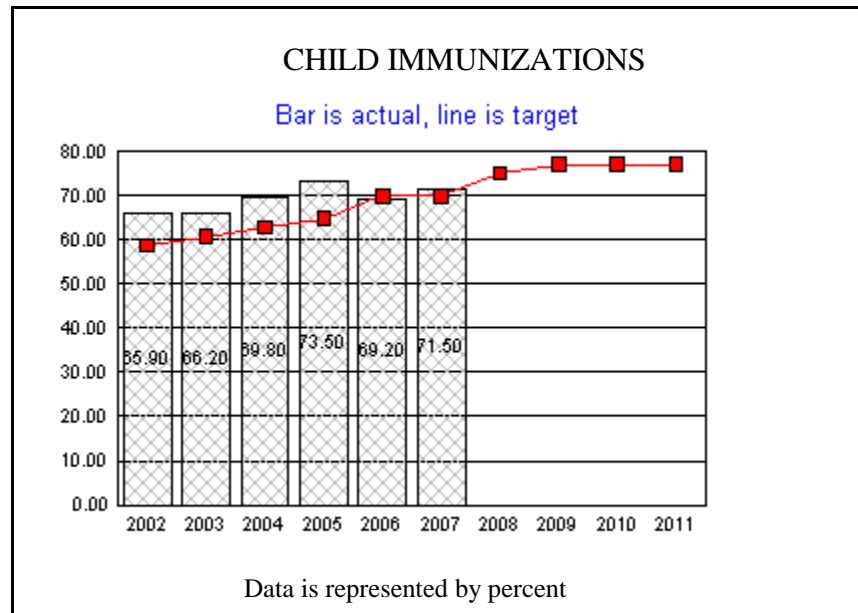
Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for a comprehensive tobacco control program would need to be increased substantially. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

7. ABOUT THE DATA

Reporting cycle – calendar year. Average per capita consumption is estimated annually by calendar year based on tobacco tax revenue collected by the Oregon Department of Revenue (DOR). The DOR's Monthly Receipt Statements include data on tax collections derived from sales of cigarettes. The number of packs of cigarettes sold is calculated by dividing the cigarette tax receipts by the tax rate per pack. The number of packs per capita is calculated by dividing the total number of cigarettes sold within the calendar year by the total population estimate for Oregon.

Advantages associated with these data are that they allow comparisons with national and other state estimates of consumption, which similarly rely on tax revenue data and population estimates. In addition, this estimator does not depend upon accurate self-reporting of smoking behavior. A disadvantage associated with this estimator is that the per capita consumption is based on the entire state population, including non-smokers, so it does not depict actual smokers' consumption levels. Another disadvantage is that packs of cigarettes purchased by Oregon consumers without taxes being collected (i.e., over the Internet, through mail order, in other states, or illegally in Oregon without tax) are not counted in this estimate. TPEP estimates that untaxed cigarettes represent a small fraction of the cigarettes Oregon smokers consume.

KPM #26	CHILD IMMUNIZATIONS – The percentage of 24 – 35 month old children served by local health departments who are adequately immunized.	2002
Goal	People are healthy.	
Oregon Context	Immunizations, Child mortality	
Data Source	Public Health Division, Office of Family Health (ALERT Registry)	
Owner	Public Health Division, Office of Family Health, Immunization Program, Collette Young, 971-673-0318	



1. OUR STRATEGY

Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Annual assessments of each local health department’s immunization rates and practices are conducted with results provided back to the agency to help improve performance.

2. ABOUT THE TARGETS

The goal is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%. In 2006-07 the methods for calculating this rate changed. Starting with 2006 data, the rates reflect only valid doses, as determined by the Advisory Committee on Immunization Practices guidelines. Valid doses are only those doses that meet minimum spacing or minimum age requirements. This resulted in a drop in the calculated rates.

3. HOW WE ARE DOING

In 2005, the percent of children immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps, rubella (MMR); three or more doses of Haemophilus Influenzae type b; and three or more doses of hepatitis B (4:3:1:3:3) reached 73.5% for those children served by local health departments. The change in methods to count only valid doses resulted in a one-time drop in rates from 2005 to 2006. This up-to-date rate continues to steadily increase.

4. HOW WE COMPARE

This KPM reflects children 24-35 months olds, served in the public sector based on data reported to the statewide registry. A national comparison is difficult because national data is based on a phone survey of a selected sample of Oregon residents 19-35 months of age, regardless of where they seek care. However the national rate for 4:3:1:3:3 in 2006 (last data point available) was 80.5% and 78.8% for Oregon.

5. FACTORS AFFECTING RESULTS

The children served in local health departments may not be representative of all Oregon children. In the majority of cases, children served in local health departments do not have a medical home, which means they face additional barriers to timely immunizations and require more state and local agency resources.

6. WHAT NEEDS TO BE DONE

To continue our success, DHS needs to:

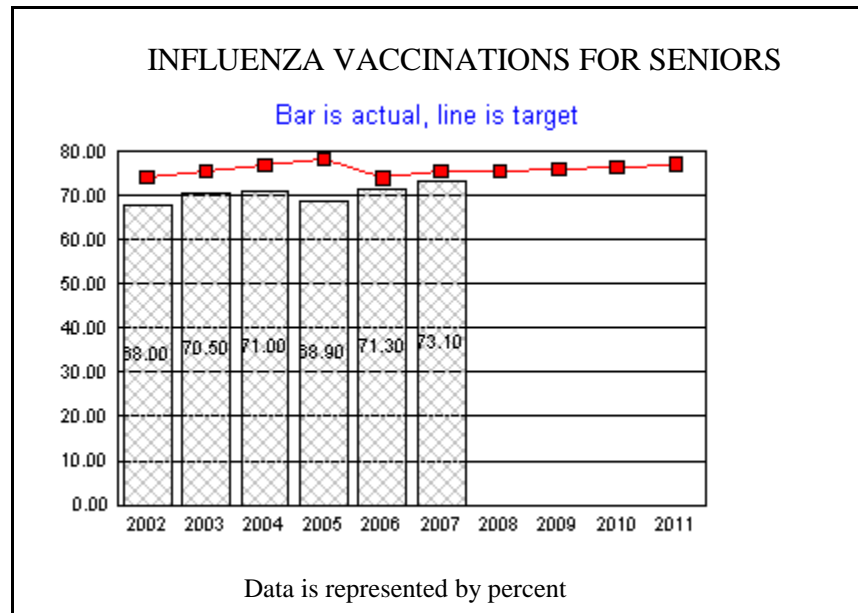
- Continue to provide funding, vaccines, and consultation to all local health departments.
- Maintain the computerized record system for the public sector, which includes reminder postcards for overdue shots.
- Increase private provider participation in the statewide ALERT immunization registry so that we can produce a consolidated record and improve providers' ability to identify under-immunized children.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measures the immunization rate for children 24-35 months of age who have received at least one immunization at a local health department. The data source is the ALERT registry, a statewide immunization registry that records reported immunization data from 100% of public providers and 88% of private providers. The immunizations assessed include 4 DTaP, 3 Polio, 1 MMR, 3 Hib, and 3 Hepatitis B (4:3:1:3:3). All immunizations reported (from both private and public sources) for the health department population are counted in the assessment. The data are generally available in April.

This Key Performance Measure was included in the Department's first performance audit during the summer of 2008. The DHS Internal Audit group certified that this key performance measure falls within the category of verified. The performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #27	INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.	2002
Goal	People are healthy	
Oregon Context	Preventable death	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS)	
Owner	Public Health Division, Office of Family Health, Immunization Program Collette Young (971) 673-0318	



1. OUR STRATEGY

Strategies include promoting adult immunizations through the DHS-funded Oregon Adult Immunization Coalition (OAIC), promotion of pre-printed orders, and an annual education summit. Additionally, influenza vaccinations are promoted and supported by local health departments.

2. ABOUT THE TARGETS

The goal is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%. However the rates in Oregon have been relatively flat over the past several years. Given the slow, incremental changes, the targets have been revised to reflect a more realistic and achievable immunization rate.

