OREGON DEPARTMENT OF HUMAN SERVICES
Annual Performance Progress Report (APPR)
for Fiscal Year 2006-07

2007-09 Budget Form 107BF04c

Due: September 30, 2007
Submitted: September 30, 2007

To obtain additional copies of this report, contact Department of Human Services at 503-945-5855, 500 Summer St NE, Salem, OR 97301, or visit http://www.oregon.gov/DAS/OPB/GOVresults.shtml#Annual_Performance_Reports.

Agency Mission

Assisting people to become independent, healthy and safe.

Table of Contents

Page

ABOUT THIS REPORT

TABLE OF MEASURES 1

PART I: EXECUTIVE SUMMARY 3

PART II: USING PERFORMANCE DATA 6

PART III: KEY MEASURE ANALYSIS 8

ABOUT THIS REPORT

Purpose of Report

The purpose of this report is to summarize the agency's performance for the reporting period, how performance data are used and to analyze agency performance for each key performance measure legislatively approved for the 2005-07 biennium. The intended audience includes agency managers, legislators, fiscal and budget analysts and interested citizens.

1. PART I: EXECUTIVE SUMMARY defines the scope of work addressed by this report and summarizes agency progress, challenges and resources used.
2. PART II: USING PERFORMANCE DATA identifies who was included in the agency's performance measure development process and how the agency is managing for results, training staff and communicating performance data.
3. PART III: KEY MEASURE ANALYSIS analyzes agency progress in achieving each performance measure target and any corrective action that will be taken. This section, the bulk of the report, shows performance data in table and chart form.

KPM = Key Performance Measure

The acronym "KPM" is used throughout to indicate **K**ey **P**erformance **M**easures. Key performance measures are those highest-level, most outcome-oriented performance measures that are used to report externally to the legislature and interested citizens. Key performance measures communicate in quantitative terms how well the agency is achieving its mission and goals. Agencies may have additional, more detailed measures for internal management.

Consistency of Measures and Methods

Unless noted otherwise, performance measures and their method of measurement are consistent for all time periods reported.

AGENCY NAME Oregon Department of Human Services

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

TABLE OF MEASURES

2005-07 KPM#	2005-07 Key Performance Measures (KPMs)	Page #
1	PEOPLE WITH DISABILITIES IN COMMUNITY SETTINGS – The percentage of individuals with developmental disabilities who live in community settings of five or fewer.	**8**
2	SENIORS AND PEOPLE WITH DISABILITIES LIVING OUTSIDE OF INSTITUTIONS – The percentage of Oregon's eligible seniors and people with disabilities who are living outside of institutions: a) seniors, b) people with disabilities (developmental)	**10**
3	OVRS CLOSED - EMPLOYED – The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.	**12**
4	SPD EMPLOYMENT – The percentage of Seniors and People with Disabilities (SPD) consumers with a goal of employment who are employed	**14**
5	TANF (WELFARE) EMPLOYMENT – The percentage of Temporary Assistance to Needy Families (TANF) adults placed for whom employment is a goal.	**17**
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.	**19**
7	TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.	**21**
8	ENHANCED CHILD CARE – The percentage of childcare providers who are providing enhanced quality of care.	**23**
9	AVERAGE EARNINGS FOR SPD CLIENTS – Average monthly earnings for persons with developmental disabilities who receive Seniors and People with Disabilities (SPD) services.	**25**
10	FOOD STAMP UTILIZATION – The ratio of Oregonians receiving food stamp assistance to the number of Oregonians living in poverty.	**27**
11	DOMESTIC VIOLENCE – The percentage of women subjected to domestic violence in the past year.	**29**
12	TEEN SUICIDE – The rate of suicides among adolescents per 100,000.	**31**
13	TIMELY ADOPTION – The median number of months from date of latest removal from home to finalized adoption.	**33**
14	CHILD RE-ABUSE – The percentage of abused/neglected children who were re-abused within 6 months of prior victimization.	**35**
15	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: a) seniors (developmental), b) adults with disabilities, c) developmental disabilities (added for 2006/07).	**37**
16	INTENDED PREGNANCIES – The percentage of births where mothers report that the pregnancy was intended.	**41**
17	EARLY PRENATAL CARE FOR LOW INCOME WOMEN – The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy.	**43**
18	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.	**45**

TABLE OF MEASURES

2005-07 KPM#	2005-07 Key Performance Measures (KPMs)	Page #
19	8TH GRADER RISK FOR ALCOHOL AND DRUG USE – Percentage of 8th graders at high risk for alcohol and other drug use.	**46**
20	TOBACCO USE – Tobacco use among: a) adults, b) youth, c) pregnant women.	**48**
21	CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.	**51**
22	CHILD IMMUNIZATIONS – The percentage of 24 – 35 month old children served by local health departments who are adequately immunized.	**53**
23	INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.	**55**
24	HIV/AIDS RATE – The annual rate of newly acquired HIV/AIDS infections per 100,000 persons.	**57**
25	ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS– The proportion of Oregon Health Plan (OHP) clients who receive routine health care services annually: a) adults, b) children	**59**
26	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – The proportion of Oregon Health Plan (OHP) clients who receive routine health care services annually: a) African Americans, b) Native Americans, c) Asian/Pacific Islanders, d) Hispanic, e) White.	**61**
27	SAFETY NET CLINIC USE – The number of uninsured Oregonians served by safety net clinics.	**65**
28	MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.	**68**
29	CUSTOMER SERVICE - Percentage of customers rating their satisfaction with DHS' customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.	**69**

