

HUMAN SERVICES, DEPARTMENT of

Annual Performance Progress Report (APPR) for Fiscal Year (2008-2009)

Proposed KPM's for Biennium (2009-2011)

Original Submission Date: 2009

2008-2009 KPM #	2008-2009 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.

2008-2009 KPM #	2008-2009 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.

2008-2009 KPM #	2008-2009 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.

2008-2009 KPM #	2008-2009 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.

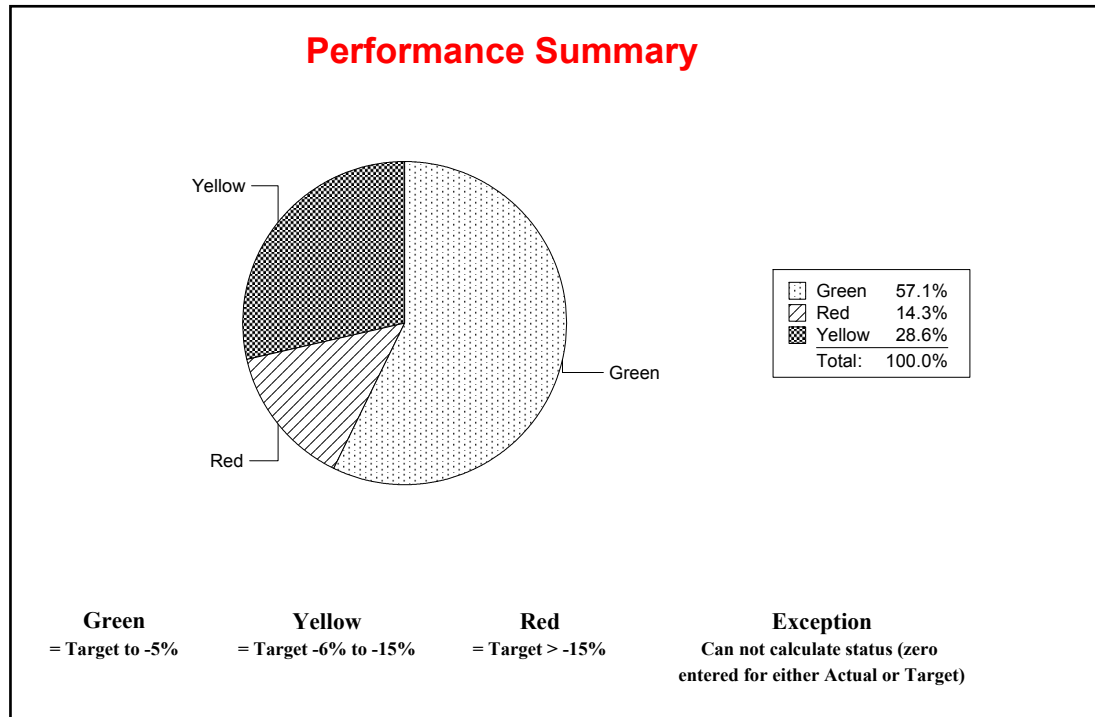
Agency Mission: Assisting people to become independent, healthy and safe.

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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 have achieved green status on over half (24) of our Key Performance Measures. 12 KPMs achieved yellow status. Six achieved red status. This totals more than 33 because some KPMs include multiple populations and are reported separately in this report. Green status = Target to -5% Yellow status = Target -6% to -15% Red status = Target > -15%

4. CHALLENGES

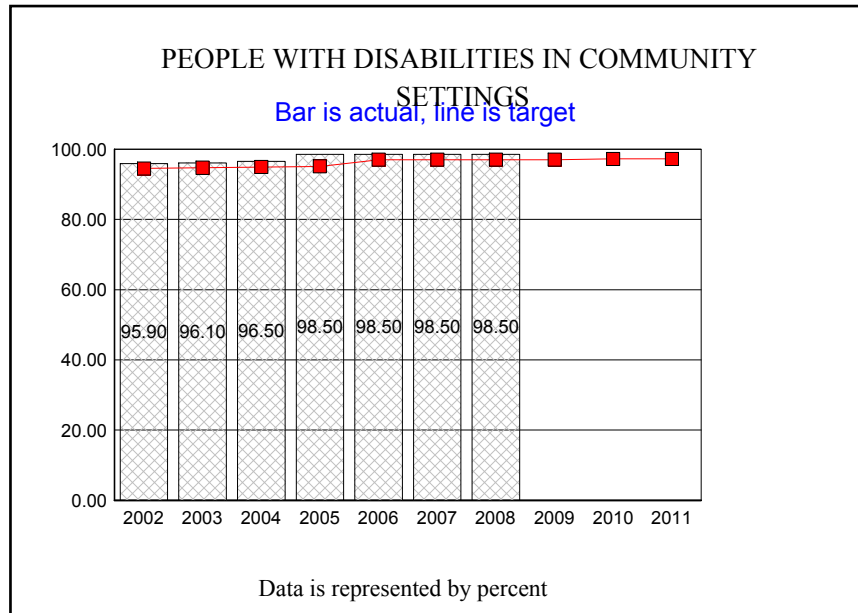
Poor economic conditions and unemployment appear to have an influence on many of our measures. Cuts in funding and limited resources (such as staff and providers) have an impact on whether or not we can achieve our desired results. Other challenges include the fact that the work of DHS is complex and 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	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 services to individuals who previously or otherwise would be provided in large congregate care settings. Critical partners include

Community 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, improved support outcomes on an individual basis have been seen, giving people a chance to experience living in an environment that approximates those experienced by others. 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 seven years.

4. HOW WE COMPARE

No data are available for comparison for 2008.

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 providing small community-based or family setting services to people with developmental disabilities. Continued implementation of crisis response services, Nursing Home diversion services, or other services designed to provide alternatives to institutional placement have been successful in avoiding the unnecessary placement of people in institutional settings. When placement into a nursing facility or other institutional setting is ruled out, smaller, community based settings are explored. Establishment of the Housing Trust Fund also support this measure by assisting people to stay in their own homes by assisting with remodeling or other home modifications. SPD reviews the programs with people greater than five persons to determine their ability to fill vacancies in the program and meet emerging program or community needs. 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 emerging client needs due to low staff to high client ratios, then strategic programmatic changes to reduce capacity may be suggested or required.

6. WHAT NEEDS TO BE DONE

Preservation of policy and funding structures, including rate setting strategies, that contribute to the maintenance and / or improvement of efforts for providing in-home services to persons with developmental disabilities and to support small home-like settings when substitute (out of home) care is needed. There needs to be continued strategic planning efforts that focus on the changing and emerging needs of individuals with developmental disabilities as more individuals currently in service are aging and that more children under the age of 18 are entering the system.

7. ABOUT THE DATA

Reporting cycle is calendar year. Data comes from the following sources:

Client Processing Monitoring System (CPMS) And Express Payment & Reporting System (eXPRS) - count of people receiving Case Management (Service Element 48).

Count of residents in settings of more than 5.

Eastern Oregon Training Center count of residents at EOTC. Data source is MMIS data ware house.

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. Formula used for this report is: Calendar Year (SE 48 Count Count of residents in settings of more than 5) / (SE 48 Count + EOTC Count). 2008 data disaggregated:

Count of people receiving Case Management = 18,551

Calendar Year (# of residents in settings 5 or fewer) = 244

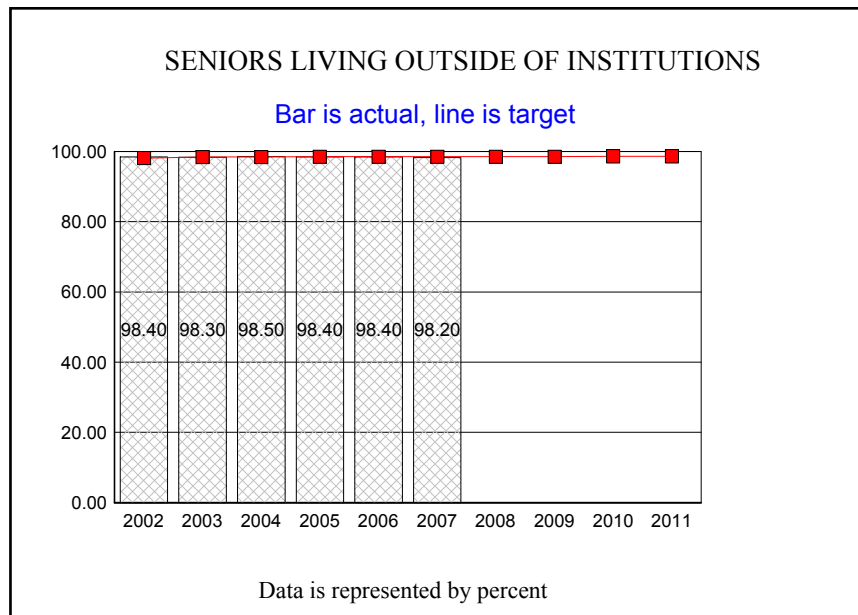
Eastern Oregon Training Center = 39

$(18,551 + 244) / (18,551 + 39) = 98.5\%$

$(18,307) / (18,590) = 0.984777$

Based on an audit conducted by the DHS Internal Audit and Consulting group, this measure was labeled as "factors prevented verification", which means that documentation is not available and controls are not adequate to ensure consistency and accuracy or the performance measure definition is not followed and the correct measure result cannot be determined. We discovered that in the past we had been calculating this number based on people who live in community settings of six or fewer rather than five or fewer during an internal audit. We have changed our methodology and changed the historical information back to 2005. Targets through 2011 have already been approved, but will be adjusted for the 2012-2013 biennium to reflect this new methodology.

KPM #2	SENIORS LIVING OUTSIDE OF INSTITUTIONS – The percentage of Oregon’s seniors who are living outside of institutions	2002
Goal	People are living as independently as possible.	
Oregon Context	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 - 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 recently awarded the Money Follows the Person grant by the Centers for Medicare & Medicaid Services, which will

enable DHS and partners to develop community-based long-term service opportunities and allow seniors and people with disabilities to return to their communities after living in nursing facilities.

7. ABOUT THE DATA

Reporting cycle is calendar year. Data are not yet available for 2008. Data comes from the following sources:

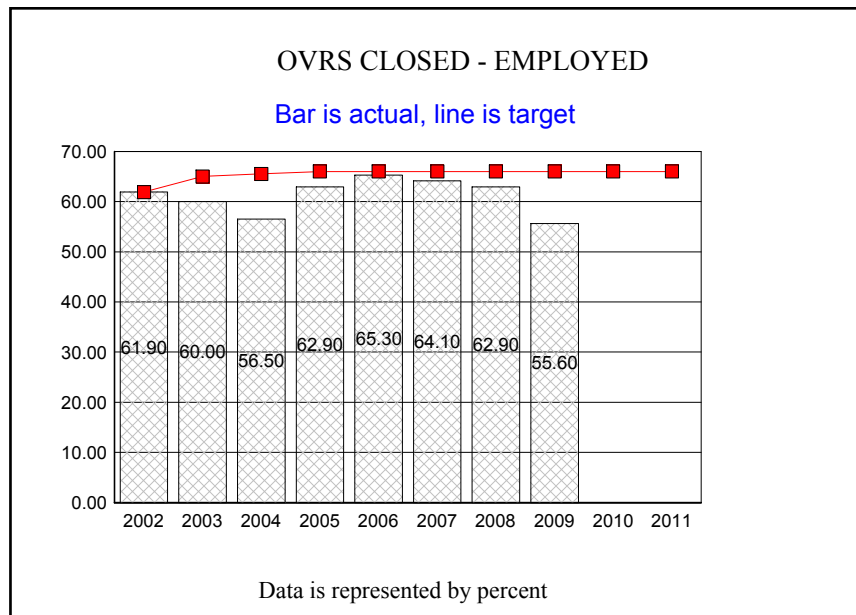
Oregon Office of Health Policy and Research (OOHPR) Nursing Facilities Survey

Portland State University Population Research Center 2007 Oregon Population Report

(http://www.pdx.edu/media/p/r/PRC_PopEst_broad_age_grps2007.pdf)

Formula: $100\% - (\text{OOHPR Nursing Facility resident days} / \text{Days in Year} / 65+ \text{Population}) \times 100 = 98.21\%$ Population over 65: 466,441 (2007 Oregon Population Report (http://www.pdx.edu/media/p/r/PRC_PopEst_broad_age_grps2007.pdf))

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	OVRS Budget and Performance Unit, David Ritacco, 503-945-6720	



1. OUR STRATEGY

Obtaining and maintaining suitable employment is consistent with the Departments 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 2008, VR clients who closed with employment earned an average wage of \$11.23 per 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

With the advent of Order of Selection and the onset of the recession, The Vocational Rehabilitation (VR) programs performance on this measure has declined. It is possible that OVRS will miss this indicator in FY 2009, as our most current performance, as of August 2009, is 55.6%, which is below the 55.8% Federal Performance level.

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 fiscal year 2000. However, it is possible that OVRS will miss this indicator in FY 209, as our current performance, as of August 2009 was 55.6% which is slightly below the 55.8% Federal Performance level.

5. FACTORS AFFECTING RESULTS

The State of Oregon unemployment rate affects the VR success rate. If there is a downturn in Oregon's economy the VR placement rate drops. The variance in the measure is significantly influenced by factors outside the programs control. The Oregon VR program provides vocational services to meet the needs of placing people with disabilities in jobs consistent with industry standards. The continuing increase in expenditures for services has resulted in OVRS going into an Order of Selection on January 15, 2009. An Order of Selection occurs when the program is unable to provide services to all clients who apply. Going into an Order of Selection means that a waiting list is established and only the clients with the most severe disabilities are served initially. This has resulted in a considerable decrease in the percentage of clients who close with employment (55.6% as of August 20, 2009).

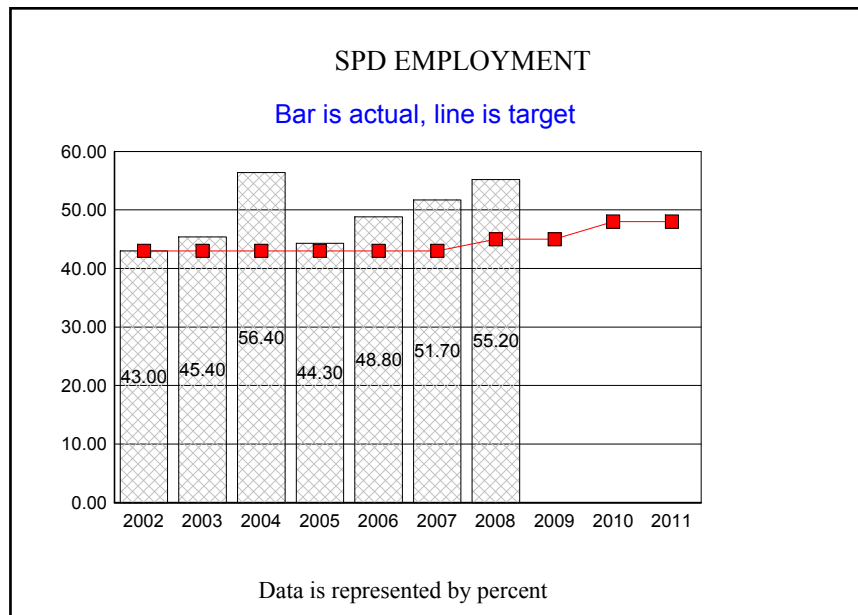
6. WHAT NEEDS TO BE DONE

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-federal 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.

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	Oregonians with physical and/or cognitive limitations 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

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 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 Developmental Disability Services (ODDS), continues efforts to increase employment outcomes by participating in the State Employment Leadership Network (SELN). SELN is a multi-state collaborative sharing effective policies, strategies and technical assistance designed specifically to improve employment outcomes for people with developmental disabilities. Two primary initiatives from this work are the implementation of an employment first policy and work on strategies for establishing service rates that support desired employment outcomes. ODDS also works with the Office of Vocational Rehabilitation Services (OVRS) in the implementation of the Competitive Employment Project, a federal grant administered by OVRS. This grant is to provide improved employment opportunities for Oregonians with disabilities.

2. ABOUT THE TARGETS

The Legislative Fiscal Office raised the targets for 2008 and 2009 from 43.0% to 45%. The present economy, 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.

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 years 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

There is no national data source that exactly compares the outcomes of this KPM to other states. 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. The Institute for Community Inclusion at the University of Massachusetts publishes national data on employment outcomes for people with developmental disabilities. For fiscal year 2007 this data indicates that Oregon would rank below mid-level (40 percentile) in providing integrated work settings for people with developmental disabilities. Integrated employment is the category of employment that best indicates progress toward the ultimate outcome of this KPM.

5. FACTORS AFFECTING RESULTS

SPD clients require unique assistance in obtaining and maintaining employment to help 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

In general there needs to be continued efforts to eliminate barriers to employment inherent in services to people with disabilities as well as continued efforts to utilized programs such as EPD that are established to facilitate employment goals. For individuals with developmental disabilities, continued efforts in the multi-state collaborative SELN that was established to improve employment outcomes for this specific population. This effort should result in improvements in data collection, rates, settings, and individual service planning as it relates to employment outcomes.