3. HOW WE ARE DOING

The percentage of older adults immunized annually against influenza has remained relatively flat over the past several years and below the targets. Following the influenza vaccine shortage during the 2004-05 season, a survey of Oregon residents found that the top reasons for not getting a flu shot were concerns about vaccine efficacy and safety.

4. HOW WE COMPARE

In 2007, the national immunization rate for persons 65 and older was 72.0%, with state rates ranging from 80.0% in Rhode Island to 61.9% in the Nevada. Oregon is ranked 19th in rates nationally.

5. FACTORS AFFECTING RESULTS

In general the flat rates are influenced by public's perception of need and efficacy of the vaccine, absence of policies in place that motivate health systems to routinely vaccinate all clients, lack of funding for adult immunizations, and access to Immunization ALERT, the statewide immunization registry that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB2188 passed, expanding ALERT to a lifespan registry. Over the next few years as the registry collects and processes data, this information will be available to healthcare providers, helping them identify candidates for vaccine and could be used for sending out reminders to clients to seek out immunization every year. During Phase 1 of the lifespan registry expansion, ALERT is focusing on increasing data capture for 0 to 23 year olds. As funding allows, ALERT will expand efforts to capture data across the lifespan. Another initiative, promoting influenza pre-printed orders in hospitals for eligible adults, will continue to create opportunities for screening and vaccinating adults. The number of hospitals supporting pre-printed orders has increased from 18 in 2004 to 26 in 2007.

6. WHAT NEEDS TO BE DONE

With the support of OAIC and depending on our available resources, we plan on the following:

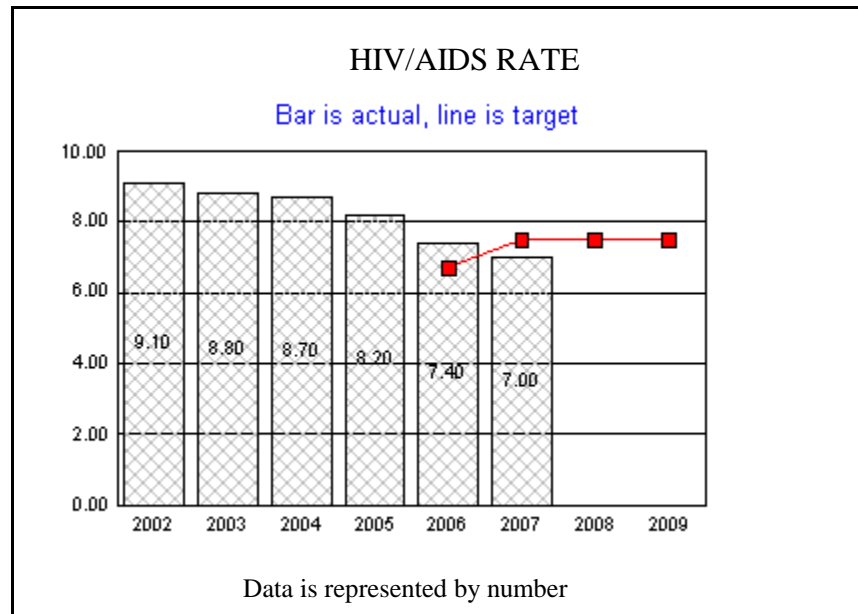
- Continue to work with hospitals to increase the number of patients, age 65 and older, who are immunized against influenza prior to discharge;

- Provide vaccine and/or clinics to agencies serving underserved populations;
- Host the 5th Annual Flu Summit to promote influenza vaccination strategies to providers; and
- Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or tetanus/diphtheria vaccine, in all health care settings.

7. ABOUT THE DATA

Reporting period - calendar year. This measures the percent of adults, 65 years and older, which reported receiving an influenza vaccination in the previous 12 months as reported on the Behavioral Risk Factor Surveillance survey (BRFSS). [Survey question: During the past 12 months, have you had a flu shot?]. The data are generally available in May.

KPM #28	HIV RATE – The annual rate of HIV infection per 100,000 persons.	2000
Goal	People are healthy.	
Oregon Context	HIV diagnosis, Communicable disease	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/AIDS Reporting Systems (HARS) database & PSU Census	
Owner	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/STD/TB Program, DHS, Jeff Capizzi, 971-673-0182	



1. OUR STRATEGY

DHS designs and administers state and federal programs for HIV prevention and treatment. Innovative HIV prevention programs include

educational campaigns, partner notification and counseling, and HIV testing (anonymous and confidential). Over 19,000 HIV tests were performed by the Oregon State Public Health Laboratory during 2005 - the majority of these funded by programs administered by DHS. HIV treatment programs serve approximately 2,000 people living with HIV statewide and include case management, housing assistance, medication, and health insurance to persons living with HIV and AIDS.

2. ABOUT THE TARGETS

Our goal is to reduce the number of new HIV infections per year. Therefore, beginning in 2006 we established goals consistent with a 20% reduction in the measured rate of new infections from 2004. Changes in HIV case reporting rules implemented during 2006 are likely to increase the proportion of new cases detected (completeness of reporting) leading to an anticipated increase in rates beginning in 2007. These increases in reported rates will reflect better public health surveillance, not a true increase in rates of new infection.

3. HOW WE ARE DOING

Slight declines in new case rates have occurred since 2002. This has occurred despite the fact that increasing survival with HIV infection means that the pool of people who might infect others increases continuously. This implies that the average person with HIV/AIDS infects fewer new persons each year and that prevention and care programs have been effective in curtailing the epidemic. Though changes in case reporting practices and extensive reporting delays for some cases of HIV/AIDS makes longitudinal comparison of rates of diagnosed and reported cases difficult, Oregon appears to be meeting optimistic targets of a further 20% reduction of newly diagnosed cases compared to 2004. Sustained reductions will require continued support of effective HIV Prevention programs leading to behavioral changes such as a reduction of high-risk behavior by those infected or at risk, possibly complemented by new treatment of those already infected to reduce their infectivity.

4. HOW WE COMPARE

The Centers for Disease Control and Prevention estimated that 22.4 HIV infections were diagnosed per 100,000 people during 2006 in 33 states that required HIV case reporting by name for at least 5 years. (Oregon switched to named reporting on April 17, 2006.) Oregon's 2007 rate of 7.0 cases per 100,000 residents is well below that level.

5. FACTORS AFFECTING RESULTS

DHS invests several million dollars each year in care for persons with HIV and AIDS and in prevention of new infections. The HIV Care Program provides case management services to over 2000 persons with HIV in Oregon each year, helping them sustain access to medical care and

treatment. These services extend life expectancy among people with HIV and AIDS and reduce risk of subsequent HIV transmission. The HIV Prevention Program invests over a million dollars annually in HIV testing and counseling. These efforts detect newly infected persons early, leading to treatment and prevention of new cases. In addition the HIV Prevention Program makes large annual investments in counseling partners of persons newly diagnosed with HIV infection and in numerous social marketing campaigns to reduce behaviors that lead to reduction in HIV transmission.