AGENCY NAME Oregon Department of Human Services

I. EXECUTIVE SUMMARY

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

Contact: Cathy Iles, Administrative Services Division	Phone: 503-945-5855
Alternate: Pam McVay, Finance and Policy Analysis	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 200 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 29 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

KPM Progress Summary	Key Performance Measures (KPMs) with Page References	# of KPMs
KPMs MAKING PROGRESS at or trending toward target achievement	1 – People with disabilities in community settings (page 8), 2 – Seniors and people with disabilities living outside of institutions (page 10), 3 - OVRS closed - employed (page 12), 4 – SPD employment (page 14), 6 – TANF re-entry (page 19), 7 – Teen pregnancy (page 21), 8 – Enhanced child care (page 23), 10 – Food stamp utilization (page 27), 11 – Domestic violence (page 29), 12 – Teen suicide (page 31), 13 – Timely adoption (page 33), 14 – Child re-abuse (page 35), 15 – Re-abuse of seniors and people with disabilities* (page 37), 16 – Intended pregnancies (page 41), 20 – Tobacco use (page 48), 21 – Cigarette packs sold (page 51), 22 – Child immunizations (page 53), 24 – HIV/AIDS rate (page 57), 25 – Routine health care provided to OHP clients (page 59), 26 – Racial/ethnic variation of routine health care provided to OHP clients (page 61), 28 – Mental health client level of functioning (page 68), 29 – Customer service (page 69)	22
KPMs NOT MAKING PROGRESS not at or trending toward target achievement	17 – Early prenatal care for low income women (page 43)	1
KPMs - PROGRESS UNCLEAR	5 – TANF employment (page 17), 9 – Average earnings for SPD clients (page 25), 18 –	6

target not yet set	Completion of alcohol and drug treatment (page 45), 19 – 8th grader risk for alcohol and drug use (page 46), 23 – Influenza vaccinations for seniors (page 55), 27 – Safety net clinic use (page 65)	
	Total Number of Key Performance Measures (KPMs)	29

* KPM15 – Re-abuse of seniors and people with disabilities – reports three different populations: a) seniors, b) adults with disabilities, c) developmental disabilities. We are making progress with populations a and b, but not c.

4. CHALLENGES

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

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

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

5. RESOURCES USED AND EFFICIENCY

2005-07 Total Fund Budget and Staffing by Cluster

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

	% FTE	**FTE**	**% Funds**	**Total Funds**
CAF – Children, Adults and Families Division	43.9%	3,974.50	23.1%	$2,268.3
Health Services (includes Division of Medical Assistance Programs, Addictions and Mental Health Division and Public Health Division)	23.9%	2,163.80	47.6%	$4,671.7
SPD – Seniors and People with Disabilities Division	21.4%	1,939.58	25.3%	$2,480.7
DWSS – Department-Wide Support Services (includes Director's Office, Administrative Services Division, Finance and Policy Analysis, Financial Services)	10.9%	983.63	3.9%	$385.3
Capital Improvement				$1.1
TOTAL	**100%**	**9,061.51**	**100%**	**$9,807.1**

Currently, DHS has no efficiency measures as part of the Key Performance Measure set. Per LFO recommendation, DHS will start reporting its current food stamp accuracy measure for the 2009-11 biennium.

DHS has been engaged in continuous improvement within the financial areas of the agency: Finance and Policy Analysis, Financial Services and Office of Payment Accuracy and Recovery. A component of continuous improvement is conducting Rapid Process Improvements: 3-5 day work sessions which focus on a specific process to find more efficient and effective ways to do the work that eliminates waste and adds value to the customer. Metrics are collected prior to and after the RPI to quantify the improvements. While these specific metrics aren't likely to be used as agency key performance measures, they will be used internally for management. We may develop a key performance measure to capture the results of these improvement events at a department level. This would likely be for the 2009-11 biennium.

II. USING PERFORMANCE DATA

Contact: Cathy Iles, Administrative Services Division	Phone: 503-945-5855
Alternate: Pam McVay, Finance and Policy Analysis	Phone: 503-945-5930

The following questions indicate how performance measures and data are used for management and accountability purposes.	
1 INCLUSIVITY Describe the involvement of the following groups in the development of the agency's performance measures.	• Staff: Feedback is sought on validity of Key Performance Measures and refinement of the measures. • Elected Officials: Provide input to agency Key Performance Measures, targets and strategies. • Stakeholders: Customer feedback will help guide strategies for service delivery. Efforts are currently underway to achieve more inclusion of stakeholder groups. Key partners are being included in conversations about the agency's key performance measures and the impact they have on the desired results. • Citizens: Community forums related to budget development and priorities as a way to validate or identify priorities, expectations and performance areas. Beginning in the fall of 2007, DHS will be undertaking a review of our entire Key Performance Measure set. This will be an inclusive process with staff and stakeholders involved.
2 MANAGING FOR RESULTS How are performance measures used for management of the agency? What changes have been made in the past year?	Performance measures are being used by each office within the Administrative Services Division (ASD). Managers share the results of their measures with the Chief Administrative Officer and his Deputy. These measures continue to be refined over time to ensure they are useful and actionable. The continuous improvement focus within the finance area of DHS includes the identification, collection, tracking and use of metrics. This is still a relatively new practice that continues to be reinforced and evolve. Within Children, Adults and Families Division (CAF), a monthly dashboard report is used by management for understanding the results of the work being done, identifying areas for improvement and decision-making.
3 STAFF TRAINING What training has staff had in the past year on the practical value and use of performance measures?	The DHS Administrative Services Division (ASD) has been in the process of developing strategic plans for each office, which includes a comprehensive set of performance measures. Managers and staff have been involved in the development, tracking and use of performance measures. The continuous improvement efforts within the finance area of DHS have included work around metrics. Specifically, metrics being collected, tracked and analyzed related to events such as a Rapid Process Improvement (RPI). These metrics are used to show improvements in cycle time, cost savings, customer service, etc. The Children, Adults and Families Division has been refining a monthly "dashboard" report which is used for managing the work in Child Welfare and Self Sufficiency.