7. ABOUT THE DATA

Reporting cycle is calendar year. Data comes from the following sources:

Client Processing Monitoring System (CPMS)
Express Payment and Reporting 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. Formula used for this report is: Numerator = Count of everyone with employment Start Date in this Calendar Year (in SE 54 + EPD + SPD in VR). Denominator = Count SE 54 + SE 540 + EPD + SPD open in VR in this Calendar Year. Definitions (and Source):

SE54 employed under Developmental Disabilities Vocational Services (eXPRS)

SE540 waitlist for Developmental Disabilities Vocational Services (CPMS)

EPD employed under Employed Persons with Disabilities (CMS)

VR Opened SPD clients with an open case in the Office of Vocational Rehabilitation Services (Oregon ACCESS and Orca2)

VR Employed clients were either employed (but not fully closed), closed as rehabilitated (employed), or receiving post employment services (employed, but need small time-limited support to remain employed) (Oregon ACCESS and Orca2)

2008 data disaggregated:

SE54 = 4107

SE540 = 2663

EPD (employed) = 780

VR Employed = 503

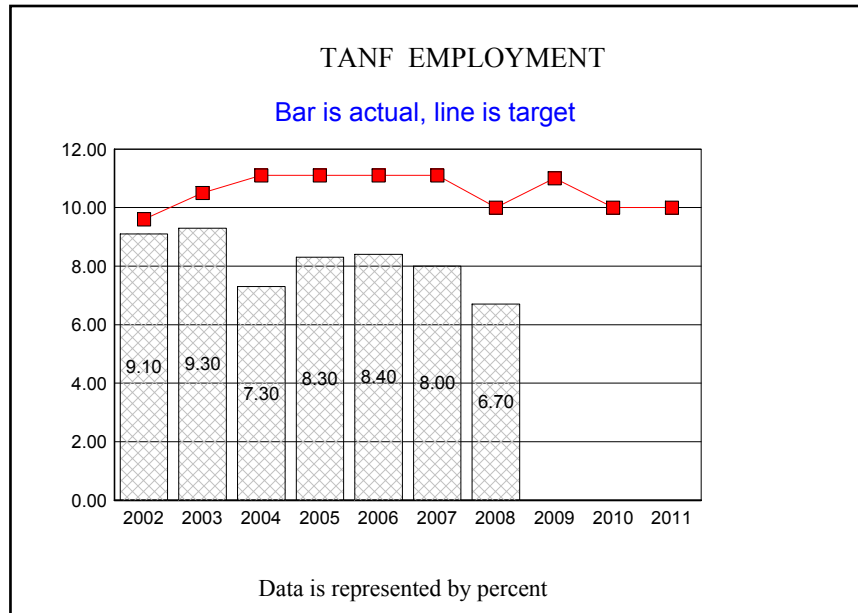
VR Open = 2218

$(4107 + 780 + 503) / (4107 + 2663 + 780 + 2218)$

$5390 / 9768 = 0.55180 = 55.2\%$

This measure has been dropped for the 2009-11 biennium. However, a KPM around integrated employment settings has been added for the 2009-11 biennium.

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 - 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 Participations 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, TANF Program Manager, 503-945-6122	



1. OUR STRATEGY

One of the departments 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 to 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, which required placements to be verified, 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

Placements decreased in 2008 from 2007 with 6.7% of work-eligible JOBS participants reporting they secured new work each month. This shift is likely the result of the current economic crisis in Oregon as reflected by steady job losses. As the economy worsens, it is anticipated that performance on this measure will continue to be affected. In addition, increased caseloads and limited resources and funding for the JOBS program have affected the level of capacity and array of services available for TANF families to access.

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

DHS has not met the targets for the past seven years. This may indicate an overly optimistic goal, given the general economic conditions and declining program resources. Achieving the placement target, in particular, has been difficult. 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 was lowered to 10% placed each month. This new target reflected

new investments in the TANF/JOBS program to better address clients needs. These new investments will provided 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. The current economic crisis has caused a reduction in jobs available statewide. The TANF caseload increased in 2008 beyond the number forecasted which affected the amount of resources available to adequately meet the capacity needed and the type of services that can be offered.

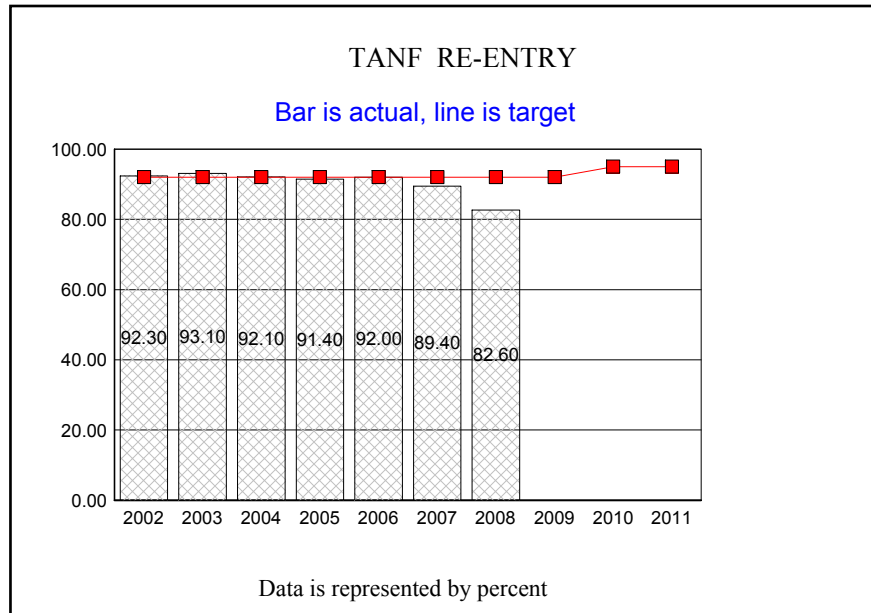
6. WHAT NEEDS TO BE DONE

We will continue to monitor the TANF/JOBS program design. This monitoring will provide data on possible further program modifications. At present, placement outcomes are difficult to forecast, given the instability of the States economy.

7. ABOUT THE DATA

Reporting cycle - calendar year. The data represented are run on a monthly basis, but reported annually. Monthly reports are issued and studied for any potential anomalies, as well as to identify trends in performance. The data are sent to program managers and interested parties. This measure has been dropped for the 2009-11 biennium.

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 - 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 are used to determine the percentage of TANF clients who left TANF due to employment and did not return to cash assistance or were still off cash assistance 18 months after case closure.	
Owner	Children, Adults and Families Division - Office of Self Sufficiency, Xochitl Esparza, 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 does not want the TANF JOBS program to be a revolving door for families to go on and off assistance. Instead, 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

This measure demonstrates the ability of the TANF/JOBS program to prepare TANF clients for the world of work. It also helps assess the ability of families to remain self-sufficient after leaving TANF due to employment. Performance on this measure reflects a higher percent of clients who left TANF cash assistance due to employment returning to assistance 18 months later. This shift is likely the result of the current economic crisis in Oregon as reflected by steady job losses. As the economy worsens, it is anticipated that performance on this measure will continue to be affected. In addition, increased caseloads and limited resources and funding for the JOBS program have affected the level of capacity and array of services available for TANF families to access. Our objective is to increase the number of families not requiring assistance after 18 months of leaving TANF due to employment. The target will remain at 92.0% and will be reassessed annually.

3. HOW WE ARE DOING

82.6% of TANF clients that left public cash assistance due to employment between January 2008 and December 2009 were not receiving cash assistance 18 months later. This indicates that a large 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 families financial independence. While the department has met or exceeded its goal for this measure from 2002 through 2006, due to the current economic crisis and as indicated by the higher unemployment rate, there are fewer jobs available, and we have experienced an increase in the number of families returning to TANF.

4. HOW WE COMPARE

This measure is unique to Oregon. However, Oregon Workforce System PRISM data can be compared to the Oregon TANF programs performance. Using the most current PRISM data, for TANF clients exiting the program with employment between April and June 2007, 48.3 percent were continuously employed through the period April and June 2008. This compares to 61.8 percent for the statewide system.

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. Caseload trends and level of resources and funding available to adequately support the number of TANF families requiring employment and training services affects the ability to meet the capacity needed and the type of services that can be offered.

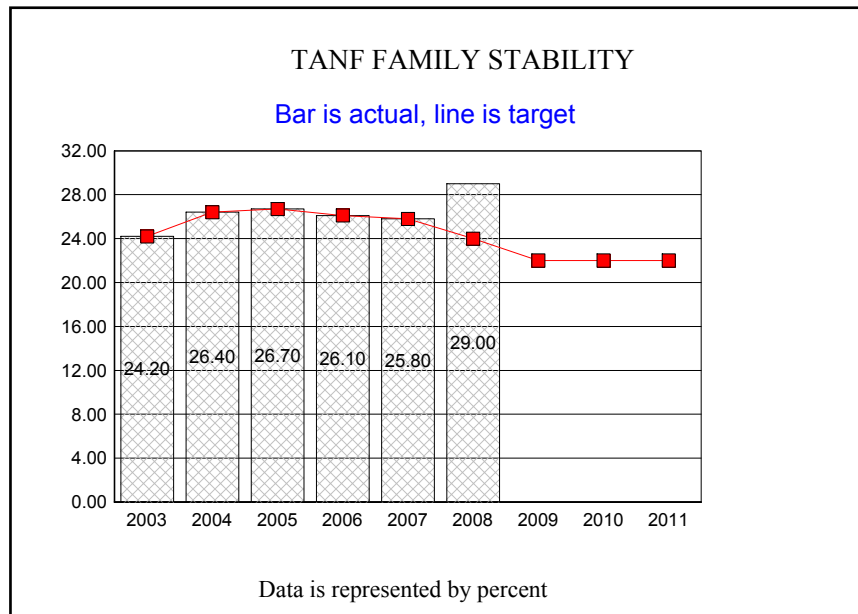
6. WHAT NEEDS TO BE DONE

We will continue to monitor TANF/JOBS program design. 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 programs 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 are sent to program managers and interested parties. This measure was included in the KPM audit performed by the DHS Internal Audit and Consulting Group in June 2009. This KPM was verified which means "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." For the 2009-11 biennium, this measure is being changed to report on the percentage of TANF cases who do not return within 18 months after exit due to employment.

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 year report cycle using AFCARS quarterly data 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 , TANF Manager 503-945-6122	



1. OUR STRATEGY

This measure tracks the movement of low-income children who leave the TANF program and enter foster care within two months of exit. The programs and services provided include supports to meet immediate needs and holistic family assessments, and prevention (Family Support and Connections). Families are offered a holistic family assessment including screenings for physical health, substance abuse, mental health, domestic violence, learning needs and other family stability issues. Family Support and Connections provides supports to prevent children in at-risk TANF families from entering the child welfare system. Home and community based services are used to guide interventions that build on family strengths and address family functioning issues. The services are designed to strengthen and support families by increasing parental protective factors and addressing risk factors related to child abuse. Temporary Assistance to Domestic Violence Survivors (TA-DVS) provides temporary financial assistance and support services to families with children in order to flee and stay free from domestic violence. TA-DVS is used to help the domestic violence survivor and the children address their safety concerns and to stabilize their living situation, thus reducing the likelihood of the survivor returning to the abuser. These services maintain the safety of these vulnerable children and their parents, and can prevent sometimes life-threatening situations. These services also help prevent child abuse and the need for child welfare intervention.

2. ABOUT THE TARGETS

Our objective is to decrease the percentage of children being served by the TANF cash assistance program who enter the foster care system. DHS used the 2003 through 2007 performance data to develop a baseline. Currently Foster Care entries are decreasing and TANF cash assistance cases are on the rise, which can cause an increase in the percentage.

3. HOW WE ARE DOING

In FFY2007, 25.8 percent of the children entering foster care had received TANF cash assistance within the prior two months. During FFY2008 29.0 percent of the children entering foster care had received TANF cash assistance within the prior two months.

4. HOW WE COMPARE

This is a unique measure for Oregon and, therefore, there is a lack of current data from other states for purposes of a comparison. However, a comparison of Aid to Families with Dependent Children (AFDC) and child welfare caseloads in California, Illinois and North Carolina found the majority of children entering foster care had been removed from AFDC-eligible households (U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, 2000).

5. FACTORS AFFECTING RESULTS

The factors affecting the results include: multiple child abuse risk factors present in families such as, alcohol or drug use, parental involvement with law enforcement, domestic violence, and unemployment. Often, there are several of these factors in families of child abuse/neglect victims. Currently Foster Care entries are decreasing and TANF cash assistance cases are on the rise which has caused an increase in the percentage.

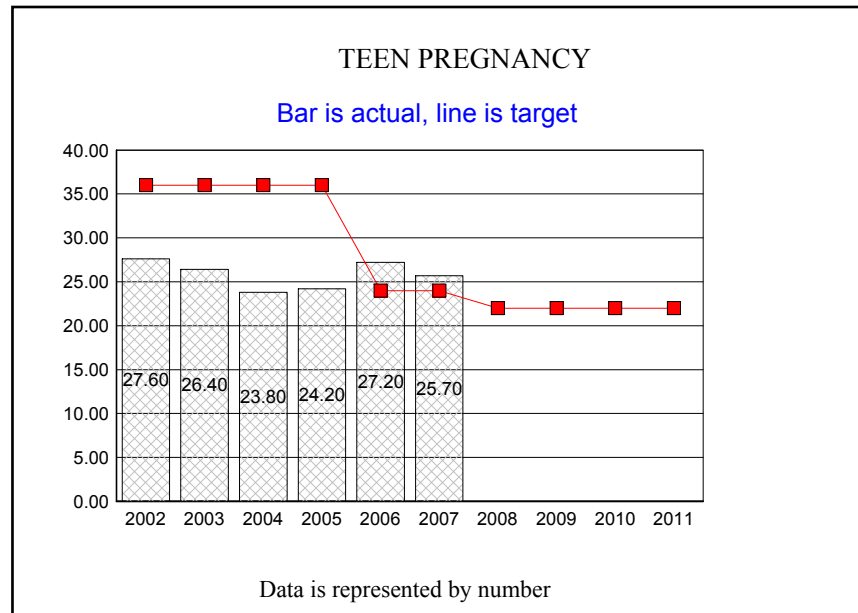
6. WHAT NEEDS TO BE DONE

We will 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 AFCARS quarterly data 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. The percentage can be skewed by differing rate of increase/decrease of the two programs. Currently Foster Care entries are decreasing and TANF cash assistance cases are on the rise, which can cause an increase in the percentage

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 - 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 statewide Teen Pregnancy Prevention and Adolescent Sexual Health Partnership (TPP/SHP) has created a new Youth Sexual Health strategic

plan for Oregon. The partnership includes representation from 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

Oregon Department of Education

Local private/non-profit organizations

The Department proposes program enhancements to expand the scope of DHS efforts related to youth services. CAF implements education programs and services to strategically promote positive youth development which enhances protective factors while reducing risk factors. Youth service efforts are inclusive and address behavior choices which put youth at greater risk. This approach will mitigate those factors that have a negative impact on families and individuals through the development and implementation of education and Positive Youth Development (PYD) strategies.

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 allows for stabilization of rates in smaller counties. Aggregation allows for analysis of the smaller population areas of the state using rates and average number of pregnancies.

3. HOW WE ARE DOING

The States teen pregnancy rate has consistently been lower than the national rate and the State has made some progress in reducing it even further over the past decade. Even though there had been a two year rise in the rate among 15-17 year-olds in Oregon, the pregnancy rate has declined again by 5.5 percent between 2006 and 2007.

4. HOW WE COMPARE

The most recent national teen pregnancy information available is for 2004, due to the delay in the reporting from states across the country. The

national teen pregnancy rate for 15 - 17 year olds was 41.5 for 2004 and the Oregon teen pregnancy rate for 2004 was 23.8.

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

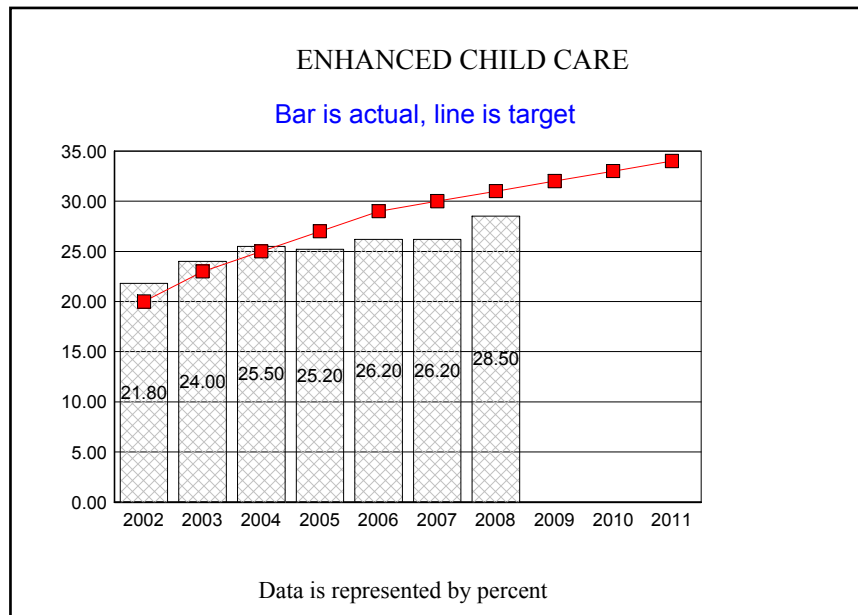
Consider underlying risks and contributing factors, such as poverty and sexual abuse

Utilize culturally sensitive approaches

7. ABOUT THE DATA

Reporting cycle - calendar year. The data are generally 1 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. National pregnancy data is found at <http://www.gutmacher.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 receiving a 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 remained below target it showed an increase from the previous year. The 2007-2009 Child Care improvements which included funding for provider training for unlicensed family child care providers caused an increase in the number of providers giving enhanced care. This resulted in approximately 1/3 of the Districts exceeding the target of 30% for a statewide average of 28.5 in 2008.

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 majority of providers who qualify for the enhanced rate are licensed. From 1997 until October 2007, DHS' maximum rates had fallen far below what most licensed providers charge. The result was that fewer licensed providers were willing to care for children whose parents received a DHS subsidy. This made it difficult to remain on target. However, the 2007 Legislature authorized significant rate increases that took effect October 1, 2007. This gave 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 an increased investment in exempt provider training resulted in a steady increase in the percentage of providers earning the enhanced rate.