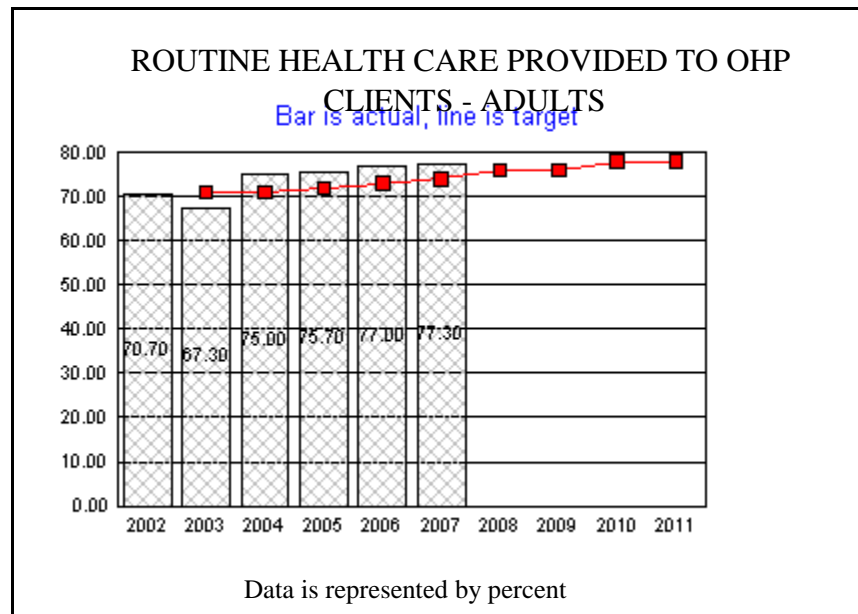
6. WHAT NEEDS TO BE DONE

HIV prevention efforts in Oregon should continue to focus on effective strategies to reduce behaviors that increase risk of infection, such as unprotected sex, sex with multiple partners, and injection drug use or sharing and reuse of drug paraphernalia. HIV testing should remain readily available to enable those at risk to obtain early diagnosis and, if infected, get into treatment. Barriers to HIV testing should be removed. Technology to shorten the interval between infection and positive laboratory tests should be adopted. More newly infected people should receive counseling about reducing the risk of transmission to sex and drug use partners. People with HIV infection need to be encouraged and assisted to identify a stable source of medical care, which has the potential to reduce risk of transmission through counseling and, while not offering a cure, through reduction of infectivity to others.

7. ABOUT THE DATA

Reporting cycle – calendar year. Currently, the median delay between diagnosis and inclusion in the HIV case reporting system is approximately 2 months. Traditionally, fifteen percent of newly diagnosed cases are reported more than 6 months after diagnosis. Because of reporting delay, HIV rates are typically reported in July for the preceding calendar year. Rates reported here for each year are based upon all cases diagnosed during that year and reported by June 30 of the following year. Population estimates are taken from the American Community Survey (<http://factfinder.census.gov>) for the preceding year. Centers for Disease Control and Prevention have estimated that 25% of people infected with HIV are unaware of their infection. In addition, about 10% of diagnosed cases are not captured by the reporting system. Therefore, reported rates probably represent less than 75% of the true number of new infections. As outlined above, changes in HIV case reporting rules were implemented during 2006. These include increased laboratory reporting requirements and a switch to named HIV case reporting. These changes have made case reporting more complete, and comparison with earlier years somewhat misleading. For interested readers, the HIV/STD/TB program publishes an annual epidemiologic profile for HIV. It is available at <http://oregon.gov/DHS/ph/hiv/data/index.shtml>.

KPM #29a	ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS– The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: adults.	2002
Goal	People are healthy	
Oregon Context	Health Care Access – DHS High Level Outcome	
Data Source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	



1. OUR STRATEGY

People who have access to and utilize routine care have improved health outcomes; and health care is delivered in a more cost-effective manner. Accessing routine care allows diseases to be diagnosed and treated before becoming serious and debilitating. In addition, preventive health screens and anticipatory guidance given as part of routine primary care helps to promote early diagnosis and treatment, healthy lifestyles and wellness.

A premise of the Oregon Health Plan (OHP) is to increase access to preventive and primary health care through routine health care visits. OHP also reduces unnecessary and more expensive health care in the hospital or emergency room setting. Routine primary and specialist care are most effectively and appropriately delivered in a clinic or office rather than an emergency room.

Clients in managed care utilize preventive and primary care services at higher rates than other clients. Therefore, one way the Division of Medical Assistance Programs (DMAP) promotes routine health care services is through enrollment in managed care. Managed care plans participate in quality improvement and prevention activities including performance improvement projects and measures. Past and present focuses include tobacco cessation, asthma, diabetes and prenatal care, early childhood cavity prevention, childhood immunizations, and strengthening the collaboration between physical health and behavioral health. Also, DMAP has a disease management and case management programs for fee-for-service (FFS) clients. In addition, DMAP sends regular preventive health care messages to all OHP clients on their monthly medical I.D. cards and regularly sends birthing hospitals reminders to enroll eligible newborns on OHP. DMAP works closely with many Public Health programs and has preventive health care messages on the DHS website with links to public health information.

2. ABOUT THE TARGETS

DMAP chose targets that gradually increase. This measure is unique to OHP, therefore, it is not known how fast the measure will change and if or when the measure will plateau. The favorable direction for this measure is high.

3. HOW WE ARE DOING

The rate for adults increased in 2007 and is above the 2007 target. The rate for children increased in 2007 by less than a percentage point but is slightly below the target set for 2007. Since 2002, for both adults and children, the general trend is a favorable increase in the proportion of OHP clients who receive routine health care services. From 2002 to 2007, the rate for adults increased 6.6 percentage points from 70.7% to 77.3% and the rate for children increased 1.3 percentage points from 70.7% to 72.0%.

4. HOW WE COMPARE

There are no public or private industry standards to compare to this performance measure. This measure was designed to measure DMAP's performance delivering routine care to clients on OHP. OHP was uniquely crafted to deliver routine health services as the key part of Oregon's Medicaid program. Typically, the certification period for OHP is six months. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. The proportion of these clients who have at least one routine health care service is

measured.

5. FACTORS AFFECTING RESULTS

Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. A barrier is health care providers that do not accept Medicaid clients due to low reimbursement rates. For clients common barriers include transportation and child care issues and perhaps a lack of understanding among some clients that routine health visits are necessary and important.

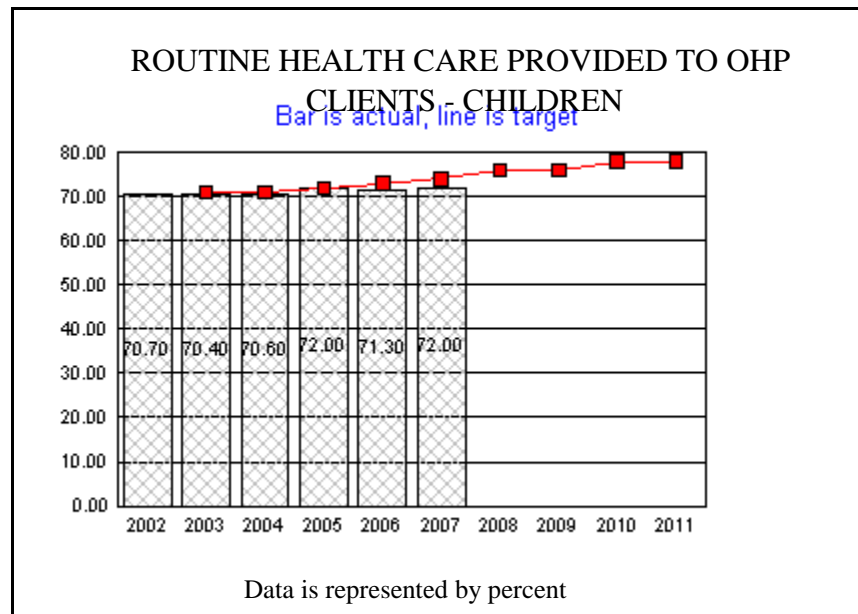
6. WHAT NEEDS TO BE DONE

DMAP has added more explicit standards to the managed care organization contracts to make certain there is adequate network capacity to provide routine and preventive services. DMAP has started requiring managed care plans meet specified goals for performance measures. DMAP has initiated a project to pay its managed care organizations incentives for increasing the provision of preventive services. DMAP will continue its current quality improvement activities. DMAP will continue to work with public health partners, promote enrollment in managed care, and utilize disease management and case management programs (for FFS clients as appropriate). DMAP continues to provide a nurse telephone advice line for FFS clients.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. So for example, for measurement year 2007, clients must be on OHP for at least six months between August 1, 2006 and December 31, 2007. This strengthens the data by taking into account the typical OHP six-month certification cycle and including the many clients who began their OHP enrollment at the end of the year before the next measurement year and continued their enrollment into the measurement year. A weakness of this measure is that it was not designed to compare managed care plans to each other or to clients in the FFS delivery system. This measure is available by county.