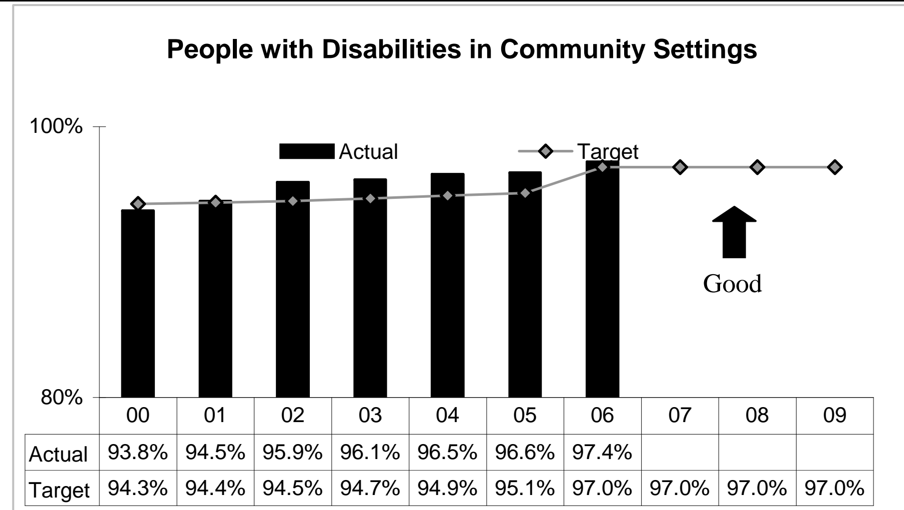
II. USING PERFORMANCE DATA

4 COMMUNICATING RESULTS How does the agency communicate performance results to each of the following audiences and for what purpose?	• Staff: Results are posted online and used for information sharing. • Elected Officials: Results are posted online and included in the agency request document for purposes of sharing performance results, showing accountability, and informing the budget development process. • Stakeholders: Results are posted online and used for information sharing • Citizens: Results are posted online and used for information sharing.

KPM #1	**PEOPLE WITH DISABILITIES IN COMMUNITY SETTINGS – The percentage of individuals with developmental disabilities who live in community settings of five or fewer.**	**Measure since: 2002**
Goal	People are living as independently as possible.	
Oregon Context	DHS high-level outcome – Increase the percentage of Oregonians with a lasting developmental, mental and/or physical disability who could live on their own with adequate support.	
Data source	Client Process Monitoring System (CPMS)	
Owner	Seniors and People with Disabilities, Julia S. Brown, (503) 947-5153	

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

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



	00	01	02	03	04	05	06	07	08	09
Actual	93.8%	94.5%	95.9%	96.1%	96.5%	96.6%	97.4%			
Target	94.3%	94.4%	94.5%	94.7%	94.9%	95.1%	97.0%	97.0%	97.0%	97.0%

3. **HOW WE ARE DOING**
   DHS has met or exceeded its target for the past six years.

4. **HOW WE COMPARE**
   No data is available for comparison for 2006.

5. **FACTORS AFFECTING RESULTS**
   SPD, through the continued implementation of the Staley Settlement Agreement and development of Family Support and other in-home type services continues momentum in providing small community-based or family setting services to people with developmental disabilities. Continued implementation of Crisis diversion assists in keeping people from ICF/MR (Intermediate Care Facility for the Mentally Retarded) placement. PASRR- the Pre-Admission Screening Resident Review is a screening tool which is used to prevent the placement of individuals with mental illness or mental retardation / developmental disabilities (MR/DD) in a nursing facility unless their medical needs clearly indicate they require the level of care provided by a nursing

facility. When placement into a nursing facility is ruled out, smaller, community based settings are explored. In-home support services and establishment of the Housing Trust Fund also support this measure.

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

6. **WHAT NEEDS TO BE DONE**

Preservation of policy and funding structures that contribute to the maintenance and / or improvement of efforts for providing in-home services to persons with developmental disabilities, and continued attention to the impact of aging family caregivers and their needs.

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

7. **ABOUT THE DATA**

Reporting cycle is calendar year.

Data comes from the following sources:
-- Client Processing Monitoring System (CPMS) - count of people receiving Case Management (Service Element 48)
-- University of Minnesota Survey Count - CPMS aggregation of residents living in settings 7 or greater
-- Eastern Oregon Training Center report # MPOPB030-01 "Mental Health Division" Population Bulletin Data – count of residents at EOTC.

Data in CPMS is dependent on submission from counties and providers. While reports are delivered to counties and providers to provide them opportunities to correct and update data in CPMS, data is not always maintained in the system. Caseload count data is reviewed monthly. University of Minnesota Survey Count data is only available as an aggregation of residents living in settings 7 or greater.

Formula used for this report is:
Calendar Year (SE 48 Count – U of Minnesota Survey Count) / (SE 48 Count + EOTC Count)
where U of Minnesota Survey Count (April 2006 snapshot) = # of residents in settings 7 or more.

2006 data disaggregated:
Count of people receiving Case Management = 17,478
University of Minnesota Survey Count (April 2006 snapshot) = 424
Eastern Oregon Training Center = 40

(17478– 424) / 17478+ 40) = 97.4%
17054/17518 =0.9735...