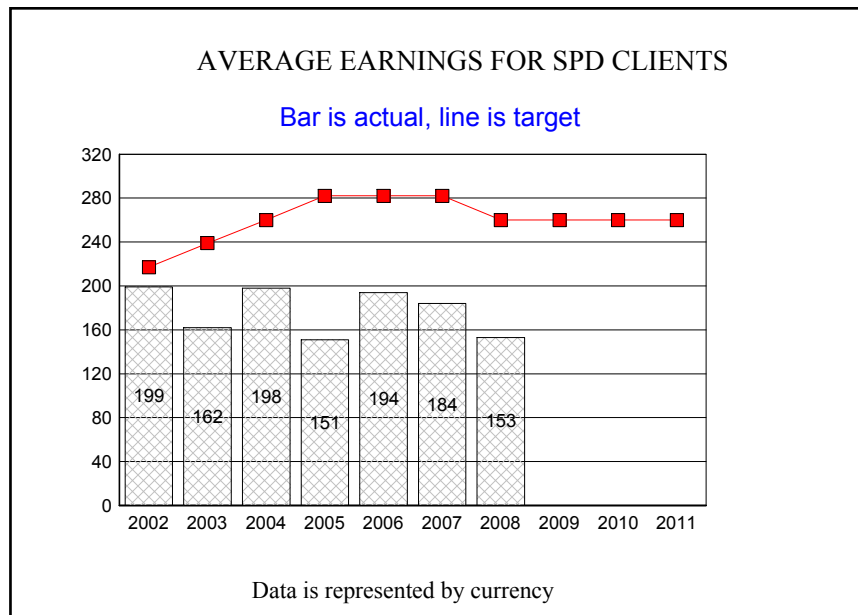
6. WHAT NEEDS TO BE DONE

Efforts to inform parents and providers of the importance of quality child care and training must continue. Exempt providers, now represented by SEIU, will be working together with DHS and Child Care Resource and Referral agencies 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. 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. For the 2009-11 biennium, this KPM will change to report the percentage of children receiving care from providers who are receiving the enhanced rate for child care subsidized by DHS.

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's goal is to expand competitive employment opportunities for people with developmental disabilities. SPD currently engages 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 grants 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 currently included in 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 are no current nationwide data available to directly compare this outcome with other states. The Institute for Community Inclusion at the University of Massachusetts publishes national data on employment outcomes for people with developmental disabilities. For fiscal year 2007 this data indicates that Oregon would rank below mid-level (40 percentile) in providing integrated work settings for people with developmental disabilities. Integrated employment is the category of employment that best indicates progress toward the ultimate outcome of this KPM. Communications with other states and national organizations indicate the lack of progress in obtaining competitive employment or other employment for persons with developmental disabilities that improves wage earning is an ongoing 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.

5. FACTORS AFFECTING RESULTS

The 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. 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.

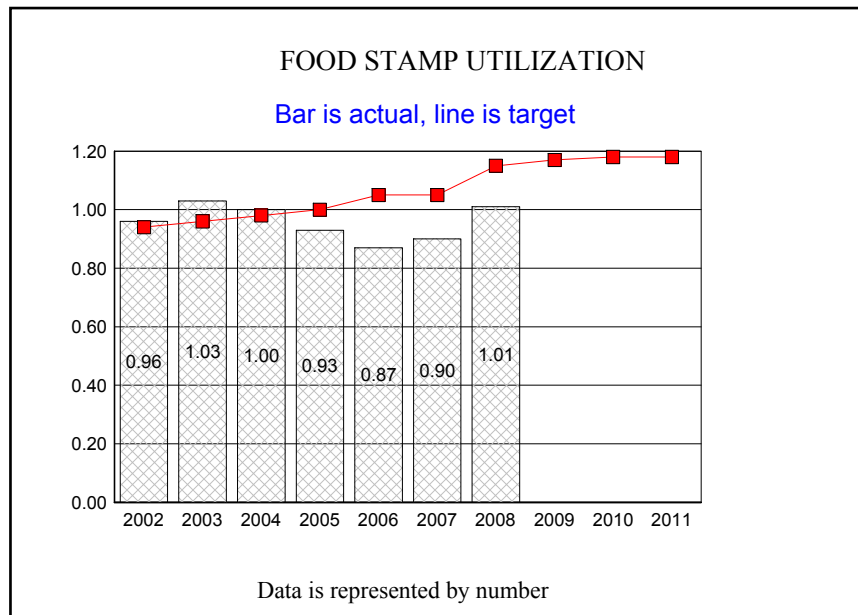
6. WHAT NEEDS TO BE DONE

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 SPDs participation in the national initiatives. With other DHS and community partners, SPD is participating in a 5-year CMS Medicaid Infrastructure Grant designed to increase competitive employment opportunities for people with disabilities. SPD is also participating along with 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. Formula: (Avg. Hours scheduled each Week X 4.2) X Avg. hourly earnings w/ 0.00 values included-----Round to whole number (Avg. Monthly Earnings)
 2008 data disaggregated: (12.06 X 4.2) X 3.01 = \$153 Full report Employment Outcomes Report is available at
<http://www.oregon.gov/DHS/spd/data/eos/0809.pdf> This KPM is being dropped for the 2009-11 biennium. However, a KPM has been added around integrated employment settings for the 2009-11 biennium.

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 - 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 maintain our outreach efforts, 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 June 2007 and June 2009, the Oregon Supplemental Nutrition Assistance Program (SNAP) (formerly referred to as food stamps) caseload increased by 39.5% (229,651 households in 06/07 to 320,268 households in 06/09). Although the caseload increased between June 05 and June 07, the ratio of Oregonians receiving food benefit assistance to the number of Oregonians living in poverty decreased during Federal Fiscal Year 2006 due to the census adjustments in the number of Oregonians living at or below the Federal Poverty level.

4. HOW WE COMPARE

For the past two years, Oregon has been among the top three states nationwide in food stamp participation based on the official Food & Nutrition Service (FNS) ranking. FNS ranking is based on the number of potential eligibles compared to the number receiving benefits; under this ranking Oregon's participation rate was 83% while the national average was 60%.

5. FACTORS AFFECTING RESULTS

Nationwide, the elderly are recognized as the most under-served population. Oregon received a federal grant and has created a simplified on-line application process. Oregon is expanding outreach efforts to identify and neutralize barriers to SNAP participation.

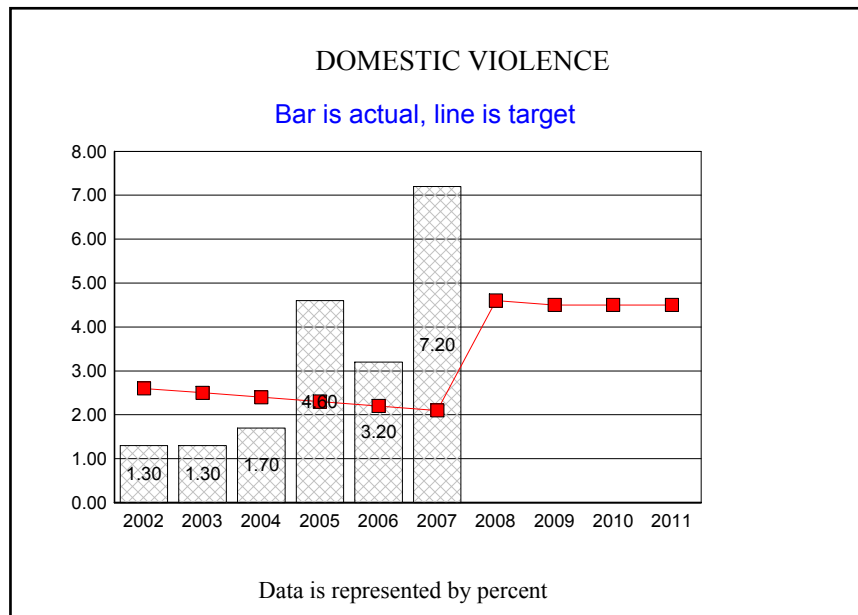
6. WHAT NEEDS TO BE DONE

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 actuals were recalculated this year, new census and poverty level data had been made available after the original calculations were made.

KPM #12	DOMESTIC VIOLENCE – The percentage of women subjected to domestic violence in the past year.	2002
Goal	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 - Preventable Death.	
Data Source	Office of Disease Prevention & Epidemiology survey and database.	
Owner	Public Health Division, Lisa Millet 971-673-1059	



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 that apply to the whole department. DHS provides training in coordination with DV service providers to staff on the dynamics of domestic violence as well as DV related policies. The Department of Administrative Services (DAS) has developed statewide policies related to domestic violence, sexual assault and stalking in the workplace. DHS staff participate on the workgroup that developed the policy and will be involved in implementation of those policies statewide. DHS supports a coordinated community response and is represented on local and statewide DV related committees, councils and task forces. DHS is represented on the AGs Batterer Intervention Standards Advisory Committee. In Multnomah County, DHS will be part of a new one-stop for domestic violence intervention that will be opening in fall/winter 2009.

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 (BRFSS). The new module includes a series of new questions on interpersonal violence. Data for 2006 show an increase due to the new question module. 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 funding slightly for local services for victims during 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.

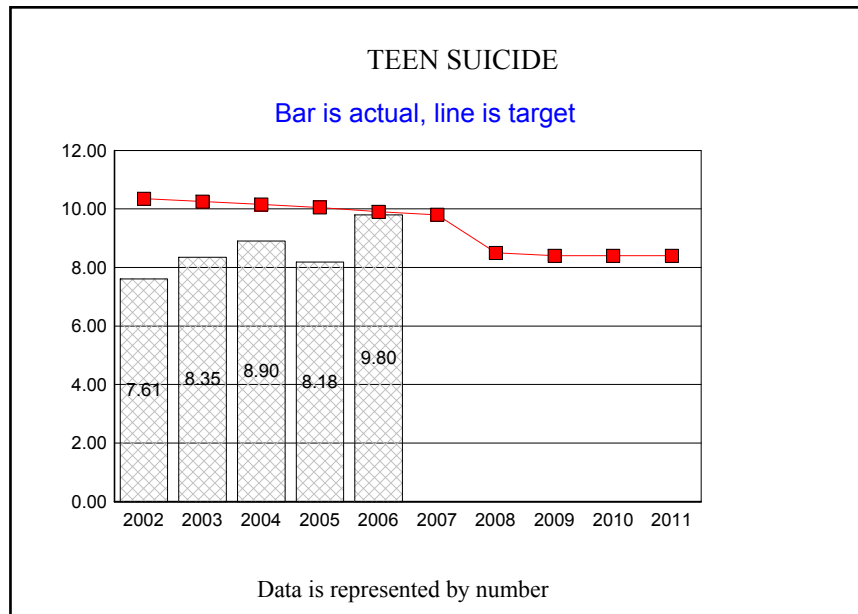
6. WHAT NEEDS TO BE DONE

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. Currently, comparisons with other states aren't 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. BRFSS data for 2008 do not yet have reliable weights for analysis. This KPM is being dropped for the 2009-11 biennium.

KPM #13	TEEN SUICIDE – The rate of suicides among adolescents per 100,000.	2002
Goal	People are safe. People are healthy.	
Oregon Context	Oregon Benchmark #45 - 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. Question #2 identifies effective strategies around teen suicide prevention.

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 implemented a new data form for the Adolescent Suicide Attempt Reporting System. This form includes 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. The state is working with

the Oregon National Guard service members, families and support communities to provide intervention skills training. The Native American Rehabilitation Association is supporting suicide prevention program activities among all nine 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 throughout the state. Bereavement groups are forming in three regions of the state to support those who have lost loved ones to suicide. The state is forming a statewide coalition to address suicide prevention. The Governors Wrap Around Project is defining how the state can increase mental health services for children and youth in Oregon.

4. HOW WE COMPARE

Oregons youth suicide rate (ages 10-24) ranks 12th among states. The state rate of 9.8 per 100,000 (2006 national comparison data) is greater than the national rate of 7.01 per 100,000. The state rate of suicide among youth aged 10-24 in 2006 is 9.8 per 100,000.

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.

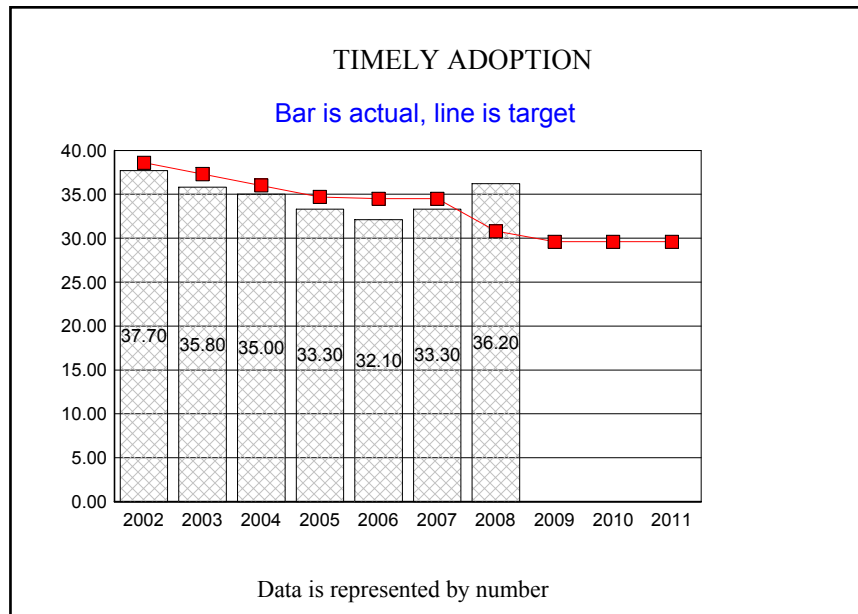
6. WHAT NEEDS TO BE DONE

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. 2007 results aren't available yet because mortality data for 2007 are not ready for analysis.

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. 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, Lois Day, 503-947-5358	



1. OUR STRATEGY

Identification and implementation of efficiencies in the adoption process intended to decrease the length of time to achieve finalization and increased

monitoring and support of cases and families as they move through the process to adoption finalization.

2. ABOUT THE TARGETS

Oregon has exceeded the benchmark for median time to adoption for Federal Fiscal Years 2002 through 2006; however, the state fell short of achieving the benchmark in Federal Fiscal Years 2007 and 2008. The data demonstrates that Oregon made consistent and steady progress toward reducing the time to achieve adoption, however, trend reversal began in 2007 and continued through 2008. 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.

3. HOW WE ARE DOING

The agency's progress toward meeting the annual goals was consistent and steady, which is a reflection of the agency's long-term strategy of changing policies and practices, and training staff to these changes in order to sustain and even further reduce the time to permanency for children, rather than taking short term corrective action which might have more dramatic and immediate results but are unsustainable in succeeding years. The agency is committed to continuous quality improvement in its practices, which lead up to and result in termination of parental rights and adoption. Wherever possible, without disregarding the best interests of the children who are the beneficiaries of the activities, the agency has, and will continue to streamline processes, procedures and paperwork in order to expedite the timeliest achievement of adoption for every child in need of this service. Continually decreasing rates achieved for this performance measure through 2006 reflects this progress. The actual median months from the date of the latest removal from home to finalized adoption increased in consecutive years 2007 and 2008. Interestingly, the total number of adoptions decreased by 9.14 percent from 2006 to 2007 and, then, increased 5.51% from 2007 to 2008. This suggests that changes in the measure are not overtly driven solely by a change in the number of finalized adoptions. Finalization numbers for the four largest counties (below) may indicate that the increase in total finalizations from 2007 to 2008 could be driven solely by the increases in Multnomah and Lane, in particular; however, there is little to correlate numbers of placements with number of months to finalization in the data that has been retrieved. County: 2006 | 2007 | 2008
 Multnomah: 204 | 153 | 222
 Marion/Polk/Yamhill: 172 | 143 | 154
 Lane: 162 | 161 | 220
 Washington: 103 | 102 | 110
 There is little deviation from 2005 through 2008 by age at the date of finalization. There was a slight decrease from 2007 to 2008 in finalizations for children 0-2 years, 10-12 years, and 13-15 years (+/- .6 to 4 percent). There was a slight increase in the same time frame in finalizations for children 3-5 years and 6-9 years. Again, there is little to suggest that the age of a child is impacting the possible trend.

4. HOW WE COMPARE

The agency's performance on the median time to adoption exceeded the targets for 2002 through 2007 and, then, fell short of the target in 2008.

Oregon's performance was slightly better than the national median of 32.4 months through 2006; however, the state's median fell short of the national median in 2007 and 2008.