KPM #29b	ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS– The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: children.	2002
Goal	People are healthy	
Oregon Context	Health Care Access – DHS High Level Outcome	
Data Source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	



1. OUR STRATEGY

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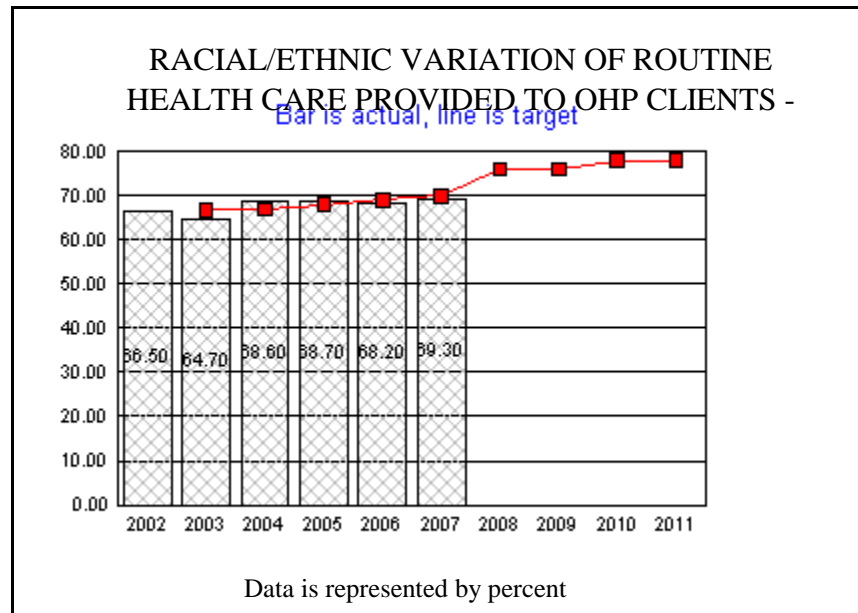
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KPM #30a	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: African Americans.	2002
Goal	People are healthy	
Oregon Context	Health Care Access and Racial /ethnic Health Status – DHS High Level Outcomes	
Data Source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	



1. OUR STRATEGY

Reducing health disparities is a priority of Oregon’s Department of Human Services. This measure examines access to routine care by racial/ethnic groups.

People who have access to and utilize routine care have improved health outcomes; and health care is delivered in a more cost-effective manner.

Accessing routine care allows diseases to be diagnosed and treated before becoming serious and debilitating. In addition, preventive health screens and anticipatory guidance given as part of routine primary care helps to promote early diagnosis and treatment, healthy lifestyles and wellness. A premise of the Oregon Health Plan (OHP) is to increase access to preventive and primary health care through routine health care visits. OHP also reduces unnecessary and more expensive health care in the hospital or emergency room setting. Routine primary and specialist care are most effectively and appropriately delivered in a clinic or office rather than an emergency room.

The Division of Medical Assistance Programs (DMAP), in collaboration with DHS's Office of Minority Health federal CHCS is developing strategies for reducing health care disparities including contracted targets and incentives for OHP managed care organizations. DMAP provides an increasing number of educational materials in languages in addition to English.

2. ABOUT THE TARGETS

DMAP chose targets that gradually increase. This measure is unique to the Oregon Health Plan, therefore, it is not known how fast the measure will change and if or when the measure will plateau. The favorable direction for this measure is high.

3. HOW WE ARE DOING

In 2007, the rates for African Americans, Asian and Pacific Islanders, and Hispanics increased by about one percentage point while the rate for Native Americans decreased by a little more than a percentage point while the rate for whites remained steady compared to 2006 rates. All race/ethnic category rates were less than one percentage point below their 2007 targets except for the Hispanics category was less than a percentage point above its target. Since 2002, for all race/ethnic categories, the general trend shows a favorable increase in the proportion of OHP clients who receive routine health care services. From 2002 to 2007, all categories have increased rates.

4. HOW WE COMPARE

There are no public or private industry standards to compare to this performance measure. This measure separates KPM #29 into five racial/ethnic categories combining adults and children.

This measure was designed to measure DMAP's performance delivering routine care to clients on OHP. OHP was uniquely crafted to deliver routine health services as the key part of Oregon's Medicaid program. Typically, the certification period for OHP is six months. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. The proportion of these clients who have at least one routine health care service is measured.

5. FACTORS AFFECTING RESULTS

Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Another facilitator is the number of clients whose medical home is a Federally Qualified Health Clinic or a Rural Health Clinic, as these clinics have a high level of cultural competence. Barriers are health care providers that do not accept Medicaid clients due to low reimbursement rates. For clients, common barriers include transportation and child care issues and perhaps a lack of understanding among some clients that routine health visits are necessary and important.

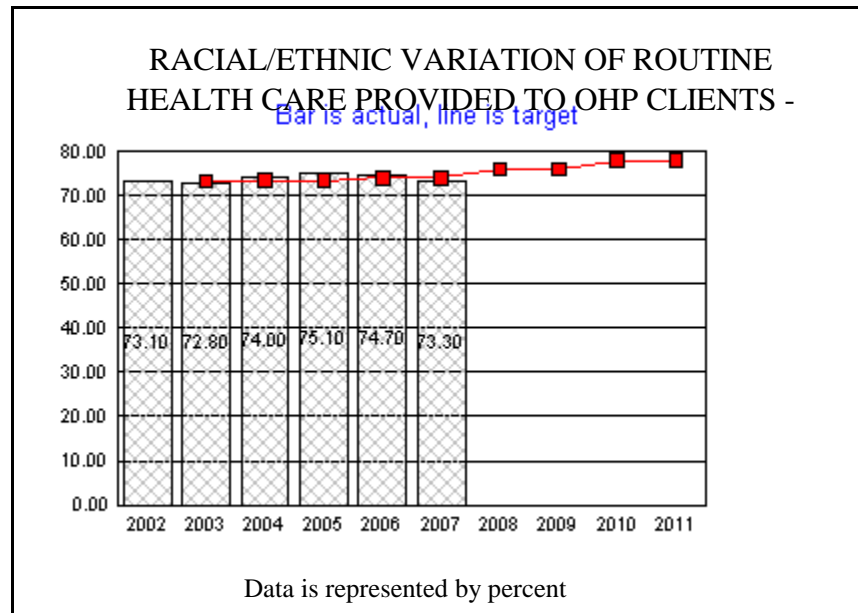
6. WHAT NEEDS TO BE DONE

DMAP will continue to collaborate with community, public health, and federal partners on initiatives and projects that focus on reducing health care disparities. DMAP continues to provide an increasing number of educational materials in languages in addition to English.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. So for example, for measurement year 2007, clients must be on OHP for at least six months between August 1, 2006 and December 31, 2007. This strengthens the data by taking into account the typical OHP six-month certification cycle and including the many clients who began their OHP enrollment at the end of the year before the next measurement year and continued their enrollment into the measurement year. Race/ethnicity is self-reported by the client or reported by their caseworker. A client may be in only one of the five racial/ethnic categories (African American, Native American, Asian American and Pacific Islander, Hispanic, or white) to be counted in this measure. In 2007, there was a change in the data system to meet the federal requirements of reporting race and ethnicity separately. The category of Hispanic became an ethnicity that can overlay any of the other races. This change resulted in most Hispanics choosing the other/unknown category for race. As a result, for this report, the Hispanic and other/unknown categories were combined. A weakness of this measure is that it was not designed to compare managed care plans to each other and to clients in the fee-for-service delivery system. This measure is available by county.

KPM #30b	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: Native Americans.	2002
Goal	People are healthy	
Oregon Context	Health Care Access and Racial /ethnic Health Status – DHS High Level Outcomes	
Data Source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	



1. OUR STRATEGY

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2. ABOUT THE TARGETS

DMAP chose targets that gradually increase. This measure is unique to the Oregon Health Plan, therefore, it is not known how fast the measure will change and if or when the measure will plateau. The favorable direction for this measure is high.