AGENCY NAME Oregon Department of Human Services

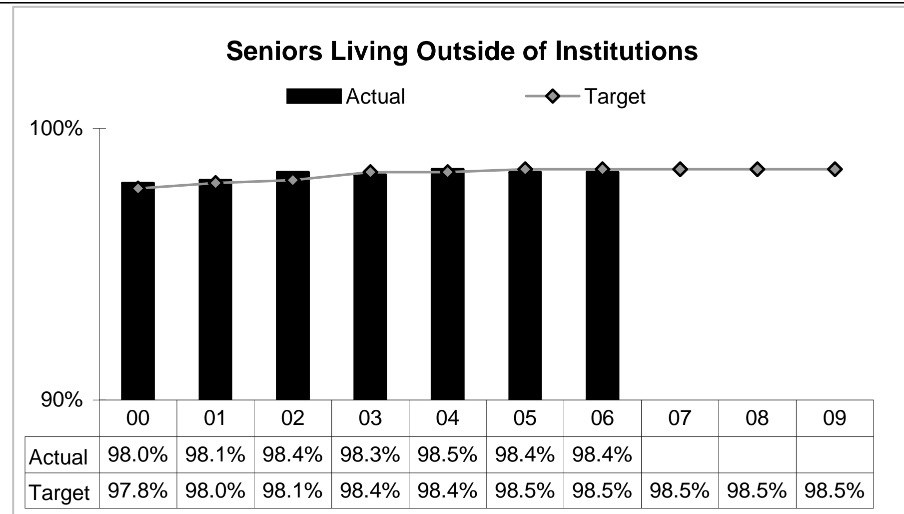
Agency Mission: Assisting people to become independent, healthy and safe.

III. KEY MEASURE ANALYSIS

KPM #2	SENIORS LIVING OUTSIDE OF INSTITUTIONS – The percentage of Oregon's seniors and people with disabilities who are living outside of institutions: a) seniors; b) people with disabilities (developmental)	Measure since: 2002
Goal	Independence – People are living as independently as possible.	
Oregon Context	DHS high-level outcome – Independent seniors	
Data source	Oregon Office of Health Policy and Research and Portland State University Population Research Center	
Owner	Seniors and People with Disabilities, Julia S. Brown, (503) 947-5153	

1. **OUR STRATEGY**
   This performance measure links to the DHS goal – "People are living as independently as possible." This measure also links to Oregon Benchmark #58 and the DHS high-level outcome "Percent of seniors (over 65) living independently." This measure concerns seniors and where they live.

   Institutionalization of people age 65 and older has historically been used as a marker of the degree to which seniors are living independently and has been extensively tracked. A nursing facility is an institution; people who live in their own homes, in the homes of family, or in community based care settings, adult foster homes, assisted living facilities, and residential care facilities are considered to be living independently. DHS strategy continues to emphasize maintaining seniors in their home communities, outside of institutions, to the maximum extent possible.



	00	01	02	03	04	05	06	07	08	09
Actual	98.0%	98.1%	98.4%	98.3%	98.5%	98.4%	98.4%			
Target	97.8%	98.0%	98.1%	98.4%	98.4%	98.5%	98.5%	98.5%	98.5%	98.5%

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

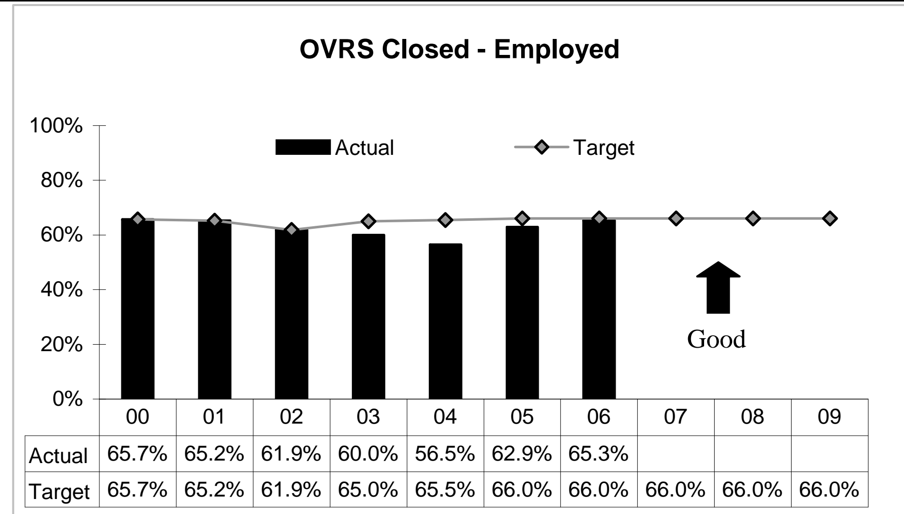
AGENCY NAME Oregon Department of Human Services

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

III. KEY MEASURE ANALYSIS

KPM #3	**OVRS CLOSED - EMPLOYED** **The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.**	**Measure since: 1997**
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	Budget and Performance Unit, David Ritacco, 503-945-6720	

1. **OUR STRATEGY**
   Obtaining and maintaining suitable employment is consistent with the department's goal of assisting people to live independently. This outcome measure shows how successful DHS and its partners are at helping people with disabilities become employed in local communities. Based on a Harris Survey of Americans with Disabilities, "Two out of three unemployed people with disabilities would prefer to be working." During State Fiscal Year 2005, VR clients who were closed as employed earn an average wage of $10.19 per hour and average 30 hours per week.



	00	01	02	03	04	05	06	07	08	09
Actual	65.7%	65.2%	61.9%	60.0%	56.5%	62.9%	65.3%			
Target	65.7%	65.2%	61.9%	65.0%	65.5%	66.0%	66.0%	66.0%	66.0%	66.0%

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

3. **HOW WE ARE DOING**
   The Vocational Rehabilitation (VR) program continues to show excellent performance. For State Fiscal Year 2005, VR had the highest percent rate in the last four years.