5. FACTORS AFFECTING RESULTS

There are a number of factors that appear to affect ability to meet or exceed the target for number of months to finalization. Implementation of the Oregon Safety Model in 2008 resulted in extensive training of field staff and a focus on the Return Home Plan. Concurrent planning, while still the emphasis in practice and policy, may have had less focus in the field as staff have been learning new practice strategies attached to the Oregon Safety Model. Emphasis has been on the Safety of the child in their current circumstances and at least anecdotally, it appears that adoption planning has had less emphasis throughout the life of each case. Recruitment assistance is increasingly available to the field (via contracts with private agencies, e.g., AFFEC), but the results of recruitment tend to get backlogged at the branch level where caseworkers are not having time to process the findings of recruitment teams. Caseworker review of adoption home studies they receive is reportedly in a suspend mode in many locations and some workers may receive as many as 50-60 studies for a child, but cannot get to them due to self-reported workload and other commitments. There are increasing comments from studied parents waiting for selection, from field staff who study families, from recruitment agencies, and from private agencies that studies are not being read and parents are not hearing from caseworkers. Consequently, parents are turning to other states to adopt. The new SAFE Home Study Module was initiated in June 2008 and is having a graduated one year roll out throughout the state. The model is a progressive home study that will result in a single study of a foster family who elects to adopt. This has required training of staff and implementation of new practice. Staff who are new to the model experience a challenging learning curve in their first several studies. This has slowed down the process and adoption workers are able to complete fewer studies than they used to in the same period of time. We've been advised that when the SAFE model has been engaged in other states, the same slowdown occurred in the capacity to complete studies and that Oregon should anticipate that with increased experience, adoption workers will adapt to the new model and the speed with which home studies are completed will increase. The new model is scientifically researched and has a good reputation for thoroughness and good results. In 2008 there were more adoptive families who were relatives. These relatives are in state and out-of-state. CAF field staff are reporting having difficulty keeping up with the workload of presenting relatives from out of state at adoption selection committees. (Assistance for other populations is available for presentation at committee of out of state families from a contracted agency, but this is not the case for relative presentation.) Changing demographics of the population of children placed in foster care are resulting in increases in relative placement have resulted in increased placement planning for transnational adoptions pursuant to the Hague Convention and the Intercountry Adoption Act of 2000. There are currently as many, or more, youngsters pending placement and/or finalization with relatives in another country than were finalized in entire 10 years prior to 2009. Convention adoptions, whether they are in this country or abroad, are far more complex and we are seeing longer delays to achieve placement and finalization. Timeframes for these adoptions are dependent, in part, on other bureaucracies. CAF is currently writing administrative rule and procedure for the ORS passed in 2009 that address the Convention and the Act. There are also several Central Adoption and Guardianship Program office issues that likely impact this measure in relationship to the direct role that program staff have with freeing children, recruitment, selection, placement, and finalization. Although the outcomes of these various efforts are expected to eventually, significantly increase efficiency and effectiveness of the overall program, the following activities have eroded, in varying

degrees, the time available for core program functions: OR-KIDS development and design; revision of multiple (22), outdated administrative rules and policies for adoption (and guardianship) and creation of several new rules; construction of a new adoption chapter for the Procedure Manual; a steady increase in requests for review of adoption selection committee decisions in the past two years that take up to several months to resolve; a reduction in staffing to one adoption placement specialist position and increasing field requests for consultation from this position; the addition of responsibilities for processing IV-E Waiver guardianship subsidies without allocated staff; and steady growth in the Adoption Assistance Program without an increased staffing allocation.

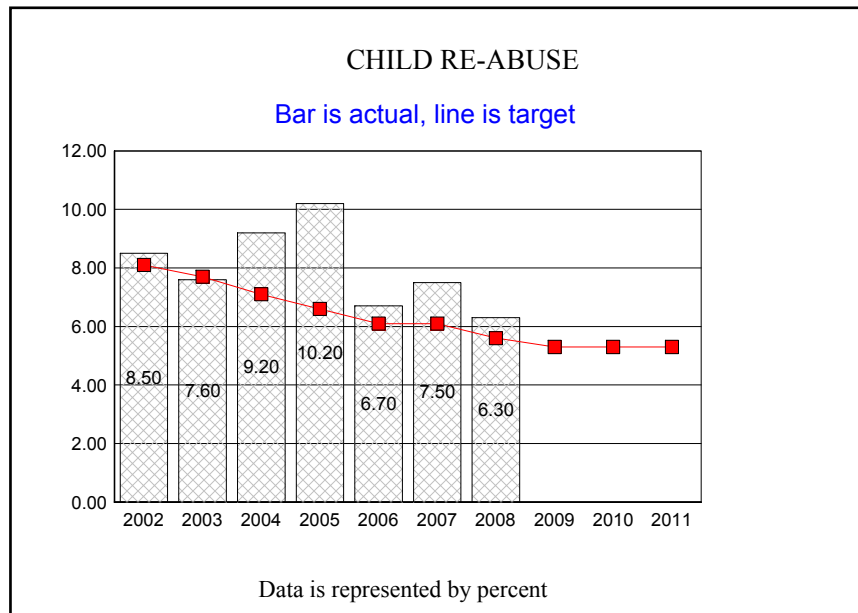
6. WHAT NEEDS TO BE DONE

From 2002 to 2006, Oregon 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, data from the last two years suggests that there is a possible trend reversal in the length of time it is taking to finalize adoptions that may be grounded in a) a need to find balance in practice and philosophy shifts such as OSM; b) caseload demographics involving nationality and origin of the birth family; c) a growing dichotomy between increasingly effective recruitment efforts and ability of caseworkers to keep up with the resource; d) time needed to build skills associated with the SAFE home study; e) consequences of multiple initiatives on program office workload; and f) outdated policy and procedure that creates confusion and increases the need for consultation. The work on the various initiatives mentioned can and should continue; however, the department needs to further examine its practices through its performance and continue to streamline and adjust them to further reduce the timelines. This can be approached through continued LEAN efforts in the adoption (and guardianship) program and strategically planning for increased permanent planning consultation from the program office. And, this can be equally approached through heightened supervisory awareness of the need to assist caseworkers, particularly those with adoptions caseloads, to regain expertise in permanency practice.

7. ABOUT THE DATA

Reporting cycle - federal fiscal year. Definition: Of all children who exited foster care to a finalized adoption during the year, the median number of months it took to finalize the adoption from the last entry into foster care. (Note: the median is the "middle" length of time- for ex., 4 is the median of the data points 1,4,5)The agency will request to drop this measure for 2011-13. The agency has approval to add the new federal Permanency Composite Measure 2: Timeliness of Adoptions for 2009-11. The new federal composite measure has five components, one of them being median months to adoption.

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 #51 -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 in conjunction with the National Resource Center for Child Protective Services (NRCCPS) developed and implemented 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 receives 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 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.

Move away from incident based child abuse assessments toward comprehensive safety assessments which focus on six factors related to child safety: 1) The extent of the abuse or neglect 2) The circumstances surrounding the abuse or neglect 3) Child functioning 4) Adult functioning 5) Parenting 6) Disciplinary practices.

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 targets for 2008 and 2009 is due to the change in the new national standard, which is $\leq 5.4\%$, which is the 75th percentile of all the state's repeat maltreatment rates (i.e. 75% of states have a repeat maltreatment rate HIGHER than 5.4%). We have set our 2008 target at 5.6%.

3. HOW WE ARE DOING

In 2005, the child repeat maltreatment rate for children in Oregon was 10.2 percent. This measure improved in 2006, dropping to 6.7 percent. In 2007 there was a slight increase to 7.5% as the Safety Intervention Model was being implemented. In 2008 Oregon achieved its lowest reabuse rate seen since 2000 of 6.3%. Our target was 5.6%

4. HOW WE COMPARE

Oregon's repeat maltreatment rate is higher than the national standard of 5.4% (or 75th percentile of all states).

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 co-occurring in families of child abuse/neglect victims. The addition of resources from the 2007 and 2009 Legislatures, which included increases in child welfare staffing levels and the legal representation package, will further support achievement of the targets for this measure in 2009.

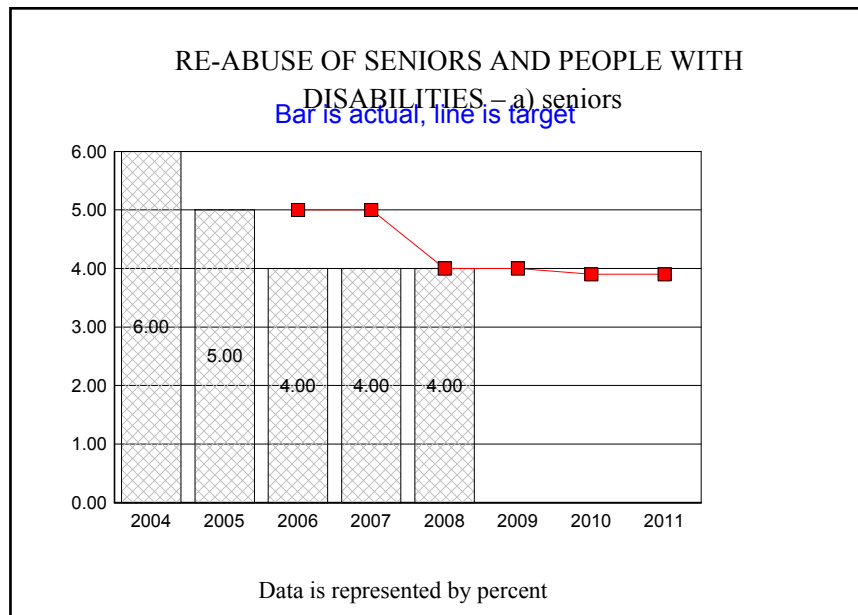
6. WHAT NEEDS TO BE DONE

Oregon has implemented a Safety Intervention model to improve safety intervention and service provision to families impacted by child abuse and neglect. As Oregon's Child Welfare system continues to improve in its use of the Safety Model and how we approach this performance measure our plan includes 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.

7. ABOUT THE DATA

Reporting cycle - federal fiscal year. Definition: Of all children who were victims of maltreatment allegation during the first 6 months of the year, the percent who were victims of another substantiated maltreatment allegation within a 6-month period. For the 2009-11 biennium, this KPM will change to report Absence of Repeat Maltreatment - the percentage of abused/neglected children who were not subsequently victimized within 6 months of prior victimization - to be consistent with Federal standards.

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	Oregon Benchmark #52 - 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

- 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). The target for this measure is to decrease the percentage of 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 Adult Protective Service (APS) Specialists;

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 the 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 contributing factors.

3. HOW WE ARE DOING

Since our Department currently meets or is below the current benchmark of 4% for the percentage of seniors and 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 individuals 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 encourages individuals to report suspected abuse. Strategies to improve the departments performance include:

On-going APS training including fundamentals of and advanced training for experienced APS workers.

Continuation of public education efforts;

Technical Assistance to field offices;

Continuous clarification, education and improvement of basic APS 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 APS clients such as the Office of Investigations and Training.

4. HOW WE COMPARE

There are no national data on re-abuse.

5. FACTORS AFFECTING RESULTS

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 Specialists;

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 individuals 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

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 Departments goals;

Gather data from public/private industry sources for comparison;

Respond to legislative request to direct efforts at maintaining to 4%.

7. ABOUT THE DATA

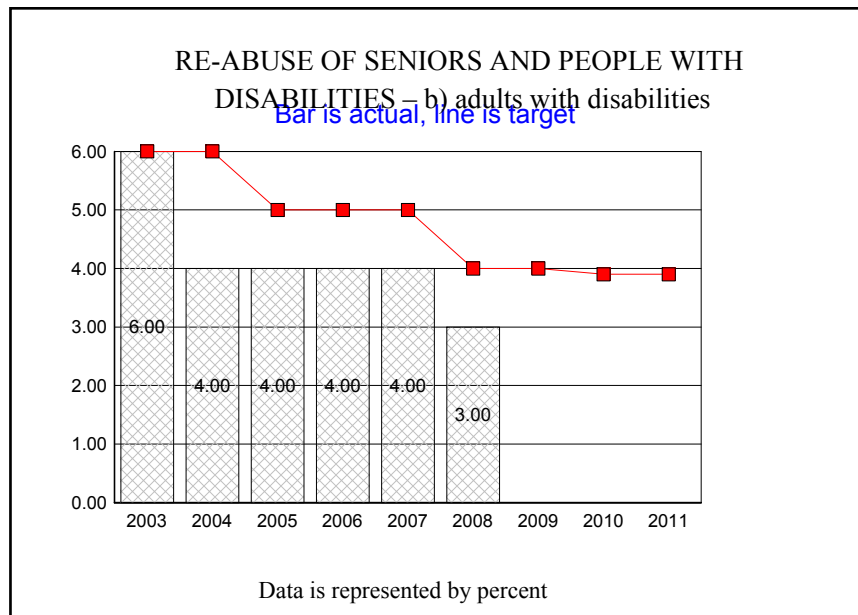
Reporting cycle is Calendar Year. Data are maintained by the Office of Licensing and Quality of Care, Quality Assessment and Monitoring Unit.

Original data source is Oregon ACCESS. Since Lane County does not use Oregon Access, abuse data is sent in electronically nightly 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.

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

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	Oregon Benchmark #52 - 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

- 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). The target for this measure is to decrease the percentage of 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 Specialists;

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 individuals 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

Since our Department currently meets or is below the current benchmark of 4% for the percentage of seniors and 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 individuals 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 departments 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;

Continuous clarification, education and improvement of 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 the Office of Investigations and Training.

4. HOW WE COMPARE

There are no national data on re-abuse.

5. FACTORS AFFECTING RESULTS

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 Specialists;

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 individuals 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

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 Departments goals;

Gather data from public/private industry sources for comparison;

Respond to legislative request to direct efforts at maintaining to 4%

7. ABOUT THE DATA

Reporting cycle is Calendar Year.Data are maintained by the Office of Licensing and Quality of Care, Quality Assessment and Monitoring Unit.

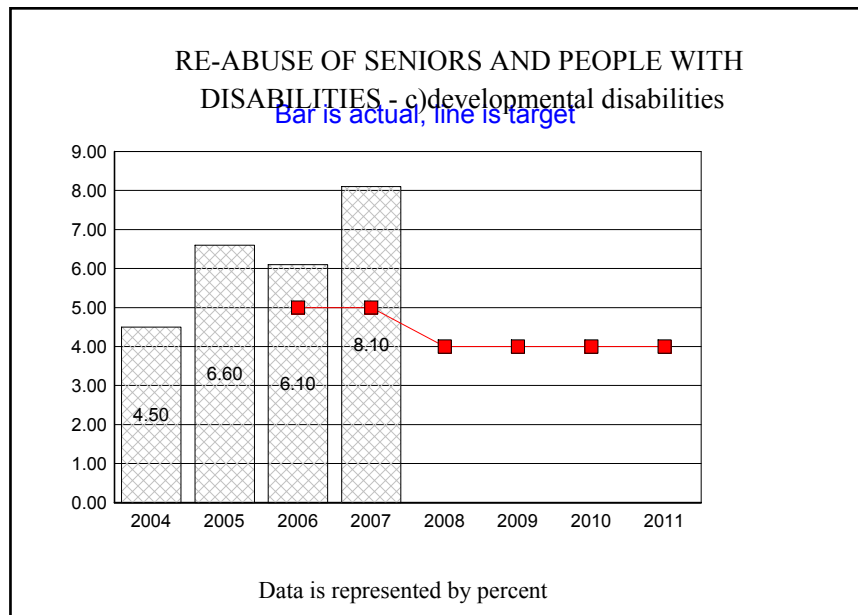
Original data source is Oregon ACCESS. Since Lane County does not use Oregon Access, abuse data is sent in electronically nightly and then appended to the abuse data. Oregon ACCESS has system edits the help prevent duplication in data. Reports are checked for duplication.Additional

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.

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

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	Oregon Benchmark #52 - 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

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). The target for this measure is to decrease the percentage of 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

Data are not yet available for 2008.

4. HOW WE COMPARE

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

5. FACTORS AFFECTING RESULTS

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 ability to respond and support developmentally disabled victims of abuse (e.g. domestic violence shelters, counseling resources)

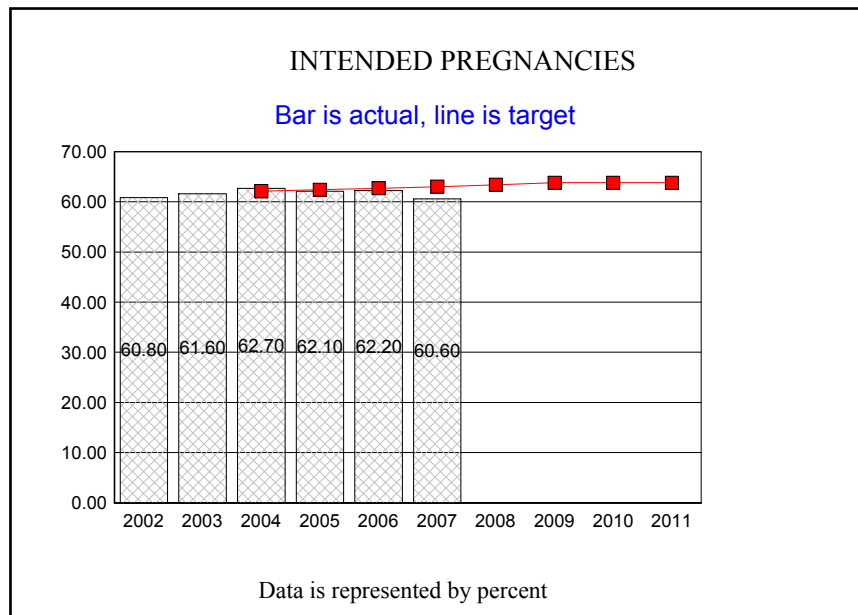
6. WHAT NEEDS TO BE DONE

Additional training for protective service investigators and brokerage staff who are serving people in their own homes.
Research and collaboration with community response system 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
Inclusion of clients, their family and the community at large

7. ABOUT THE DATA

Reporting cycle is Calendar Year. Data are 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 Seniors and Adults with Disabilities can be obtained by contacting the Office of Licencing & Quality of Care Adult Protective Services.
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	Oregon Benchmark #39 - 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 given the complex nature of pregnancy intent.

3. HOW WE ARE DOING

The trend over the last six years has been relatively flat. 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 according to the most recent data available from the National Survey of Family Growth . http://www.cdc.gov/nchs/nsfg/abc_list_i.htm#intended

5. FACTORS AFFECTING RESULTS

Access to, and utilization of, family planning services are key factors affecting what proportion of births result from intended pregnancies. In Oregon, publicly accessible family planning services have two major sources of funding: Title X, the federal grant program devoted to family planning and reproductive health care, and a family planning Medicaid waiver known as FPEP. Access to Title X-funded services has declined over the past several years due to a combination of flat funding and increased medical costs, especially for prescription contraceptive methods. Utilization of FPEP services declined sharply when federal eligibility restrictions changes were implemented in 2006 but recent outreach efforts are beginning to increase program enrollment again. Beyond access and demand, pregnancy intent is influenced by an often complex mix of feelings about pregnancy, childbearing, intimate relationships and other issues. Given the importance of these factors, 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.