3. HOW WE ARE DOING

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4. HOW WE COMPARE

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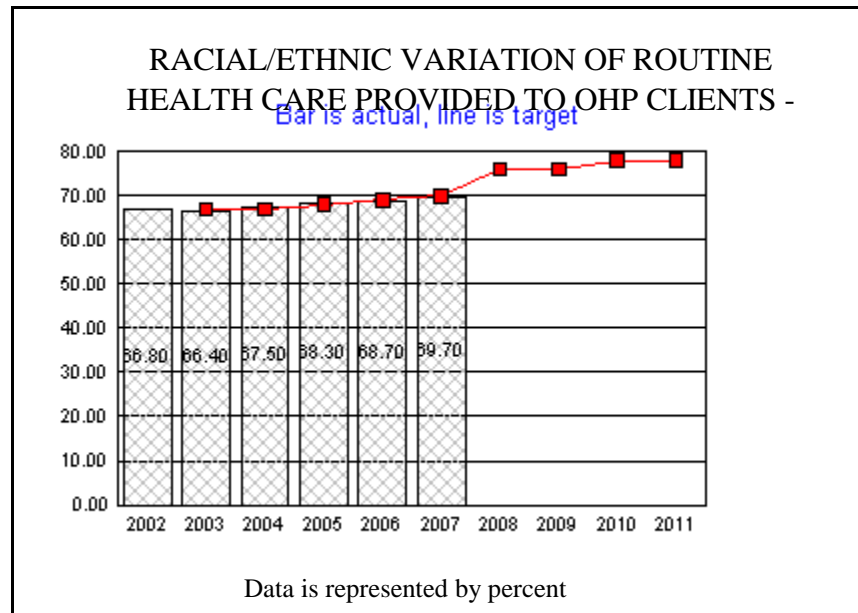
6. WHAT NEEDS TO BE DONE

DMAP will continue to collaborate with community, public health, and federal partners on initiatives and projects that focus on reducing health care disparities. DMAP continues to provide an increasing number of educational materials in languages in addition to English.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. So for example, for measurement year 2007, clients must be on OHP for at least six months between August 1, 2006 and December 31, 2007. This strengthens the data by taking into account the typical OHP six-month certification cycle and including the many clients who began their OHP enrollment at the end of the year before the next measurement year and continued their enrollment into the measurement year. Race/ethnicity is self-reported by the client or reported by their caseworker. A client may be in only one of the five racial/ethnic categories (African American, Native American, Asian American and Pacific Islander, Hispanic, or white) to be counted in this measure. In 2007, there was a change in the data system to meet the federal requirements of reporting race and ethnicity separately. The category of Hispanic became an ethnicity that can overlay any of the other races. This change resulted in most Hispanics choosing the other/unknown category for race. As a result, for this report, the Hispanic and other/unknown categories were combined. A weakness of this measure is that it was not designed to compare managed care plans to each other and to clients in the fee-for-service delivery system. This measure is available by county.

KPM #30c	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: Asian/Pacific Islanders.	2002
Goal	People are healthy	
Oregon Context	Health Care Access and Racial /ethnic Health Status – DHS High Level Outcomes	
Data Source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	



1. OUR STRATEGY

Reducing health disparities is a priority of Oregon’s Department of Human Services. This measure examines access to routine care by racial/ethnic groups.

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The Division of Medical Assistance Programs (DMAP), in collaboration with DHS's Office of Minority Health federal CHCS is developing strategies for reducing health care disparities including contracted targets and incentives for OHP managed care organizations. DMAP provides an increasing number of educational materials in languages in addition to English.

2. ABOUT THE TARGETS

DMAP chose targets that gradually increase. This measure is unique to the Oregon Health Plan, therefore, it is not known how fast the measure will change and if or when the measure will plateau. The favorable direction for this measure is high.

3. HOW WE ARE DOING

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4. HOW WE COMPARE

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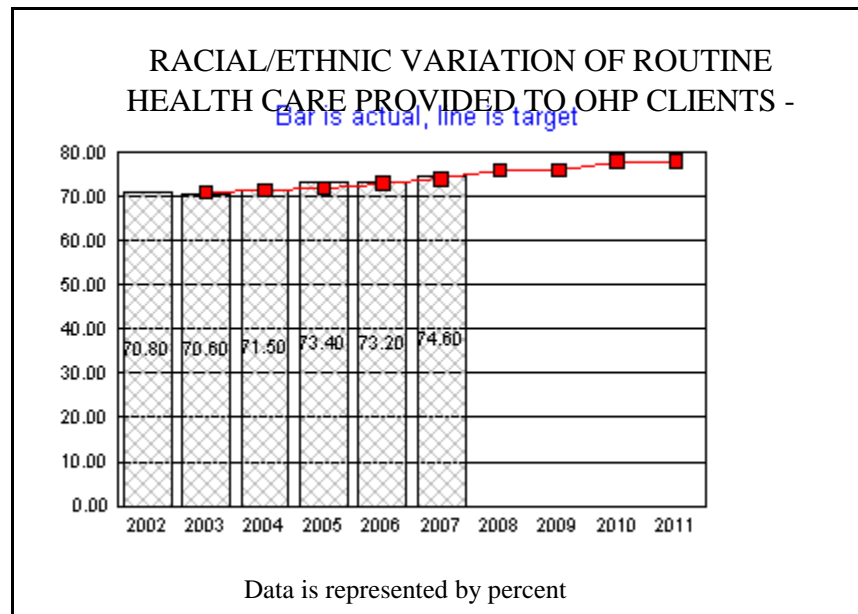
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KPM #30d	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: d) Hispanic.	2002
Goal	People are healthy	
Oregon Context	Health Care Access and Racial /ethnic Health Status – DHS High Level Outcomes	
Data Source	Oregon MMIS (Medicaid Management Information System)	
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This measure was designed to measure DMAP's performance delivering routine care to clients on OHP. OHP was uniquely crafted to deliver routine health services as the key part of Oregon's Medicaid program. Typically, the certification period for OHP is six months. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. The proportion of these clients who have at least one routine health care service is measured.

5. FACTORS AFFECTING RESULTS

Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Another facilitator is the number of clients whose medical home is a Federally Qualified Health Clinic or a Rural Health Clinic, as these clinics have a high level of cultural competence. Barriers are health care providers that do not accept Medicaid clients due to low reimbursement rates. For clients, common barriers include transportation and child care issues and perhaps a lack of understanding among some clients that routine health visits are necessary and important.