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.

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

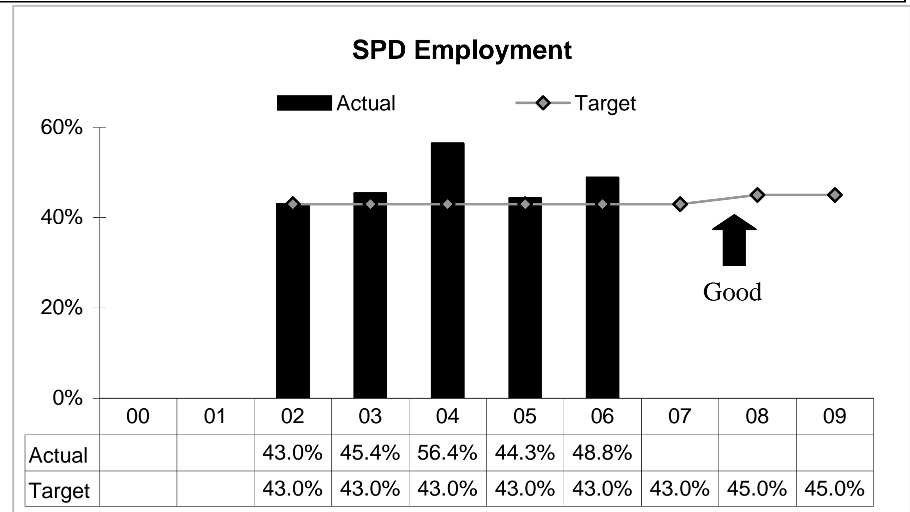
6. **WHAT NEEDS TO BE DONE**
   The VR program will continue to conduct program monitoring and implement any necessary program improvements based on data analysis and new VR regulations enacted through the Rehabilitation Act and its implementing regulations.

7. **ABOUT THE DATA**
   Reporting cycle - fiscal year. The success rate calculation is based on dividing the number of clients who exited the VR program in employment by the number of clients who exited the VR program after receiving services, multiplied by 100.

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

III. KEY MEASURE ANALYSIS

KPM #4	SPD EMPLOYMENT – The percentage of Seniors and People with Disabilities (SPD) consumers with a goal of employment who are employed	Measure since: 2002
Goal	People are living as independently as possible.	
Oregon Context	DHS high-level outcome – Oregonians with disabilities living in poverty	
Data source	Oregon ACCESS, Orca2, Client Maintenance System (CMS) and Client Process Monitoring System (CPMS)	
Owner	Seniors and People with Disabilities, Julia S. Brown, (503) 947-5153	



	00	01	02	03	04	05	06	07	08	09
Actual			43.0%	45.4%	56.4%	44.3%	48.8%			
Target			43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	45.0%	45.0%

1. **OUR STRATEGY**

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

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

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

2. **ABOUT THE TARGETS**

The Legislative Fiscal Office raised the targets for 2008 and 2009 from 43.0% to 45%. The present employment market and tight human service budgets represent a threat to the employment to individuals receiving services from SPD. Achieving our target of 45% will represent significant efforts by SPD in light of the downward trend in employment of people with disabilities. Our hope is that we in fact exceed targeted levels.

3. **HOW WE ARE DOING**

DHS has met its target since 2002; however, a discrepancy was found in 2004 in how the data for this measure has been accessed in the past, resulting in prior year's performance reporting including only a portion of the people served. In 2005, this process was further refined as noted.

Even with the adjustments to more accurately reflect the outcomes, SPD is maintaining at present levels.

4. **HOW WE COMPARE**

DHS has not compared this performance measure to other standards; however, as the measure is reconsidered, national standards for comparable programs and services will be sought for comparison.
When comparing employment data from the EPD program with other buy-in programs in the nation, Oregon has the fourth highest average earnings and are in the top ten in enrollment per capita.

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

5. **FACTORS AFFECTING RESULTS**

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

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

6. **WHAT NEEDS TO BE DONE**

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

7. **ABOUT THE DATA**

Reporting cycle is calendar year.

Data comes from the following sources:
-- Client Processing Monitoring System (CPMS)
-- Express Payment and Recovery System (eXPRS)
-- Client Maintenance System (CMS)
-- Oregon ACCESS
-- Orca2

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

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)

2006 data disaggregated:
SE54 = 3710
SE540 = 2625
EPD (employed) = 745
VR Employed = 264
VR Open = 2595

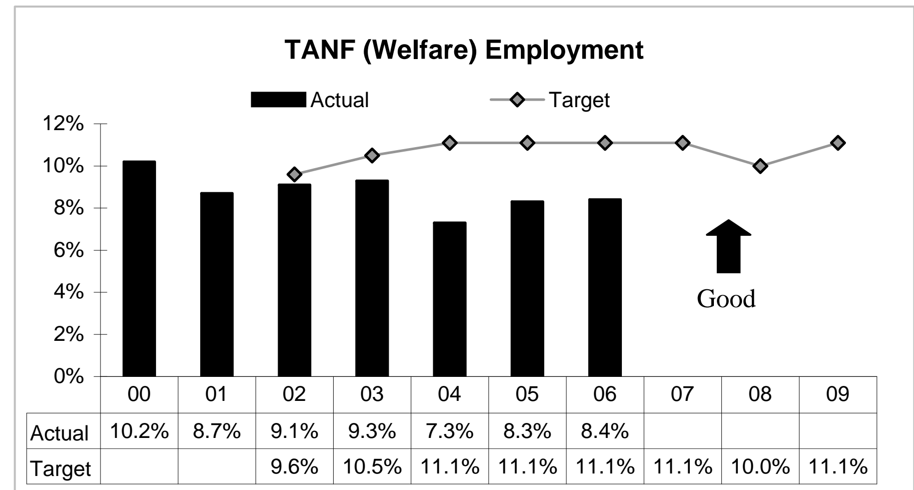
(3710 + 745 + 264) / (3710 + 2625 + 745 + 2595)