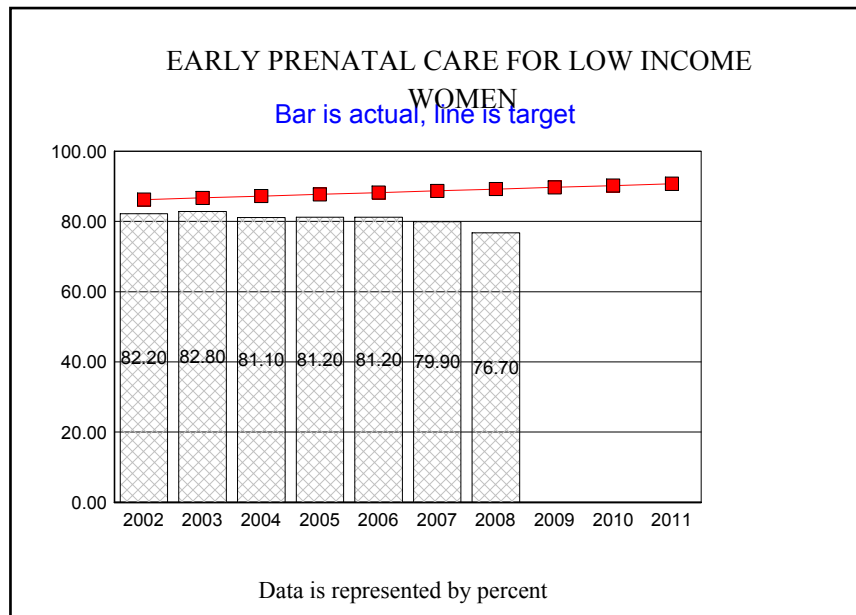
6. WHAT NEEDS TO BE DONE

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 calendar year. Their foremost strength is that they directly reflect womens own reports of pregnancy intent; the population-based design and high response rate of the PRAMS survey are also assets for this measure. The primary limitation of the data is that the complexity of womens feelings about pregnancy and childbearing can make pregnancy intent difficult to measure accurately. This measure was included in the KPM audit performed by the DHS Internal Audit and Consulting Group in June 2009. This KPM was verified which means "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 #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	Oregon Benchmark #40 - 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, Kathleen Anger 971-673-0257 / 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 the Division of Medical Assistance Programs (DMAP), the agency that administers the Oregon Health Plan (OHP), to assist pregnant women in entering early prenatal care. The OMC program has expanded from five sites serving fewer than 1,000 low-income women in 2000 to 29 sites that served more than 5,100 women in 2008 with over 31,067 referrals to prenatal care and other services. OFH also promotes SafeNet, the toll-free hotline for referrals to local prenatal services. In addition, DMAP expedites applications for OHP from pregnant women. Weekly, DMAP sends its contracted managed care plans a download of members from which the plan can identify pregnant women. Plans use this information to make timely contact and help arrange the first prenatal visit. 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 2008 is 89.2%. There has been a slightly downward trend since 2002. The targets were developed based on a different data source (survey) that yielded slightly higher rates. The present rates are 4 to 7 percentage points below these targets. The National Title V Performance Measure and the Healthy People 2010 target for early prenatal care is 90% of infants born to pregnant women, of all income ranges, initiating prenatal care in the first trimester.

3. HOW WE ARE DOING

76.7% of low-income women who gave birth in 2008 began their prenatal care in the first four months of pregnancy. Because the data is from the revised birth certificate (that Oregon began using in January 2008), it is not possible to reliably say whether there were significant changes in prenatal care initiation from 2007 to 2008.

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 85% of clients apply for OHP) and OHP clients in general might be helpful. In 2008 approximately 88% of women receiving services through OMC during their first trimester entered prenatal care during the first trimester or within 15 days of their OMC visit. This includes women who are low-income but ineligible for Oregon Health Plan (OHP) coverage. Among women who report OHP/Medicaid as their delivery payment source, the percent of first trimester care is consistently slightly less than 70%. Four months was chosen for this measure because many women do not learn they are pregnant until their second or third month of pregnancy and then become eligible for OHP due to their pregnancy status (in addition to their low-income). Although OHP applications from pregnant women are expedited, Oregon is not one of the thirty-one 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.

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

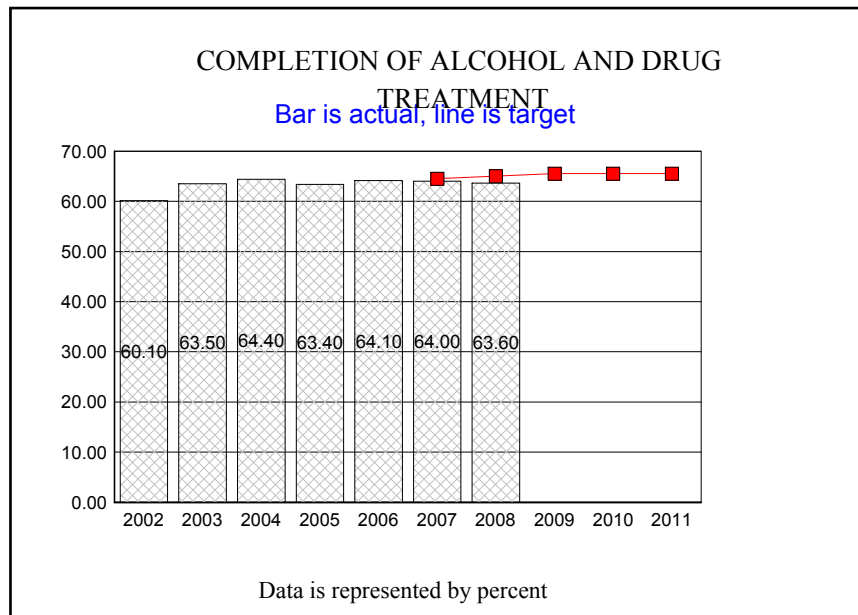
OFH and DMAP will continue to collaborate through the Oregon Mothers Care program and whenever possible. Trends will continue to be tracked, comparing Medicaid and non-Medicaid women for the entire state as well as by county. The use of other data sources and measures will be considered including further use of birth record data and perhaps birth record data linked to OHP/Medicaid-DMAP data. Options for comparing OMC and DMAP data for the first three months of pregnancy will be explored. 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

As of August 31, 2009, data for 2008 are not yet available. At the time of updating the data in July 2007, it was found that the data presented in the table were correctly computed for all previous years but improperly translated into the table. The graph reflects now correct actual and target values. For 2008, as in previous years, birth certificate data were used to calculate initiation of prenatal care in the first four months of pregnancy. In previous years, the birth certificate data included a field that indicated the month that prenatal care was initiated. Beginning with 2008, the birth certificate no longer indicates the month of initiation of prenatal care. However, information is now available for both the (first day of) the last menstrual period before pregnancy and for the date of the woman's first prenatal care visit. These two variables were used to calculate the month in which prenatal care began. As in previous years, income data was not available; therefore, OHP/Medicaid as a source of payment for labor and delivery was used as a surrogate for low income. The data for 2008 are preliminary. This measure Early Prenatal Care for Low Income Pregnant Women was shared by the Public Health Office of Family Health (OFH) and DMAP and is being replaced by two new measures one from the OFH

and one from DMAP. Both DMAP and OFH struggled with this measure because the data sources did not align with the program efforts of each agency. In addition, the original data source, the PRAMS survey, changed an income range question several times and determining the number in the household was always problematic. Using the birth certificate dataset as the source did not align with DMAPs administrative data of OHP clients. DMAP and OFH agreed to discontinue sharing this measure and have each developed their own prenatal KPM that better reflects their specific roles in improving prenatal care. OFH has changed the proxy for determining low income from OHP covered births to another method and changed the required initiation of prenatal care to first trimester rather than first four months. DMAPs new measure shows the percentage of pregnant OHP clients who received an adequate number of prenatal care visits while on OHP. DMAP will use the modified Kessner Criteria to determine the adequate number of visits per week of cumulative gestation and begin date of OHP coverage. This better measures DMAPs scope of responsibility for improving prenatal care. 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. OFH will use birth certificates record information reported by the mother about her pregnancy collected into a dataset used nationally to monitor trends in birth outcomes. For monitoring trends for disparity in access to early prenatal care from this data source, a proxy for low income and non-low income women is the number of women reporting that they were enrolled, and not enrolled, in the Supplemental Nutrition Program (WIC) for one or more months during pregnancy. Eligibility for enrollment requires a family income of $\leq 185\%$ Federal Poverty Level (FPL) and is the best available data for estimating low income status in pregnancy. The measure has two parts: a) Low income women with first trimester care: The numerator is the number of live births whose mothers report prenatal care in the first 3 months and who report enrollment in WIC during pregnancy and the denominator is all mothers who report enrollment in WIC during pregnancy, and b) Non-low income women with first trimester care: The numerator is the number live births whose mothers report prenatal care in the first 3 months and who report not being enrolled in WIC during pregnancy and the denominator is all mothers who reported not enrolled in WIC during pregnancy.

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	Oregon Benchmark #50a - 8th Grade Substance Abuse (alcohol), #50b - 8th Grade Substance Abuse (illicit drugs), #53a - Alcohol Abstinence During Pregnancy, #53b - Tobacco Abstinence 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 hovering around 64% for the past several 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 47% in 2006, according to reports available from the Substance Abuse and Mental Health Services Administration Office of Applied Studies (<http://www.samhsa.gov/newsroom/advisories/0906222801.aspx>).

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)
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

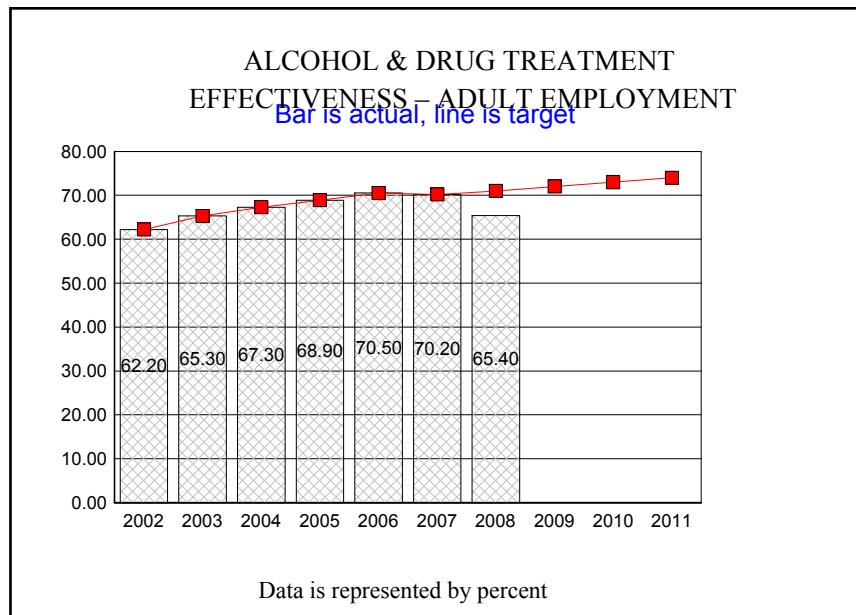
The Division will continue quality improvement and process improvement efforts to improve completion rates.

7. ABOUT THE DATA

Data are 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. Data were corrected since the FY 2006 annual performance progress report. Targets were

adjusted based on the corrected data. All clients engaged in treatment (the length of stay was at least 7 days), receiving outpatient, intensive outpatient and residential services in 2008, and discharged are reported in this key performance measure. This measure was included in the KPM audit performed by the DHS Internal Audit and Consulting Group in June 2009. This KPM was verified which means "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 #20	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of adults employed after receiving Alcohol and Drug treatment.	2007
Goal	People are living as independently as possible	
Oregon Context	Achieving employment 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 problems, but no insurance.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

Oregon has been doing well regarding employment at discharge but due to the economy and employment conditions in Oregon, beginning in 2008, it is expected that the employment percentage at discharge will decrease compared to previous 2-3 years.

4. HOW WE COMPARE

Oregon, along with all states, reports to the federal government about employment at admission and discharge from treatment for outpatient, intensive outpatient, and residential services. According to SAMHSA (<http://nationaloutcomemeasures.samhsa.gov>) in 2008, 42.8% of clients were working part or full-time at discharge. For 2008 and part-time or full-time work only, 58.2% of Oregonians are employed. The KPM includes individuals who work at some level no matter how limited.

5. FACTORS AFFECTING RESULTS

State unemployment rates significantly affect reported employment rates for clients served.

6. WHAT NEEDS TO BE DONE

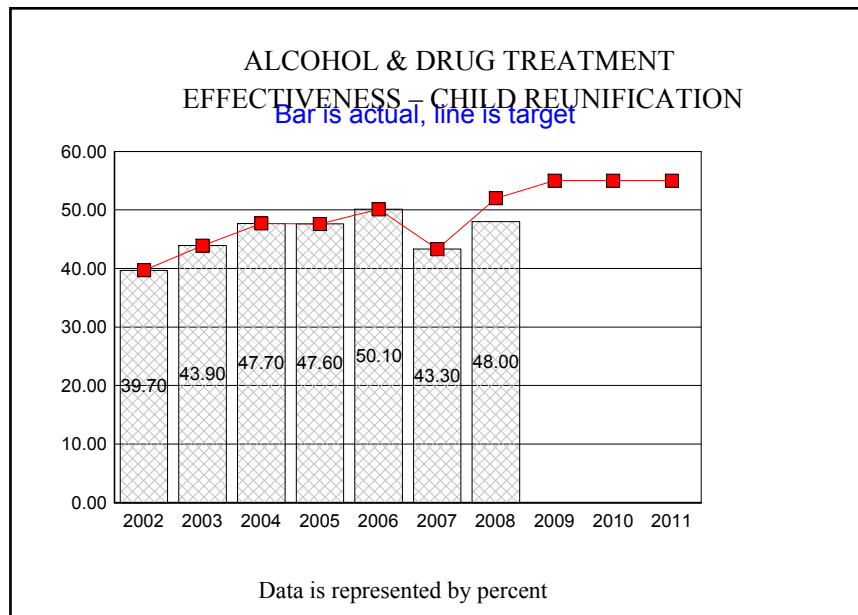
More emphasis needs to be placed on co-occurring disorder treatment, additional case management services, supported employment strategies, and recovery management services.

7. ABOUT THE DATA

Data are 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. Data were corrected since the FY 2006 annual performance progress report. Targets were adjusted based on the corrected data. The included 2008 year used any youth receiving outpatient, intensive outpatient or residential treatment

services and discharged from treatment during the calendar year. If a client reported partial employment (less than 17 hours/week), part-time or full-time employment they were counted as employed.

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	People are healthy.	
Oregon Context	Prevention of out-of-home placements	
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

While the rate still did not meet our goal or rise as high as the 2006 figure, it did represent an improvement over last year and is definitely moving in the right direction.

4. HOW WE COMPARE

We do not have any national data to compare ourselves to.

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. Access is limited to a variety of services including outpatient, residential, housing, and recovery options.

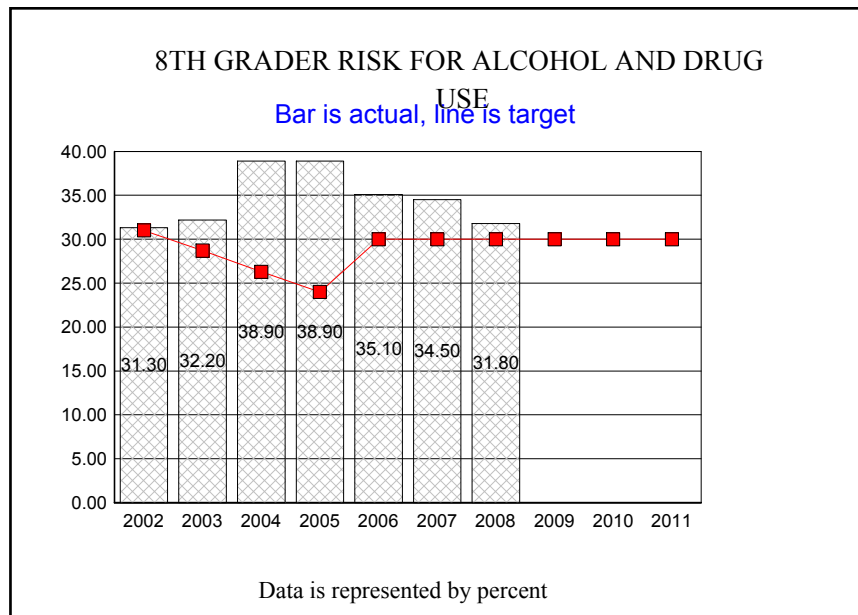
6. WHAT NEEDS TO BE DONE

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 wraparound services for the entire family.

7. ABOUT THE DATA

Data are extracted from the Divisions 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. Data were corrected since the FY 2006 annual performance progress report. Targets were adjusted based on the corrected data. The included 2008 year used any youth receiving outpatient, intensive outpatient or residential treatment services and discharged from treatment during the calendar year. Parents were counted as yes or no, that had a requirement to sufficiently the Child Welfare Service Agreement to progress towards regaining custody of their children.

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	Oregon Benchmark #50a - 8th Grade Substance Abuse (alcohol), #50b - 8th Grade Substance Abuse (illicit drugs)	
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. In the

comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking. 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 efforts directed at social policies related to underage drinking and parent programs that help parents in setting clear and specific guidelines concerning alcohol and other drug use. AMH will continue to provide community grants to implement programs to reduce underage drinking on the local level, utilizing Oregon Healthy Teens Survey data. 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.

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 for the third consecutive year, but still exceeds the target. However, eleven counties have reached or are doing better than the target: Baker, Benton, Clackamas, Curry, Harney, Hood River, Lincoln, Linn, Marion, Morrow and Washington.

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 2008, 16.1% of Washington 8th graders reported using alcohol in the past 30 days, while 29.1% of Oregon 8th graders did. This is the last year that Oregon will report this measure. Beginning in 2009, this measure will be replaced by two measures for 8th graders: alcohol use in the past month and illicit drug use in the past month.