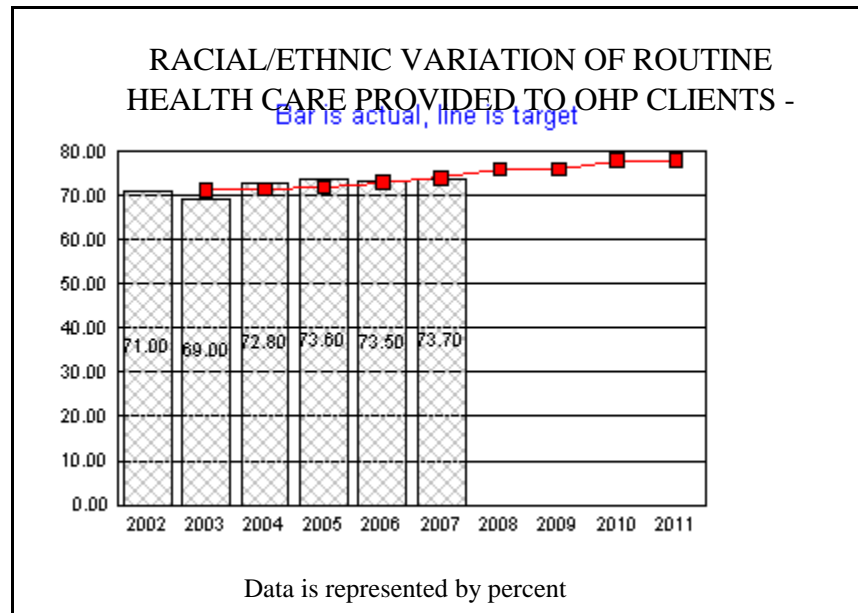
6. WHAT NEEDS TO BE DONE

DMAP will continue to collaborate with community, public health, and federal partners on initiatives and projects that focus on reducing health care disparities. DMAP continues to provide an increasing number of educational materials in languages in addition to English.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. So for example, for measurement year 2007, clients must be on OHP for at least six months between August 1, 2006 and December 31, 2007. This strengthens the data by taking into account the typical OHP six-month certification cycle and including the many clients who began their OHP enrollment at the end of the year before the next measurement year and continued their enrollment into the measurement year. Race/ethnicity is self-reported by the client or reported by their caseworker. A client may be in only one of the five racial/ethnic categories (African American, Native American, Asian American and Pacific Islander, Hispanic, or white) to be counted in this measure. In 2007, there was a change in the data system to meet the federal requirements of reporting race and ethnicity separately. The category of Hispanic became an ethnicity that can overlay any of the other races. This change resulted in most Hispanics choosing the other/unknown category for race. As a result, for this report, the Hispanic and other/unknown categories were combined. A weakness of this measure is that it was not designed to compare managed care plans to each other and to clients in the fee-for-service delivery system. This measure is available by county.

KPM #30e	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients provided routine health care services annually: White.	2002
Goal	People are healthy	
Oregon Context	Health Care Access and Racial /ethnic Health Status – DHS High Level Outcomes	
Data Source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	



1. OUR STRATEGY

Reducing health disparities is a priority of Oregon’s Department of Human Services. This measure examines access to routine care by racial/ethnic groups.

People who have access to and utilize routine care have improved health outcomes; and health care is delivered in a more cost-effective manner.

Accessing routine care allows diseases to be diagnosed and treated before becoming serious and debilitating. In addition, preventive health screens and anticipatory guidance given as part of routine primary care helps to promote early diagnosis and treatment, healthy lifestyles and wellness. A premise of the Oregon Health Plan (OHP) is to increase access to preventive and primary health care through routine health care visits. OHP also reduces unnecessary and more expensive health care in the hospital or emergency room setting. Routine primary and specialist care are most effectively and appropriately delivered in a clinic or office rather than an emergency room.

The Division of Medical Assistance Programs (DMAP), in collaboration with DHS's Office of Minority Health federal CHCS is developing strategies for reducing health care disparities including contracted targets and incentives for OHP managed care organizations. DMAP provides an increasing number of educational materials in languages in addition to English.

2. ABOUT THE TARGETS

DMAP chose targets that gradually increase. This measure is unique to the Oregon Health Plan, therefore, it is not known how fast the measure will change and if or when the measure will plateau. The favorable direction for this measure is high.

3. HOW WE ARE DOING

In 2007, the rates for African Americans, Asian and Pacific Islanders, and Hispanics increased by about one percentage point while the rate for Native Americans decreased by a little more than a percentage point while the rate for whites remained steady compared to 2006 rates. All race/ethnic category rates were less than one percentage point below their 2007 targets except for the Hispanics category was less than a percentage point above its target. Since 2002, for all race/ethnic categories, the general trend shows a favorable increase in the proportion of OHP clients who receive routine health care services. From 2002 to 2007, all categories have increased rates.

4. HOW WE COMPARE

There are no public or private industry standards to compare to this performance measure. This measure separates KPM #29 into five racial/ethnic categories combining adults and children.

This measure was designed to measure DMAP's performance delivering routine care to clients on OHP. OHP was uniquely crafted to deliver routine health services as the key part of Oregon's Medicaid program. Typically, the certification period for OHP is six months. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. The proportion of these clients who have at least one routine health care service is measured.

5. FACTORS AFFECTING RESULTS

Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Another facilitator is the number of clients whose medical home is a Federally Qualified Health Clinic or a Rural Health Clinic, as these clinics have a high level of cultural competence. Barriers are health care providers that do not accept Medicaid clients due to low reimbursement rates. For clients, common barriers include transportation and child care issues and perhaps a lack of understanding among some clients that routine health visits are necessary and important.

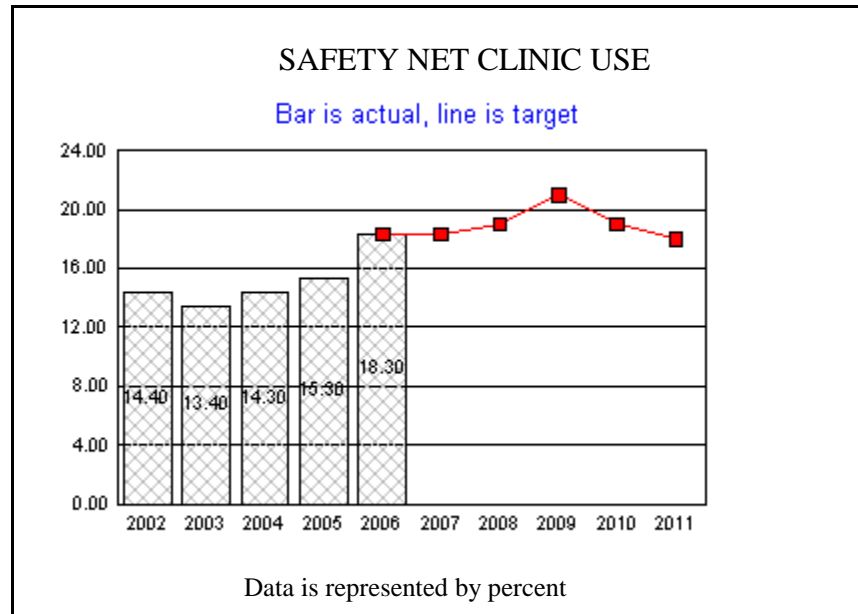
6. WHAT NEEDS TO BE DONE

DMAP will continue to collaborate with community, public health, and federal partners on initiatives and projects that focus on reducing health care disparities. DMAP continues to provide an increasing number of educational materials in languages in addition to English.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measure was designed to include clients who have been enrolled for six months or more within a seventeen-month period. So for example, for measurement year 2007, clients must be on OHP for at least six months between August 1, 2006 and December 31, 2007. This strengthens the data by taking into account the typical OHP six-month certification cycle and including the many clients who began their OHP enrollment at the end of the year before the next measurement year and continued their enrollment into the measurement year. Race/ethnicity is self-reported by the client or reported by their caseworker. A client may be in only one of the five racial/ethnic categories (African American, Native American, Asian American and Pacific Islander, Hispanic, or white) to be counted in this measure. In 2007, there was a change in the data system to meet the federal requirements of reporting race and ethnicity separately. The category of Hispanic became an ethnicity that can overlay any of the other races. This change resulted in most Hispanics choosing the other/unknown category for race. As a result, for this report, the Hispanic and other/unknown categories were combined. A weakness of this measure is that it was not designed to compare managed care plans to each other and to clients in the fee-for-service delivery system. This measure is available by county.

KPM #31	SAFETY NET CLINIC USE – The percentage of uninsured Oregonians served by safety net clinics.	2002
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	Oregon Primary Care Association, Oregon Population Survey and Portland State University	
Owner	Public Health Division, Office of Community Health and Health Systems, Health Systems Planning, Juanita Heimann 971-673-1267	



1. OUR STRATEGY

Safety Net clinics provide health care to Medicaid clients, Medicare, and uninsured clients. This has been a critical role as the Oregon Health Plan (OHP) has shrunk and the number of uninsured has increased. Health Systems Planning (HSP) monitors policy implications and staffs the Safety Net Advisory Council. HSP determines health professional shortage areas and areas of unmet need and makes that information available to

communities. HSP provides technical assistance to communities and sites interested in establishing or expanding sites. HSP assists communities with workforce needs in underserved areas of the state.