4719 /9675 = 0.4877… = 48.8%

III. KEY MEASURE ANALYSIS

KPM #5	TANF (WELFARE) EMPLOYMENT The percentage of Temporary Assistance to Needy Families (TANF) adults placed for whom employment is a goal.	Measure since: 1991
Goal	People are able to support themselves and their families.	
Oregon Context	This measure links to the DHS goal, "People are able to support themselves and their families." It also links to Oregon Benchmark #14 and the DHS high-level outcome; "Percentage of covered Oregon workers with earnings of 150% or more of the poverty level for a family of four."	
Data source	Placement and Number of Mandatory JOBS 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 particiopate in the JOBS program.	
Owner	Children, Adults and Families Division – Office of Self-Sufficiency, Dave Lyda, TANF Manager, 945-6122	

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



	00	01	02	03	04	05	06	07	08	09
Actual	10.2%	8.7%	9.1%	9.3%	7.3%	8.3%	8.4%			
Target			9.6%	10.5%	11.1%	11.1%	11.1%	11.1%	10.0%	11.1%

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

3. **HOW WE ARE DOING**
   2006 increased by 0.1% over 2005. Over 8% of work-eligible JOBS participants report having secured new work each month. For clients, this represents either the first job, a return to the workforce, or a new job that allows them to earn enough to completely leave cash assistance. While it is hoped that JOBS clients will secure employment in the highest paying jobs possible, many times these first jobs pay minimum or near-minimum wages. It is believed that the best way for most individuals to become employed in higher wage jobs in the future is to build their experience and resumes over time. This is best explained by the phrase "First job, better job, career." This program helps clients enter or re-enter the workforce. In doing so, they can start up the ladder to a long-term career in the workplace.

4. **HOW WE COMPARE**
   We are not aware of any public or private industry standards that would be a relevant comparison.

5. **FACTORS AFFECTING RESULTS**
   DHS has not met the targets for the past five years. This may indicate an overly optimistic goal, given the general economic conditions and declining program resources during the last number of years. Although the economic picture has improved and the unemployment rate has declined, we were not able to reach the target.

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

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

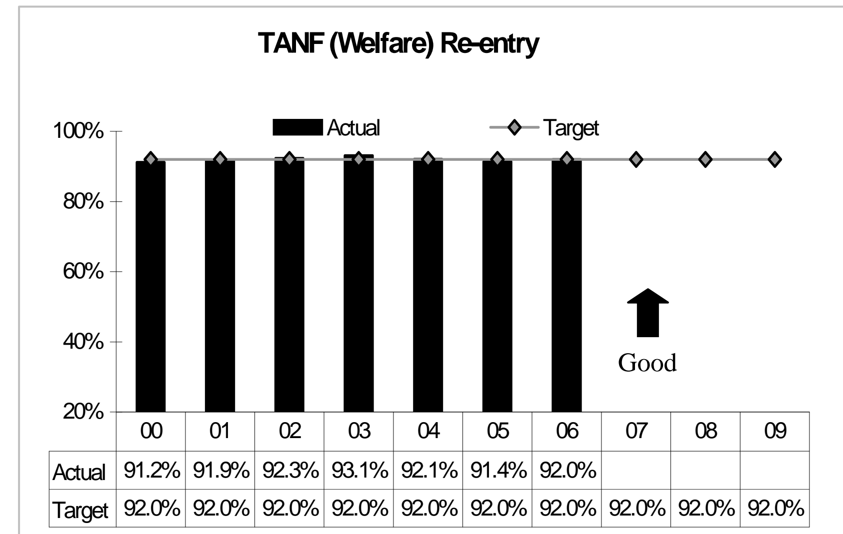
7. **ABOUT THE DATA**
   Reporting cycle – calendar year. The data represented is run on a monthly basis, but reported annually. Monthly reports are issued on a monthly basis and studied for any potential anomalies, as well as to identify trends in performance. The data is sent to program managers and interested parties.

KPM #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.	Measure since: 1991
Goal	People are able to support themselves and their families.	
Oregon Context	This performance links to the DHS goal, "People are able to support themselves and their families." It also links to Oregon Benchmark #14 and the DHS high-level outcome; "Percentage of covered Oregon workers with earnings of 150% or more of the poverty level for a family of four."	
Data source	JAS/TRACS system placement data and Client Maintenance system public assistance data is used to determine the TANF clients who left TANF due to employment and did not return to case assistance ore were still off case assistance 18 months after case closed.	
Owner	Children, Adults and Families Division - Office of Self Sufficiency, Dave Lyda, TANF Manager, 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.



	00	01	02	03	04	05	06	07	08	09
Actual	91.2%	91.9%	92.3%	93.1%	92.1%	91.4%	92.0%			
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

2. **ABOUT THE TARGETS**

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

3. HOW WE ARE DOING

92.0% of TANF clients that left public cash assistance due to employment between July 2004 and June 2005 were not receiving cash assistance 18 months later. This indicates that a larger majority of TANF clients that leave the program due to employment are having relative success in the workplace, or have found other resources to maintain their own and their family's financial independence. The department has met or exceeded its goal for this measure in four of the past five years.