5. FACTORS AFFECTING RESULTS

Perceptions of youth 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 its okay to drink, as long as they don't drive.

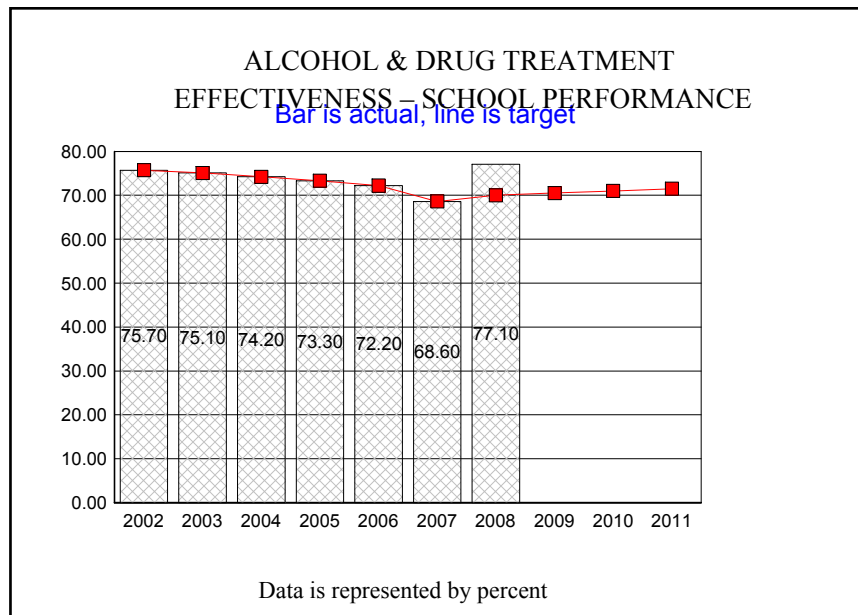
6. WHAT NEEDS TO BE DONE

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 its 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 are extracted from the Oregon Healthy Teens Survey. The survey is administered annually to 8th and 11th graders across the state. This is the last year that this performance measure will be reported. Beginning in 2009, this measure will be replaced by two new 8th grade measures; one for past month alcohol use and another for past month illicit drug use.

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, Karen Wheeler, 503-945-6191	



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

Better than expected given the prior trend.

4. HOW WE COMPARE

This measure looks at academic performance; most national data available only tracks improvement in attendance. This makes comparison data at a state level difficult. Using past performance, positive strides were made this past year.

5. FACTORS AFFECTING RESULTS

Capacity of school counselors and other school personnel to refer youth to treatment and provide educational supports to youth who have accessed treatment.

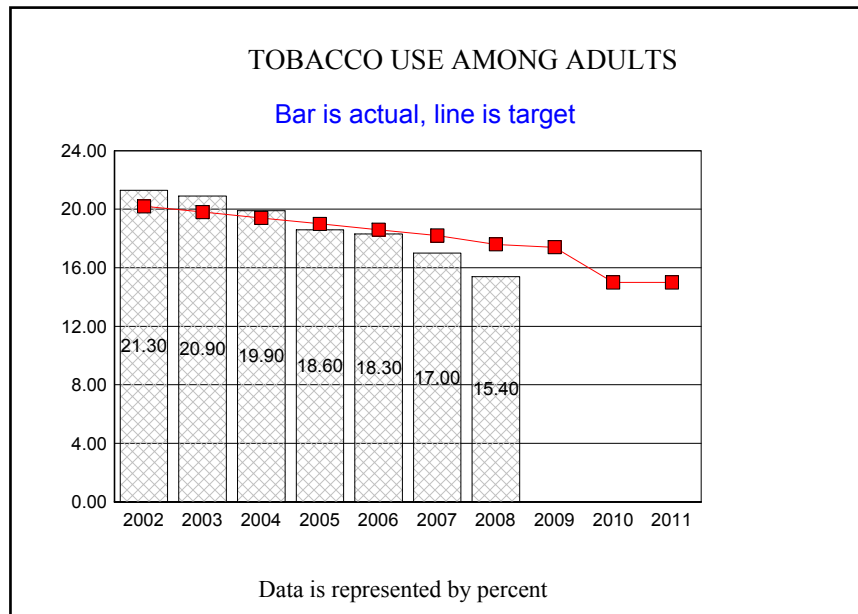
6. WHAT NEEDS TO BE DONE

More emphasis placed on youth specific co-occurring disorder treatment, additional case management services, recovery management services, and additional wraparound services. In addition, more coordination with school personnel including school counselors needs to occur.

7. ABOUT THE DATA

Data are extracted from AMHs 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	Oregon Benchmark #44 - Adult non-smokers, Oregon Benchmark #45 - Preventable death	
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 as 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 2008, the prevalence of smoking in Oregon was 15.4% for the general adult population and 8.6% among 8th grade adolescents. In 2007, 12.3% of pregnant women smoked. 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 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% in Oregon. If this success continues, Oregon's 11th grade smoking rates should stay on course for achieving the 16% target for 2010. The performance measure of tobacco use during pregnancy met or exceeded targeted levels in earlier years, but has been worse than target since 2005. Oregon's smoking prevalence during pregnancy has historically been higher than the national rate, although national data for 2007 are not currently available.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health (CDC) 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 CDC recommends funding tobacco prevention at \$11.60 per capita, which amounts to \$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 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 has recently increased back to those approved by the voters in 1996, Oregon today spends only one-third of the CDC recommended minimum 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. After funding was restored to previous levels, per capita consumption began dropping again.

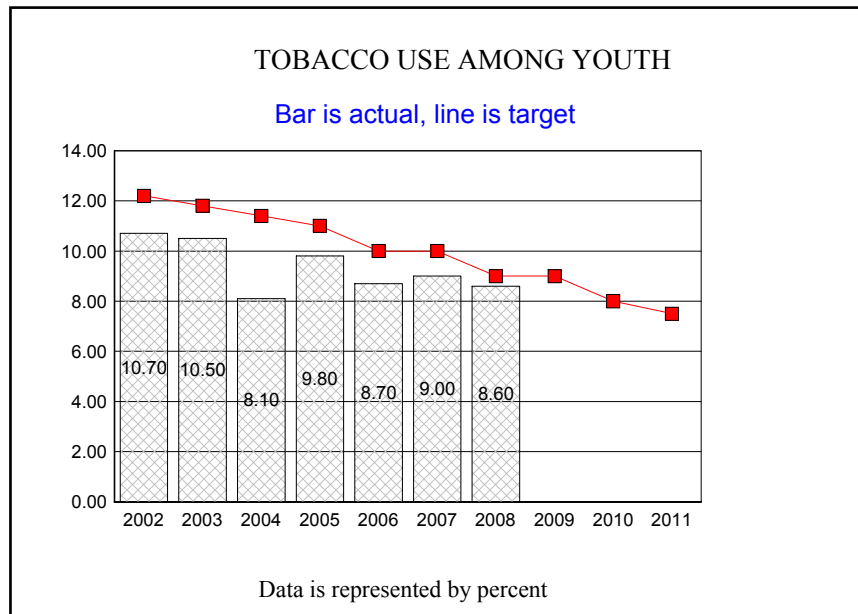
6. WHAT NEEDS TO BE DONE

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. 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 the Tobacco Prevention and Education Programs data report, Tobacco Facts and Laws.

KPM #24b	TOBACCO USE – Tobacco use among youth.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmark #45 - Preventable death, Oregon Benchmark #50c - 8th grade substance abuse (cigarettes)	
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

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2. ABOUT THE TARGETS

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3. HOW WE ARE DOING

In 2008, the prevalence of smoking in Oregon was 15.4% for the general adult population and 8.6% among 8th grade adolescents. In 2007, 12.3% of pregnant women smoked. 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 pregnant women.

4. HOW WE COMPARE

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5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health (CDC) 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 CDC recommends funding tobacco prevention at \$11.60 per capita, which amounts to \$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 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 has recently increased back to those approved by the voters in 1996, Oregon today spends only one-third of the CDC recommended minimum 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. After funding was restored to previous levels, per capita consumption again began dropping.

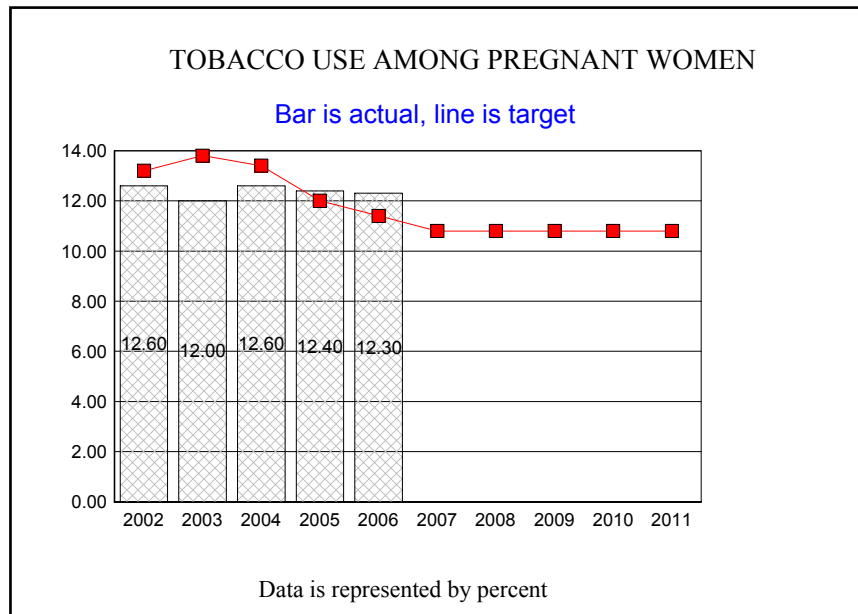
6. WHAT NEEDS TO BE DONE

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. 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. Additional years of data are available via our website by downloading the latest version of the Tobacco Prevention and Education Programs data report, Tobacco Facts and Laws.

KPM #24c	TOBACCO USE – Tobacco use among pregnant women.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmark #45 - Preventable Death, Oregon Benchmark #53b - Tobacco Abstinence 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 2008, the prevalence of smoking in Oregon was 15.4% for the general adult population and 8.6% among 8th grade adolescents. In 2007, 12.3% of pregnant women smoked. 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 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% in Oregon. If this success continues, Oregon's 11th grade smoking rates should stay on course for achieving the 16% target for 2010. The performance measure of tobacco use during pregnancy met or exceeded targeted levels in earlier years, but has been worse than target since 2005. Oregon's smoking prevalence during pregnancy has historically been higher than the national rate, although national data for 2007 are not currently available.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health (CDC) 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 CDC recommends funding tobacco prevention at \$11.60 per capita, which amounts to \$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 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 has recently increased back to those approved by the voters in 1996, Oregon today spends only one-third of the CDC recommended minimum 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. After funding was restored to previous levels, per capita consumption again began dropping.

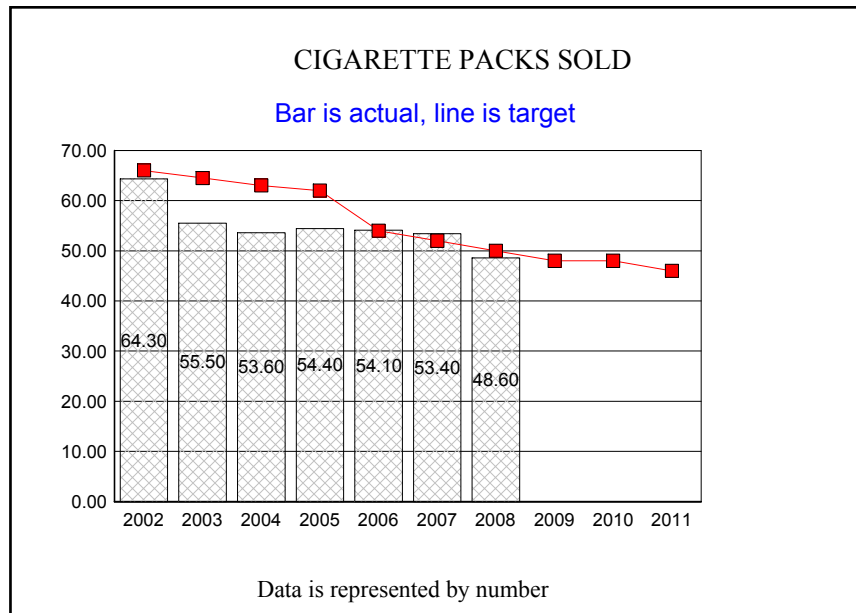
6. WHAT NEEDS TO BE DONE

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. 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). 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 by downloading the latest version of the Tobacco Prevention and Education Programs data report, Tobacco Facts and Laws.

KPM #25	CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmark #44 - Adult Non-Smokers, Oregon Benchmark #45 - Preventable Death, Oregon Benchmark #50c - 8th Grade Substance Abuse (cigarettes), Oregon Benchmark #53b - 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 has significant health benefits, and reducing smoking helps those who continue to smoke to be more likely to quit smoking in the future. 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 peoples health, both in the short-term and long-term.

3. HOW WE ARE DOING

In 2008, the number of cigarette packs sold in Oregon was 48.6 packs per capita. This measure is better than the desired target for 2008. Moreover, this data point represents a welcome change compared with the previous five years data, which had demonstrated an extended period of stagnation in per capita cigarette packs sold.

4. HOW WE COMPARE

In 1997, prior to the TPEPs inception, Oregon had greater per capita sales of cigarette packs than the rest of the country (92.1 Oregon, 87.2 U.S.). In 2008, conversely, U.S. per capita sales of cigarette packs was 54.6 (6.0 packs per capita higher than Oregon). 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, Oregons per capita pack sales in 2005 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 (CDC) 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 CDC recommends funding tobacco prevention at \$11.60 per capita, which amounts to \$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 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 has recently increased back to those approved by the voters in 1996, Oregon today spends only one-third of the CDC recommended minimum 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. These data demonstrate that after funding was restored to previous levels, per capita consumption began dropping again.

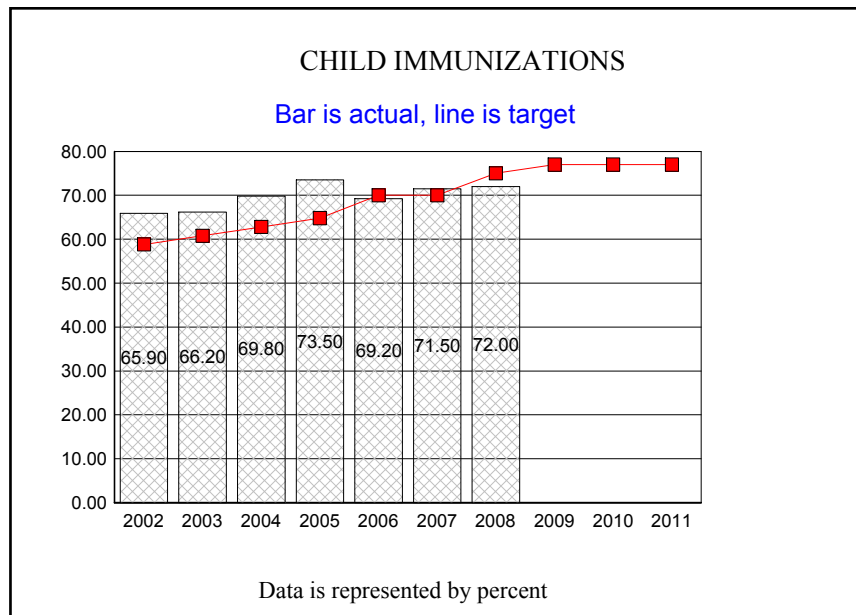
6. WHAT NEEDS TO BE DONE

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 DORs 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	Oregon Benchmark #41 - Infant Mortality, Oregon Benchmark #42 - 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. Each year an assessment 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%.

3. HOW WE ARE DOING

The percentage of adequately immunized two year olds who receive immunizations at local health departments 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 2008 was 78.2% and 72.3% for Oregon.

5. FACTORS AFFECTING RESULTS

In the majority of cases, children served in local health departments do not have a medical home, which means they have additional barriers preventing 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 new computerized record system for the public sector, which includes reminder postcards for overdue shots.

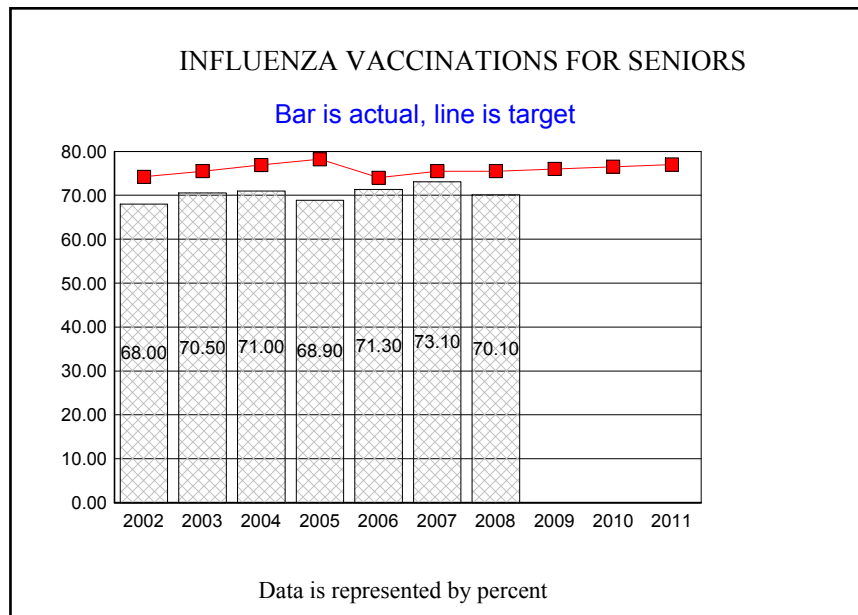
Increase private provider participation in the statewide ALERT immunization registry so that we can produce a consolidated record and improve providers' ability to identify under-immunized children.