2. ABOUT THE TARGETS

We originally assumed that using percentages of uninsured served would quantify the work of the safety net and that increasing percentages would further indicate both the needs of the uninsured and the role of the safety net. However with the diminishing size of OHP enrollment and the increasing number of uninsured the OHP percentage served by the safety net declined even though in absolute numbers the safety continued to see more and more uninsured in addition to the Medicaid and Medicare clients in their patient load. In 2000, the safety net served over 80,000 uninsured Oregonians. By 2006 that number had risen to over 105,000. In 2007 the number rose to 127,000. The targets for 07, 08, and 09 assumed that additional children and perhaps some adults would be covered through the implementation of Healthy Kids and therefore the percentage of uninsured Oregonians served by the safety net will decline although actual numbers served would have remained high because the safety net would continue to serve many OHP patients among the newly covered. Of course the Healthy Kids measure did not pass and we will not see significant numbers of children added to the plan in 08. However with the SB 329 planning process underway and with likely recommendations to the 09 legislature there is a fair chance that additional children if not some adults will be covered in 09 and with higher numbers in 2010. Because the recommendations have not yet been finalized it is difficult at this stage to reassess targets. They may still be accurate depending on legislative action in the next session.

3. HOW WE ARE DOING

Because the total number of uninsured persons statewide is only available every two years we are not able to comment on 2007 except to mention the increase in absolute numbers served noted above (127,000). Thus we are only able to provide the analysis for the previous report.

Percentages served by the safety net have remained high since 2000 reflecting an economic downturn, some level of recovery between 2002 and 2005 and then a subsequent increase in the percentage in 2005 with an even greater increase in 2006 bringing the safety percentage back to numbers more like those of 2000. SB 329 was approved by the legislature and its future implementation may also have some significant impact on the number of uninsured Oregonians and the percentage served by the safety net as noted above. That impact would not likely be visible until 2009 or after. This is, of course, barring another downturn in the economy. If we assume that the purpose of the safety net is to enable the state to provide care to a significant number of uninsured whatever the barriers they face then we would have to assume that the safety net is doing its job. This is especially true when we consider that safety net providers also serve Medicaid and Medicare patients and are part of the capacity equation for these populations. Of some concern from a policy perspective is the fact that the safety net has served increasing numbers of uninsured without corresponding increases in revenue. We are also aware that there are capacity needs in the current Medicare and Medicaid programs and that

capacity will be strained as baby boomers retire. The likely shortage of providers will have a significant impact on the safety net unless it is addressed.

4. HOW WE COMPARE

We don't have other comparisons we can make in Oregon and comparative data are not currently available for other states, although we believe safety net roles and dynamics are similar.

5. FACTORS AFFECTING RESULTS

Factors have been noted above in #2 and #3.

6. WHAT NEEDS TO BE DONE

SB 329 passed in the recent session provides an opportunity to develop a roadmap to covering most Oregonians. The DHS director, OHPD director, and the new Health Fund Director, and the legislature will be key to facilitating the development and implementation of that roadmap. Understanding the shifting payer source for safety net providers will be important to understanding the role the safety net can and should play in an environment where many more people are covered. In that light we will need to especially understand the relative proportions of uninsured, Medicaid, and Medicare served by the safety net. Medicare access is increasingly problematic in Oregon and Fully Capitated Health Plans (FCHPs) depend to a good extent on the safety net as part of their panel to assure access. Work is currently being done within the SB 329 process to consider the evolving role of the safety net in the context of delivery system redesign. Workforce shortages will also play a part in understanding both the contribution of the safety net and the challenges it faces. It is important to understand the role the safety net plays as a part of total health system capacity to provide care to both those who are uninsured (assuming there will always be some) and those who are covered by Medicare or Medicaid. Targets will need to be reassessed based on 09 legislative action regarding SB 329 OHFB recommendations.

7. ABOUT THE DATA

This measure is calculated from three data sources: The Oregon Primary Care Association, Uniform Data System (number of uninsured served by FQHC clinics), the Oregon Population Survey (total uninsured rates), and Portland State University, Population Research Center (population estimates). All data are reported by calendar year except the population estimates, which represent a mid-year average. The formula used is: $(\# \text{ uninsured served by FQHC clinics}) / ((\% \text{ uninsured in the population}) * (\text{total population}))$

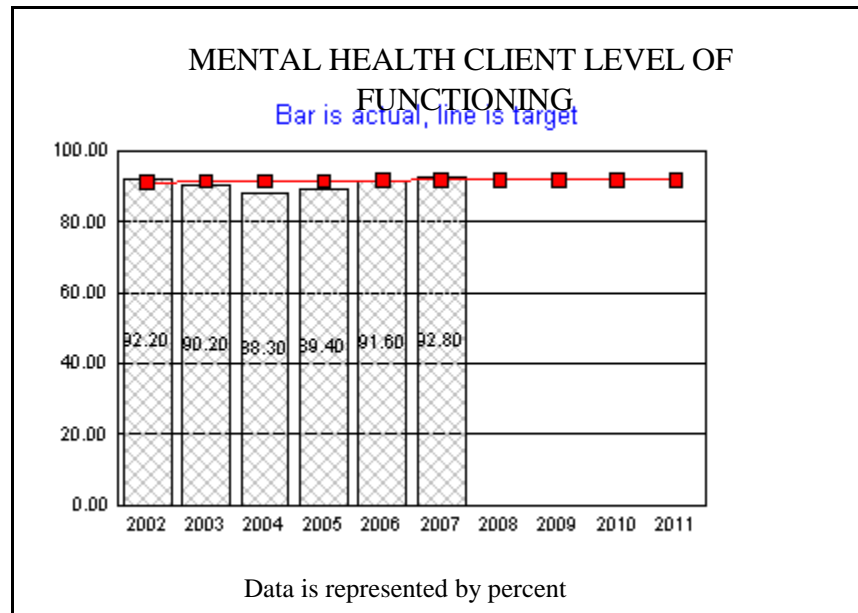
The Uniform Data System (UDS) collects data on all clinics in the U.S. receiving federal funds through section 330 of the Public Health Service (PHS) Act and administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). These clinics are known as Federally Qualified Health Centers (FQHC's). The Oregon Primary Care Association (OPCA) provides annual calendar year figures of the total number of uninsured persons in Oregon served by these clinics. For more information about the UDS see <http://bphc.hrsa.gov/uds/>. In the calculation of this measure FQHC's are used as a proxy for the entire safety-net clinic system in Oregon. However, this undercounts the number of people served by the safety-net because it does not include some other types of safety-net clinics such as: community sponsored clinics, Indian/Tribal clinics, rural health clinics, and school based health centers. Unfortunately, a comparable data system does not exist for these other types of clinics.

Previously, the values for years 2000 to 2004 incorporated an estimate of the number of uninsured persons served by non-Federally Qualified Health Centers (FQHCs) safety net clinics as well as the number served by FQHC clinics from the Uniform Data System (UDS). FQHCs serve the largest number of both Medicaid and uninsured of all safety net entities and have the most robust reporting system as a federal requirement. Both figures were provided by the Oregon Primary Care Association (OPCA). However, the non-FQHC component has not actually been calculated since 2001 and the calculation is not replicable because other safety net clinics (ex. School Based Health Centers, Rural Health Clinics) do not have a data system similar to the UDS. Because the only known available data is from the Uniform Data System, clinics included in that database must be proxies for all safety net clinics in Oregon. This methodological change has resulted in a decrease in the estimate of safety net coverage. However, this new method will continue to be replicable in the future because the data source used is well-established and reliable.

The Population Research Center at Portland State University publishes annual estimates of the total Oregon population based on births, deaths and migration on their website at: <http://www.pdx.edu/prc/>. These estimates are widely used by the state and local governments, various organizations and agencies for revenue sharing, funds allocation, and planning purposes.

The Oregon Population Survey (OPS) is a biennial statewide telephone survey of Oregon households. Data on the percent of Oregonians who are uninsured are derived from survey questions, which ask if the household member has any kind of health care coverage (including Medicare, Medicaid, Oregon Health Plan, CareOregon or the Indian Health Service). OPS data are available on-line through the Oregon Office of Economic Analysis (<http://www.oea.das.state.or.us/DAS/OEA/popsurvey.shtml>). Because the survey is only conducted in even years, estimates of uninsured rates for odd years are calculated by interpolating between the even years.