4. HOW WE COMPARE

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

5. FACTORS AFFECTING RESULTS

This measure may be affected by several things, including the status of the labor market and industry, the effectiveness of the JOBS program that determines, coordinates, and provides services to assist TANF clients find and retain employment, and offer strategies to enhance wage gain efforts. As mentioned above, the new Post-TANF program, which will offer on-going cash payments to eligible former TANF recipients and applicants who enter employment, will increase the performance on this measure. Investments in improved assessment/evaluation services, case management and employment and training services should better prepare clients to maintain employment once they leave the program. Changes in TANF Related Medical policy beginning in October 2008 allowing more families to qualify for Extended Medical Assistance may also increase performance in the coming years.

6. WHAT NEEDS TO BE DONE

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

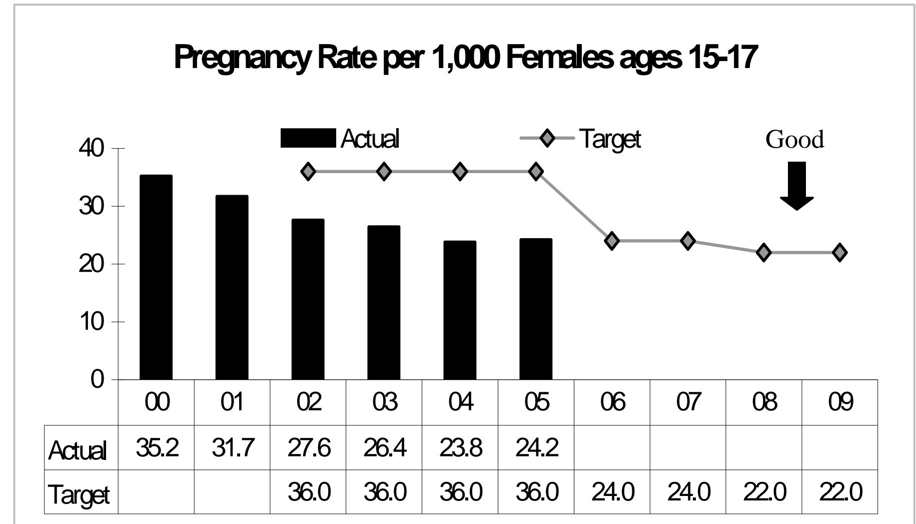
7. ABOUT THE DATA

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

III. KEY MEASURE ANALYSIS

KPM #7	TEEN PREGNANCY The number of female Oregonians ages 15-17, per 1,000 who are pregnant.	Measure since: 2000
Goal	Self-Sufficient – People are able to support themselves and their families.	
Oregon Context	This performance measure links to the DHS goal, "People are able to support themselves and their families." This measure also links to Oregon Benchmark #39 and the DHS high-level outcome, "**Pregnancy rate per 1,000 females ages 15-17**."	
Data source	DHS Health Services and PSU Center for Population and Census estimates….Based on births and induced terminations and population estimates provided by the Center for Population and Census.	
Owner	Children, Adults and Families Division, Belit Stockfleth (503) 947-5389	

1. **OUR STRATEGY**
   The Governor approved a proposal for a new permanent, statewide Teen Pregnancy Prevention and Adolescent Sexual Health Partnership (TPP/SHP) to create a new strategic action plan for Oregon. The partnership includes the following:
   - DHS/Children, Adults and Families Division (CAF)
   - Commission on Children and Families
   - Oregon Teen Pregnancy Task Force
   - DHS/Office of Family Health
   - Planned Parenthood Health Services of SW Oregon
   - DHS/HIV Program
   - Multnomah County Health Department, Adolescent Health Promotion
   - Jackson County Health and Human Services
   - Benton County Health Department
   - Oregon Department of Education



	00	01	02	03	04	05	06	07	08	09
Actual	35.2	31.7	27.6	26.4	23.8	24.2				
Target			36.0	36.0	36.0	36.0	24.0	24.0	22.0	22.0

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

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

III. KEY MEASURE ANALYSIS

3. **HOW WE ARE DOING**
The State's teen pregnancy rate has consistently been lower than the national rate and the State has made great progress in reducing it even further over the past decade. Among 15-17 year-olds in Oregon, the pregnancy rate fell almost 50% between 1990 and 2004.

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

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

6. **WHAT NEEDS TO BE DONE**
We will continue to use new and existing data that examine our statistics, trends, demographics and behavioral factors related to adolescent sexual health.

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

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

7. **ABOUT THE DATA**

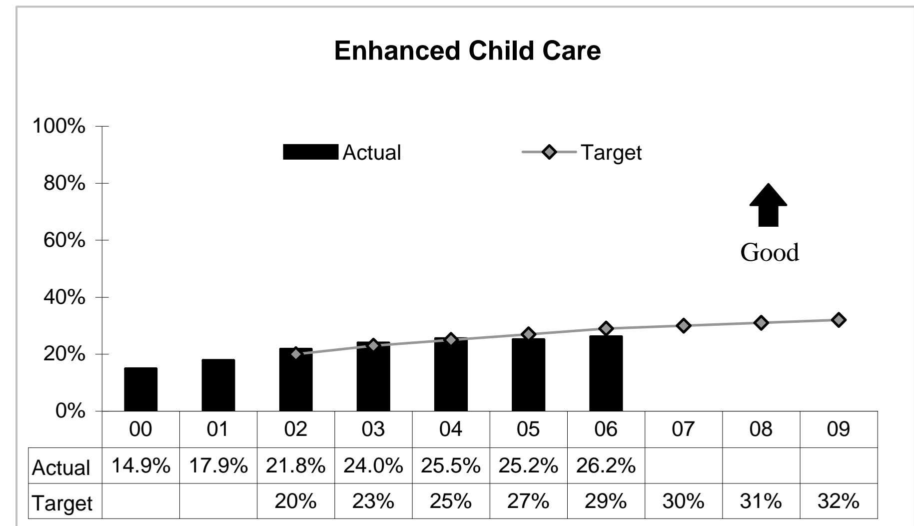
Reporting cycle - calendar year. The data are generally 1 ½ to 2 years behind. The data, which are collected locally and out-of-state, cannot be pulled until the end of the full year. The data used here reflects the prevalence of pregnancy among teens aged 15-17. National pregnancy data is found at http://www.guttmacher.org/pubs/2006/09/12/USTPstats.pdf