Continue to work with the Centers for Disease Control (CDC), vaccine manufacturers and providers to assure that appropriate strategies are in place for a potential vaccine shortage.

7. ABOUT THE DATA

This KPM will be modified for 2009 through 2011 to reflect the immunization status of all Oregon 2 year olds. 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.

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	Oregon Benchmark #45 - 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 hospital standing 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. Additionally, using 2005 data, a disparity in coverage rates was identified between persons self-identified as White and non-White in Oregon.

4. HOW WE COMPARE

In 2008, the national immunization rate for persons 65 and older was 71.1%, with state rates ranging from 78.1% in New Hampshire to 57.1% in Nevada. Oregon ranked 30th in rates nationally, with a rate decrease from 73.1% to 70.1%.

5. FACTORS AFFECTING RESULTS

The flat rates are influenced by the 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 limited 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. Another initiative, promoting influenza standing orders in hospitals for eligible adults, will continue to create opportunities for screening and vaccinating adults. The number of hospitals supporting standing orders has increased from 18 in 2004 to 26 in 2007.

6. WHAT NEEDS TO BE DONE

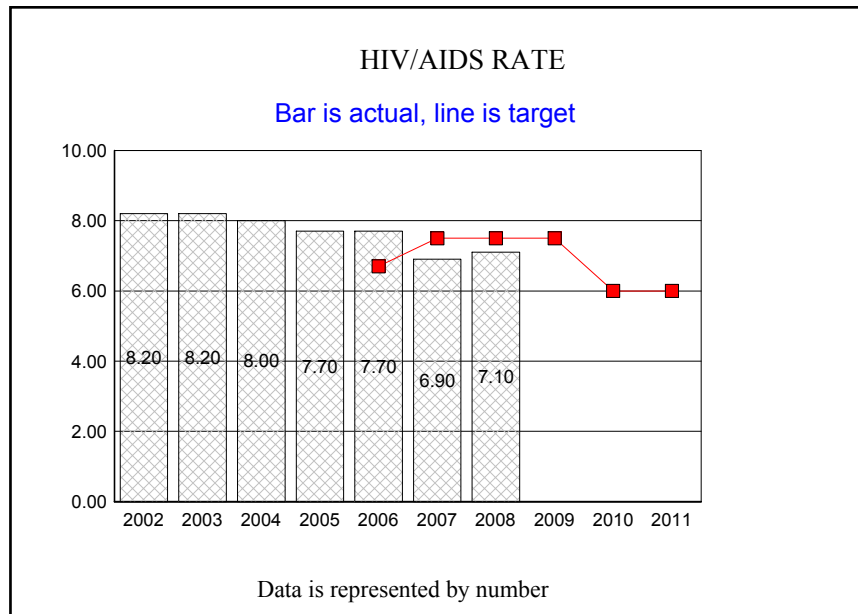
With the support of OAIC and depending on our available resources, we plan on the following:
Continue to work with hospitals to increase the number of patients, age 65 and older, who are immunized against influenza prior to discharge;

Host the 7th Annual Flu Summit to promote influenza vaccination strategies to providers; and
Continue to promote the administration of influenza vaccine in all health care settings, whenever immunization providers give any other immunization, such as pneumococcal vaccine or tetanus/diphtheria vaccine.

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 of each year.

KPM #28	HIV RATE – The annual rate of HIV infection per 100,000 persons.	2000
Goal	People are healthy.	
Oregon Context	Oregon Benchmark #43a - HIV diagnosis (number of new infections), Oregon Benchmark #43b - HIV diagnosis (rate per 100,000), 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 15,000 HIV tests are performed annually in Oregon with state and federal support the majority of these funded by programs administered by DHS. HIV treatment programs affect several thousand 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, we established initial targets during 2006 that were consistent with approximately 20% reduction in the measured rate of new infections from 2004.

3. HOW WE ARE DOING

Declines in rates of newly diagnosed HIV infection by year 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 partially effective in curtailing the epidemic. Meeting optimistic targets of a further 20% reduction for 2009 and beyond must occur as a result of 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 19.8 HIV infections were diagnosed per 100,000 people during 2005 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 estimate 7.7 newly diagnosed cases per 100,000 residents for the same year 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 several thousand 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.

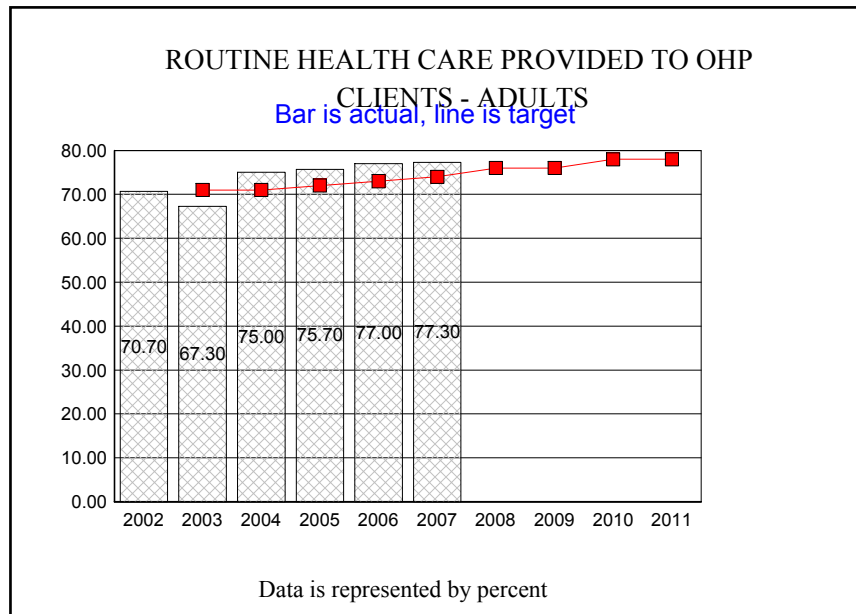
6. WHAT NEEDS TO BE DONE

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. 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. Centers for Disease Control and Prevention have estimated that 21% 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 80% of the true number of new infections. 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 made case reporting more complete, and comparison possibly misleading. In addition, cases diagnosed during previous years can be reported to DHS up to several years later in some instances. Consequently, official estimates of newly diagnosed cases and rates of new diagnoses (per 100,000 population) for past years are subject to change each year as new cases are reported for previous years. In addition, Oregon began using slightly different population estimates from the US Census Bureau beginning in 2006 that caused small changes in reported estimates of population rates. For interested readers, the HIV/STD/TB program publishes an annual epidemiologic profile for HIV. It is available at <http://egov.oregon.gov/DHS/ph/hiv/data>. For the 2009-11 biennium, this KPM will change to report 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.

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	
Data Source	Oregon MMIS (Medicaid Management Information System) DSSURS (Decision Support Surveillance and Utilization Review System) DMAP Legacy 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 disease management and case management programs for fee-for-service (FFS) clients. In addition, DMAP 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 are reasonable and attainable. 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 but remains slightly below the 2007 target. Since 2002, for both adults and children, the general trend shows 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 DMAPs 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. Barriers include health care providers that do not accept Medicaid clients and a lack of understanding among some clients that routine health visits are necessary and important.

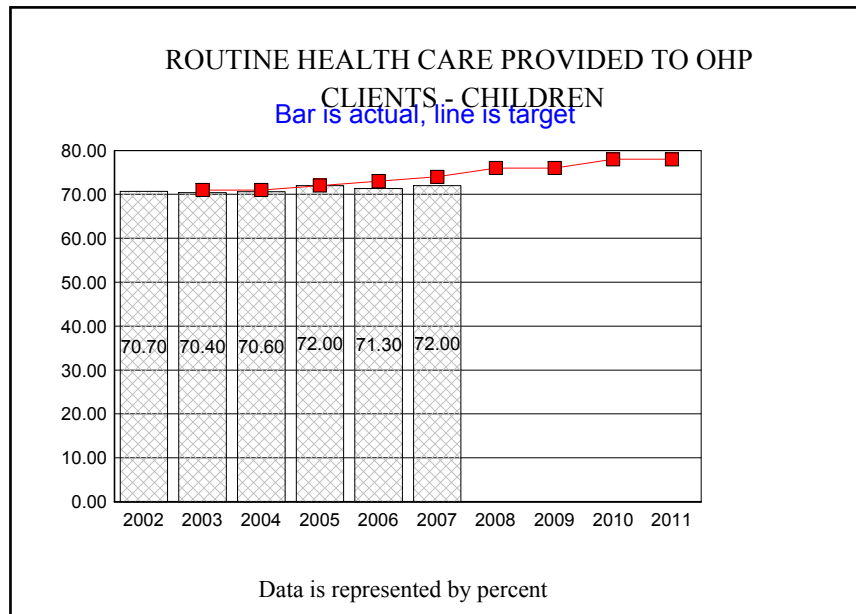
6. WHAT NEEDS TO BE DONE

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 to meet specified goals for performance measures. 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 has added a nurse telephone advice line for FFS clients. In response to inquiries concerning rates of preventive services for OHP clients, DMAP has changed this measure to two new measures. The new measures are based on line 003 of the prioritized list of health services entitled: Preventive Services for Birth to 10 years of age and on line 004 of the prioritized list of health services entitled: Preventive Services for over age of 10. The Health Services Commission has 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). Although not shown here as a Key Performance Measure, for quality improvement and management purposes, further divisions are by race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

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 and to clients in the FFS delivery system. This measure is available by county. Due to the transition to a new DSSURS system, 2008 data is not available at this time.

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	
Data Source	Oregon MMIS (Medicaid Management Information System) DSSURS (Decision Support Surveillance and Utilization Review System) DMAP Legacy 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 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 are reasonable and attainable. 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 but remains slightly below the 2007 target. Since 2002, for both adults and children, the general trend shows 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 DMAPs 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. Barriers include health care providers that do not accept Medicaid clients and a lack of understanding among some clients that routine health visits are necessary and important.

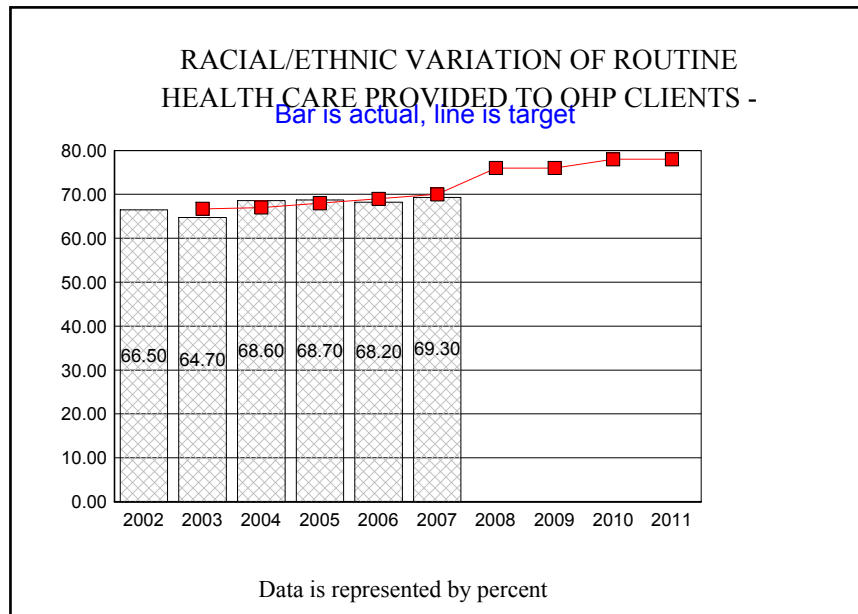
6. WHAT NEEDS TO BE DONE

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 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 has added a nurse telephone advice line for FFS clients. In response to inquiries concerning rates of preventive services for OHP clients, DMAP has changed this measure to two new measures. The new measures are based on line 003 of the prioritized list of health services entitled: Preventive Services for Birth to 10 years of age and on line 004 of the prioritized list of health services entitled: Preventive Services for over age of 10. The Health Services Commission has 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). Although not shown here as a Key Performance Measure, for quality improvement and management purposes, further divisions are by race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

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 and to clients in the FFS delivery system. This measure is available by county. Due to the transition to a new DSSURS system, 2008 data is not available at this time.

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, racial /ethnic health status	
Data Source	Oregon MMIS (Medicaid Management Information System) DSSURS (Decision Support Surveillance and Utilization Review System) DMAP Legacy 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 the federal CHCS (Center for Health Care Strategies) is developing performance measures 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 are reasonable and attainable. 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

The 2007 rates remained steady compared to 2006 rates all changes were within a percentage point and a half or less. All categories increased from 2006 to 2007, except for Native American category which decreased by less than a percentage point and a half from 2006 to 2007. All race/ethnic categories were within a fraction of a percentage point of their 2007 targets. The Hispanics category was slightly above their 2007 target while all the other categories were slightly below their 2007 targets. 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.

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 DMAPs 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 and a lack of understanding among some clients that routine health visits are necessary and important.

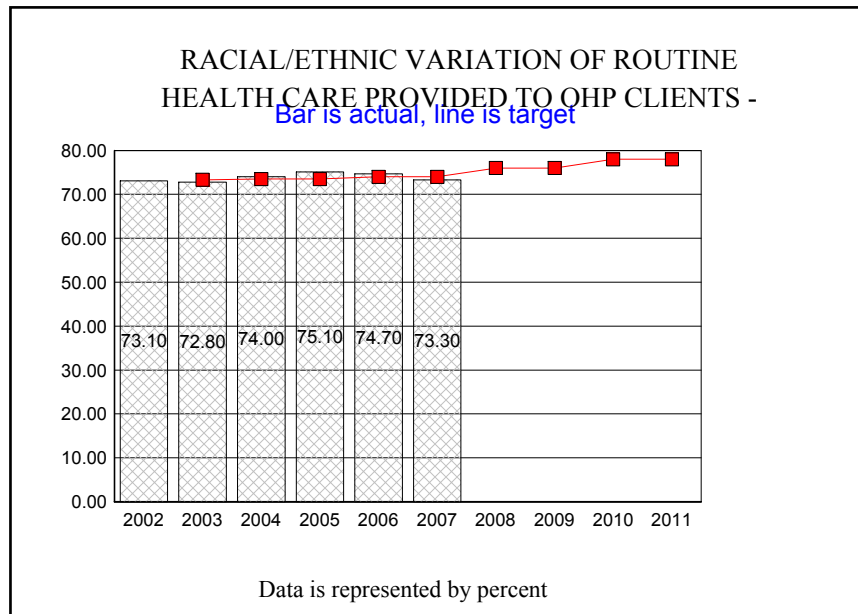
6. WHAT NEEDS TO BE DONE

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. In response to inquiries concerning rates of preventive services for OHP clients, DMAP has changed this measure to two new measures. The new measures are based on line 003 of the prioritized list of health services entitled: Preventive Services for Birth to 10 years of age and on line 004 of the prioritized list of health services entitled: Preventive Services for over age of 10. The Health Services Commission has 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 DMAP's reimbursement to managed care plans of which 80% of OHP clients are enrolled (for physical health services). Although not shown here as a Key Performance Measure, for quality improvement and management purposes, further divisions are by race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

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. 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. Due to the transition to a new DSSURS system, 2008 data is not available at this time.

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, racial /ethnic health status	
Data Source	Oregon MMIS (Medicaid Management Information System) DSSURS (Decision Support Surveillance and Utilization Review System) DMAP Legacy 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 the federal CHCS (Center for Health Care Strategies) is developing performance measures 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 are reasonable and attainable. 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

The 2007 rates remained steady compared to 2006 rates all changes were within a percentage point and a half or less. All categories increased from 2006 to 2007, except for Native American category which decreased by less than a percentage point and a half from 2006 to 2007. All race/ethnic categories were within a fraction of a percentage point of their 2007 targets. The Hispanics category was slightly above their 2007 target while all the other categories were slightly below their 2007 targets. 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.

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 DMAPs 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 and a lack of understanding among some clients that routine health visits are necessary and important.

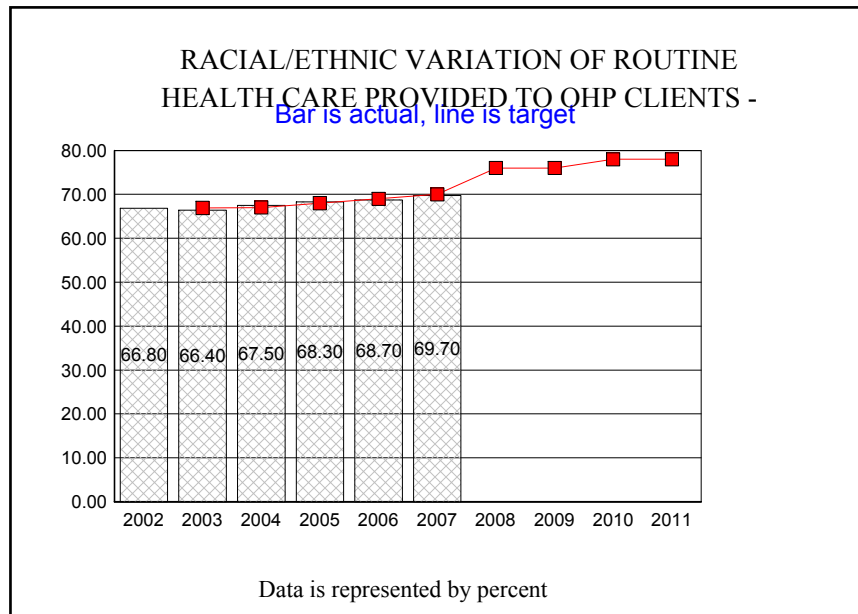
6. WHAT NEEDS TO BE DONE

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. In response to inquiries concerning rates of preventive services for OHP clients, DMAP has changed this measure to two new measures. The new measures are based on line 003 of the prioritized list of health services entitled: Preventive Services for Birth to 10 years of age and on line 004 of the prioritized list of health services entitled: Preventive Services for over age of 10. The Health Services Commission has 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 DMAP's reimbursement to managed care plans of which 80% of OHP clients are enrolled (for physical health services). Although not shown here as a Key Performance Measure, for quality improvement and management purposes, further divisions are by race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

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. 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. Due to the transition to a new DSSURS system, 2008 data is not available at this time.