KPM #32	MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.	2002
Goal	People are healthy	
Oregon Context	Mental health consumer activities	
Data Source	Addictions and Mental Health Division, Client Process Monitoring System database	
Owner	Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

To deliver services that promote recovery.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

It appears that many people are benefiting from mental health services. One concern is that this measure is not sensitive enough to truly assess improvement.

4. HOW WE COMPARE

We don't have any national data to compare.

5. FACTORS AFFECTING RESULTS

The tool used to measure level of functioning is not particularly sensitive. Addictions and Mental Health Division (AMH) is exploring the use of an alternative means to assess this measure.

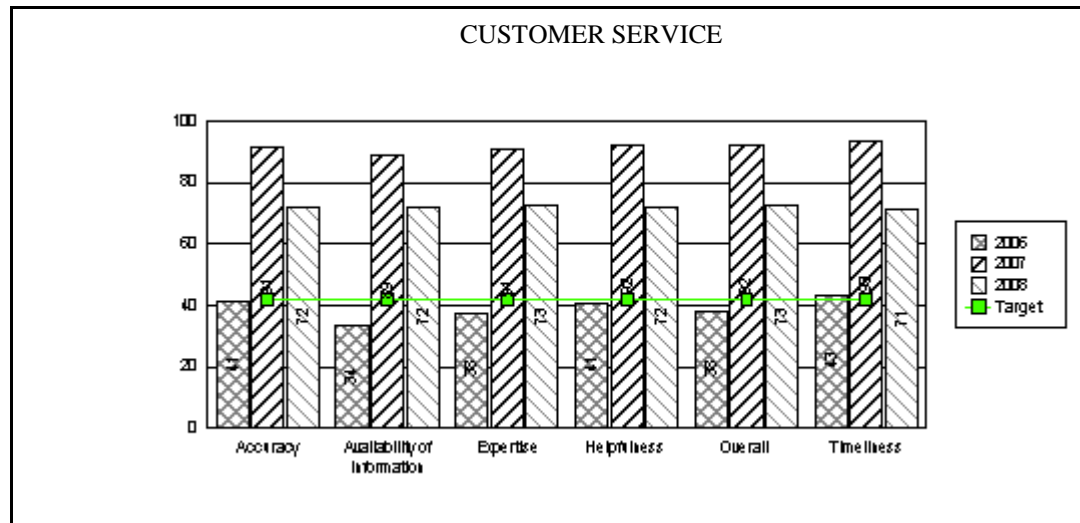
6. WHAT NEEDS TO BE DONE

AMH will continue quality improvement efforts and the encouragement of the use of evidence-based practices.

7. ABOUT THE DATA

Reporting cycle – calendar year. Data is extracted from AMH's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. AMH produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate/accurate data is submitted to the CPMS.

KPM #33	CUSTOMER SERVICE - Percentage of customers rating their satisfaction with DHS above average or excellent: overall, timeliness, accuracy, helpfulness, expertise, availability of information.	2005
Goal	People are independent, self-sufficient, safe & healthy.	
Oregon Context	DHS Mission – Assisting people to become independent, healthy and safe.	
Data Source	Consumer Assessment of Health Plans Survey (CAHPS)	
Owner	Administrative Services Division, Cathy Iles, 503-945-5855	



1. OUR STRATEGY

We continue to improve the methodology for gathering customer feedback, with our initial focus on clients receiving direct services from DHS.

2. ABOUT THE TARGETS

The 2008 and 2009 targets were set by LFO, based on our 2006 results. Our methodology has varied greatly from year to year making it very

difficult to develop meaningful targets.

3. HOW WE ARE DOING

This is our third year reporting on customer service. Each year we've used a different methodology, therefore it's impossible to determine whether or not we're seeing an improvement in the service we provide to clients.

4. HOW WE COMPARE

At this time, we are unable to compare our results to other agencies, organizations or jurisdictions. We can't compare our results from year to year because of the changes in methodology.

5. FACTORS AFFECTING RESULTS

We continue to focus on identifying a repeatable and consistent methodology for gathering customer feedback in a meaningful way. The results of each survey are analyzed and shared with the respective program managers and staff for the purposes of continuous improvement. However, it remains a challenge to conduct a survey that provides enough meaningful data for managers and decision-makers without overwhelming our customers with long surveys and risk a negative impact on response rates.

6. WHAT NEEDS TO BE DONE

We will continue to look at viable ways to gather feedback from our customers – not just an annual survey, but also more rapid cycle feedback to facilitate continuous improvement.

7. ABOUT THE DATA

Reporting cycle - fiscal year.

The 2007 results are from the Consumer Assessment of Health Plans Survey (CAHPS). It was administered through the Division of Medical Assistance Programs (DMAP) over a 10-week period (October – December 2007) using a mixed-mode (mail and telephone) five-wave protocol. This protocol consisted of a pre-notification letter, an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and reminder postcard to non-respondents. Phone follow-up was conducted for members who had not responded to the mailings. Respondents were surveyed in English and Spanish.

The sampling plan for the adult and child surveys called for a random sample of 900 eligible members per plan in each age group. To be eligible,

members had to have been enrolled in Oregon Health Plan for at least six months as of December 31, 2006. The final selected sample consisted of 13,962 adult OHP enrollees and 13,747 child OHP enrollees.

For the customer service questions, we received approximately 10,600 responses.

Agency Mission: Assisting people to become independent, healthy and safe.

Contact: Cathy Iles, Administrative Services Division

Contact Phone: 503-945-5855

Alternate: Pam McVay, Finance and Policy Analysis

Alternate Phone: 503-945-5930

The following questions indicate how performance measures and data are used for management and accountability purposes.

<p>1. INCLUSIVITY</p>	<p>* Staff : Staff are involved in the identification and refinement of Key Performance Measures. Feedback is sought to validate the measures.</p> <p>Over the next biennium, staff will become more involved in identifying, tracking and using performance metrics to make improvements to the work we do. These metrics should ultimately link to our KPMs or other high-level measures and inform us of our progress.</p> <p>* Elected Officials: Elected officials provide input to the agency KPMs, targets and strategies.</p> <p>* Stakeholders: Customer feedback is gathered to help guide strategies for effective service delivery. Efforts are currently underway to collect more consistent and meaningful customer input and to achieve more inclusion of key stakeholder groups.</p> <p>* Citizens: Community forums related to budget development and priority-setting is a way to identify and validate priorities, expectations and performance areas.</p>
<p>2 MANAGING FOR RESULTS</p>	<p>As a result of the Transformation Initiative, there is an emphasis on gathering, tracking, reporting and using metrics to assure we are continuously improving and that we're sustaining those improvements.</p> <p>Key Performance Measures provide a high-level picture of our results, but the underlying metrics, many of which will be identified through rapid process improvement events (RPI's) will provide us with a more meaningful and actionable management tool.</p>
<p>3 STAFF TRAINING</p>	<p>The Lean Leader training, which is a large component of the Transformation Initiative contains a module about metrics. As a result, Lean Leaders as well as staff throughout the organization, are being exposed to</p>

	<p>performance measures and the value of using the information to ensure we are seeing improvements. Executive Management will also receive training in fall 2008.</p> <p>Over the course of the Transformation Initiative and beyond, metrics will continue to be emphasized and made more visible at all levels of the organization.</p>
<p>4 COMMUNICATING RESULTS</p>	<ul style="list-style-type: none"> * Staff : The annual performance report is posted online and used for information sharing. One goal of the Transformation Initiative is to make data and metrics more visible at all levels of the organization. Visual display boards will provide more immediate feedback to staff about the results we are achieving. * Elected Officials: The annual performance report is posted online and included in the agency request document for purposes of sharing performance results, showing accountability, and informing the budget development process. * Stakeholders: The annual performance report is posted online and used for information sharing. * Citizens: The annual performance report is posted online and used for information sharing.