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, racial/ethnic health status	
Data Source	Oregon MMIS (Medicaid Management Information System) DSSURS (Decision Support Surveillance and Utilization Review System) DMAP Legacy 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 the federal CHCS (Center for Health Care Strategies) is developing performance measures 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 are reasonable and attainable. 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

The 2007 rates remained steady compared to 2006 rates all changes were within a percentage point and a half or less. All categories increased from 2006 to 2007, except for Native American category which decreased by less than a percentage point and a half from 2006 to 2007. All race/ethnic categories were within a fraction of a percentage point of their 2007 targets. The Hispanics category was slightly above their 2007 target while all the other categories were slightly below their 2007 targets. 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.

4. HOW WE COMPARE

There are no public or private industry standards to compare to this performance measure. This measure separates KPM #25 into five racial/ethnic categories combining adults and children. This measure was designed to measure DMAPs 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 and a lack of understanding among some clients that routine health visits are necessary and important.

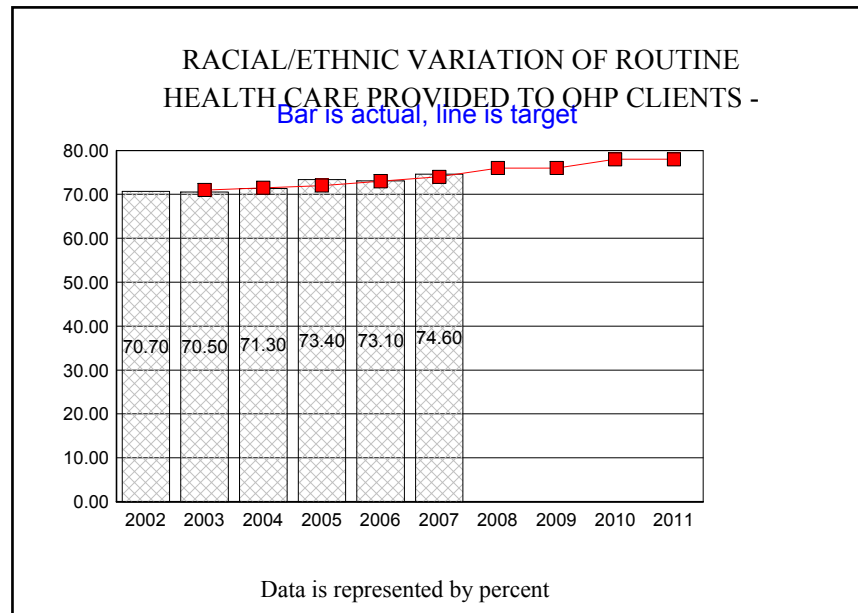
6. WHAT NEEDS TO BE DONE

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. In response to inquiries concerning rates of preventive services for OHP clients, DMAP has changed this measure to two new measures. The new measures are based on line 003 of the prioritized list of health services entitled: Preventive Services for Birth to 10 years of age and on line 004 of the prioritized list of health services entitled: Preventive Services for over age of 10. The Health Services Commission has 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 DMAP's reimbursement to managed care plans of which 80% of OHP clients are enrolled (for physical health services). Although not shown here as a Key Performance Measure, for quality improvement and management purposes, further divisions are by race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

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. 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. Due to the transition to a new DSSURS system, 2008 data is not available at this time.

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, racial/ethnic health status	
Data Source	Oregon MMIS (Medicaid Management Information System) DSSURS (Decision Support Surveillance and Utilization Review System) DMAP Legacy 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 the federal CHCS (Center for Health Care Strategies) is developing performance measures 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 are reasonable and attainable. 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

The 2007 rates remained steady compared to 2006 rates all changes were within a percentage point and a half or less. All categories increased from 2006 to 2007, except for Native American category which decreased by less than a percentage point and a half from 2006 to 2007. All race/ethnic categories were within a fraction of a percentage point of their 2007 targets. The Hispanics category was slightly above their 2007 target while all the other categories were slightly below their 2007 targets. 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.

4. HOW WE COMPARE

There are no public or private industry standards to compare to this performance measure. This measure separates KPM #25 into five racial/ethnic categories combining adults and children. This measure was designed to measure DMAPs 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 and a lack of understanding among some clients that routine health visits are necessary and important.

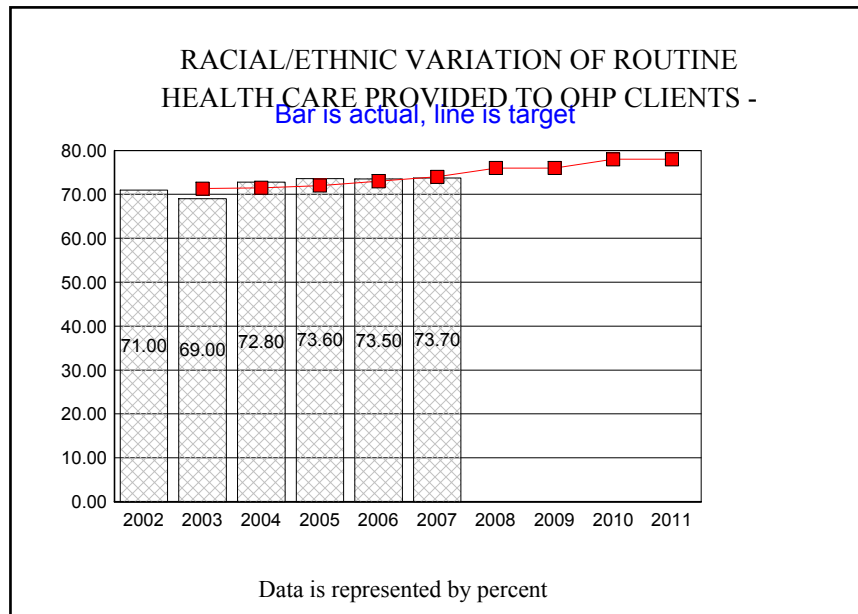
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DMAP will continue to collaborate with community, public health, and federal partners on initiatives and projects that focus on reducing health care disparities. DMAP continues to provide an increasing number of educational materials in languages in addition to English. In response to inquiries concerning rates of preventive services for OHP clients, DMAP has changed this measure to two new measures. The new measures are based on line 003 of the prioritized list of health services entitled: Preventive Services for Birth to 10 years of age and on line 004 of the prioritized list of health services entitled: Preventive Services for over age of 10. The Health Services Commission has 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 DMAP's reimbursement to managed care plans of which 80% of OHP clients are enrolled (for physical health services). Although not shown here as a Key Performance Measure, for quality improvement and management purposes, further divisions are by race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

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. 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. The data for 2002, 2003, 2004 and 2006 changed slightly and can be attributed to either rounding errors, retroactive eligibility or claims lag issues. This measure is available by county. Due to the transition to a new DSSURS system, 2008 data is not available at this time.

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, racial/ethnic health status	
Data Source	Oregon MMIS (Medicaid Management Information System) DSSURS (Decision Support Surveillance and Utilization Review System) DMAP Legacy 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

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2. ABOUT THE TARGETS

DMAP chose targets that are reasonable and attainable. 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

The 2007 rates remained steady compared to 2006 rates all changes were within a percentage point and a half or less. All categories increased from 2006 to 2007, except for Native American category which decreased by less than a percentage point and a half from 2006 to 2007. All race/ethnic categories were within a fraction of a percentage point of their 2007 targets. The Hispanics category was slightly above their 2007 target while all the other categories were slightly below their 2007 targets. 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.

4. HOW WE COMPARE

There are no public or private industry standards to compare to this performance measure. This measure separates KPM #25 into five racial/ethnic categories combining adults and children. This measure was designed to measure DMAPs 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 and a lack of understanding among some clients that routine health visits are necessary and important.

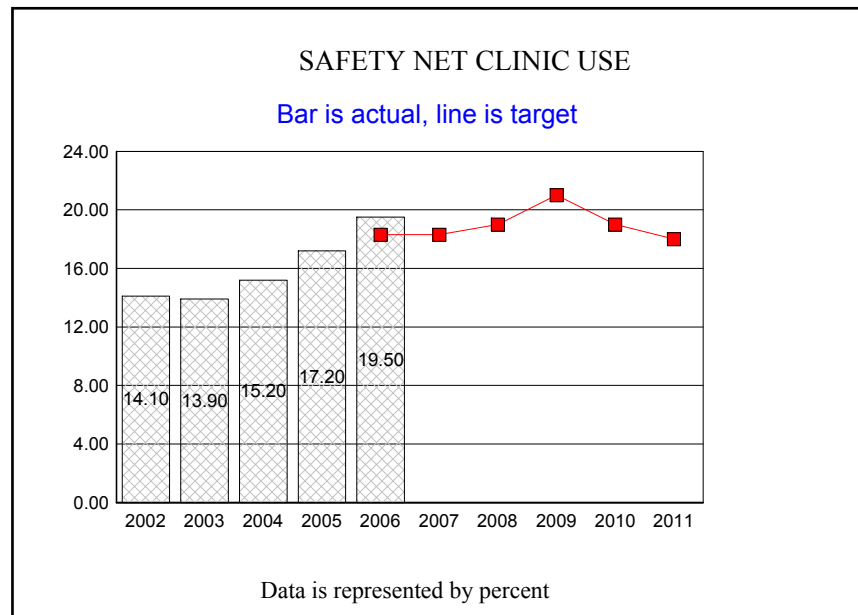
6. WHAT NEEDS TO BE DONE

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7. ABOUT THE DATA

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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 uninsured, Medicaid, and Medicare clients, many of whom face multiple barriers to care not only due to income status. This has been a critical role in recent years as Oregon Health Plan (OHP) enrollment shrank and the number of uninsured increased.

Health care provider frustration also increased as a result of low rates of payment and the current challenges of providing primary care. Health Systems Planning (HSP) is concerned with assuring the viability of the safety net, 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 clinics 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 effectively quantify the work of the safety net and that changes in percentages would further indicate both the needs of the uninsured and the role of the safety net. However with the diminished size of OHP enrollment and the increasing number of uninsured in recent years the OHP percentage served by the safety net declined even though in absolute numbers the safety net continued to see more and more uninsured, Medicaid and Medicare clients in their patient load. The targets for 2009, and 2010 assume that additional children and some adults will be covered through the implementation of Healthy Kids and that it will take a while for new enrollment to occur at significant levels. Enrollment will be distributed across the entire OHP delivery system with the safety net realizing a proportionate share. During this same period a substantial number of uninsured will remain. Once the 25,000 eligible adults are enrolled those who still do not have coverage may seek access through the safety net. In addition other adults who are not eligible for the OHP but are uninsured may also seek safety net services as the result of outreach activities. These variables make predictions challenging to make. On balance we estimate a slight drop in the percentage of the uninsured population served by the safety net in 2010 and 2011.

3. HOW WE ARE DOING

Percentages served by the safety net have remained high since 2002 with an overall upward trend toward 2010. The current recession is a significant contributing factor to increases in the number of uninsured seen by the safety net. The passage of HB 2116 will add about 65,000 children and 25,000 adults to coverage under OHP. The increased OHP enrollment will begin to show up late in 2009 and early 2010. If we assume that the purpose of the safety net is to enable the state to provide at least primary care to a significant number of uninsured whatever the barriers they face then we would have to assume that the safety net is substantially performing this function. 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 OHP access and 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

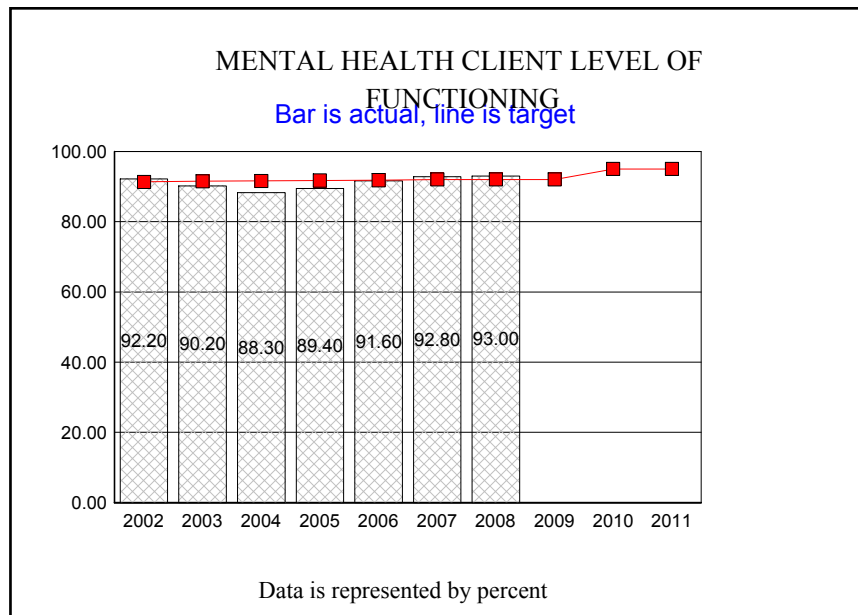
Targets should include both percentages and absolute numbers to effectively document the role of the safety net relative to the uninsured. The passage of HB 2009, with its focus on expanding both coverage and access makes it imperative to gather and analyze safety net data and related metrics in evaluating success of HB 2009 and the role played by the safety net. 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 depend to a good extent on the safety net as part of their panel to assure capacity and access. It is important to understand the role the safety net plays as a part of total health system capacity. It must assure some level of access to Oregonians regardless of upturns or downturns in the economy and any corresponding increases or decreases in who is covered. From a policy perspective the safety net will benefit from increased revenue as a result of expanded OHP coverage and the availability of resources for health information technology. In addition it is currently providing leadership regarding the development of primary care homes and will benefit from state policy supportive of the primary care home model. However the safety net is also unique in its role, diversity of models, and vulnerable population and will benefit from state policy that takes this unique role into account.

7. ABOUT THE DATA

Although updated data for the number of uninsured persons served by FQHCs is available for 2007 and 2008, the denominator data required to calculate the percent for this measure are not yet available for those years. The percentages reported here for 2002 through 2006 do not match figures previously reported. An error in the figures for number of uninsured served by the safety net used to calculate this measure was discovered and corrected last year. 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 Administrations (HRSA) Bureau of Primary Health Care (BPHC). These clinics are known as Federally Qualified Health Centers (FQHCs). 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 FQHCs 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. The latest year of data currently available is 2006.

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 dont 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.

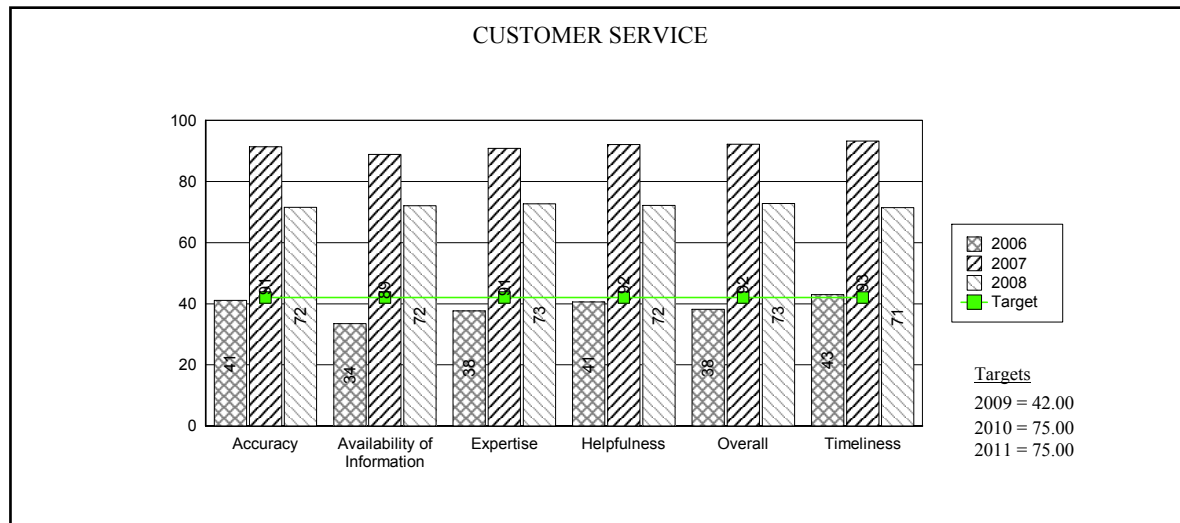
6. WHAT NEEDS TO BE DONE

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 AMHs 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/Director's Office, 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

2010 and 2011 targets were set based on 2008 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 used a different methodology, therefore its impossible to determine whether or not we were 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 2008 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. We will continue to use the CAHPS survey, which is a biennial survey, to report on customer service. We won't have updated data until the 2010 annual performance progress report.

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.

1. INCLUSIVITY

* **Staff:** Staff are involved in the identification and refinement of Key Performance Measures. Feedback is sought to validate the measures. 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.

* **Elected Officials:** Elected officials provide input to the agency KPMs, targets and strategies.

* **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. We continue to work closely with Legislative Fiscal Office and DAS Budget and Management to ensure we are making continuous improvement to our KPMs and that they are providing useful and relevant information for decision-making and management.

* **Citizens:** Community forums related to budget development and priority-setting is a way to identify and validate priorities, expectations and performance areas.

2 MANAGING FOR RESULTS

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. 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.

3 STAFF TRAINING

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 performance measures and the value of using the information to ensure we are seeing improvements. Executive Management will also receive training in fall 2008. 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.

4 COMMUNICATING RESULTS

* **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.