KPM #8	**ENHANCED CHILD CARE** **The percentage of child care providers who are providing enhanced quality of care.**	**Measure since: 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, Mark Anderson (503) 945-6108	

1. **OUR STRATEGY**

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

DHS partners with Child Care Resource & Referral Agencies (CCR&R) and the Oregon Registry. The CCR&Rs assist with provider training that is required to qualify for the DHS enhanced rate. The Oregon Registry documents provider training and encourages trained providers to care for families on the DHS subsidy. DHS, the CCR&Rs, and the Oregon Registry team together to publicize the enhanced rate.



	00	01	02	03	04	05	06	07	08	09
Actual	14.9%	17.9%	21.8%	24.0%	25.5%	25.2%	26.2%			
Target			20%	23%	25%	27%	29%	30%	31%	32%

2. **ABOUT THE TARGETS**

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

3. **HOW WE ARE DOING**

There was a steady increase in the percentage of providers receiving the enhanced rate from 2000 through 2004. This measure was consistently above target until 2005. The general trend in 2005 showed a decrease and was below target. Although 2006 remains below target it shows an increase over 2005.

4. **HOW WE COMPARE**

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

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

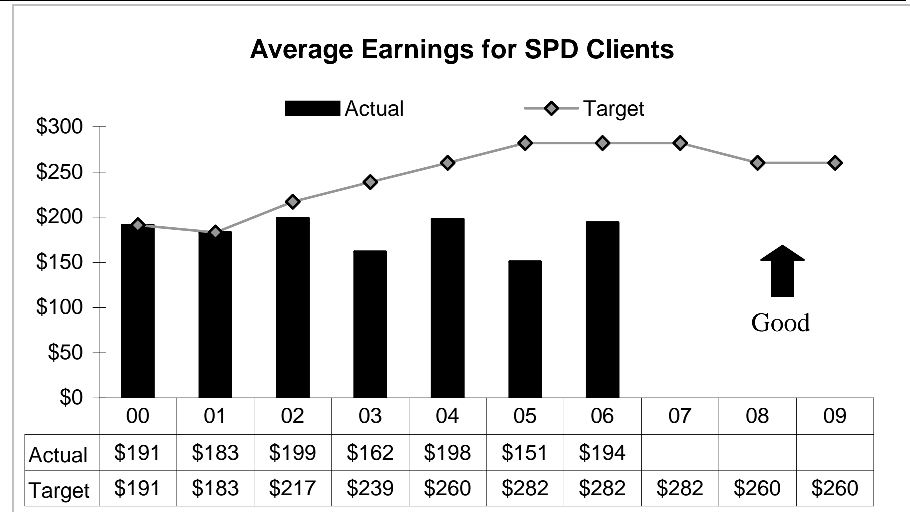
6. **WHAT NEEDS TO BE DONE**
   Efforts to inform parents and providers of the importance of quality child care and training must continue. Exempt providers are now represented by SEIU. DHS, Child Care Resource and Referral agencies and SEIU will be working together to promote the enhanced rate and help exempt providers access the training required to earn the enhanced rate.

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

III. KEY MEASURE ANALYSIS

KPM #9	AVERAGE EARNINGS FOR SPD CLIENTS – Average monthly earnings for persons with developmental disabilities who receive Seniors and People with Disabilities (SPD) services.	Measure since: 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, Julia S. Brown, (503) 947-5153	

1. **OUR STRATEGY**
   SPD will expand competitive employment opportunities for people with developmental disabilities. SPD is currently engaging providers (including private businesses) and other key stakeholders in discussions about strategies to create more employment opportunities for people with developmental disabilities. The agency is using grant and other resources to support this effort. Through this same effort the agency is looking at methods to collect employment related data on clients served that is not included in currently available data sources.



	00	01	02	03	04	05	06	07	08	09
Actual	$191	$183	$199	$162	$198	$151	$194			
Target	$191	$183	$217	$239	$260	$282	$282	$282	$260	$260

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

3. **HOW WE ARE DOING**
   SPD has not met the target since 2001.

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

5. **FACTORS AFFECTING RESULTS**
The recent economic factors in recent years have had a negative impact on the opportunities for competitive employment for people with developmental disabilities. Paid employment opportunities have diminished and the stability/capacity of provider organizations that work to develop employment opportunities has been compromised. As mentioned above, the implementation in recent years of the Staley Settlement Agreement has changed the available data since several hundred people with developmental disabilities previously included in the data have changed their service arrangements and are no longer part of the data pool. Correspondingly, there are no data system 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 are SPD's participation in the national initiatives identified in response #4. With other DHS and community partners, SPD is participating in a 4-year CMS Medicaid Infrastructure Grant designed to increase competitive employment opportunities for people with disabilities. SPD is also participating along with 13 other states in the Supported Employment Leadership Network created by NASDDDS.

7. **ABOUT THE DATA**
Reporting cycle is fiscal year.

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

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)

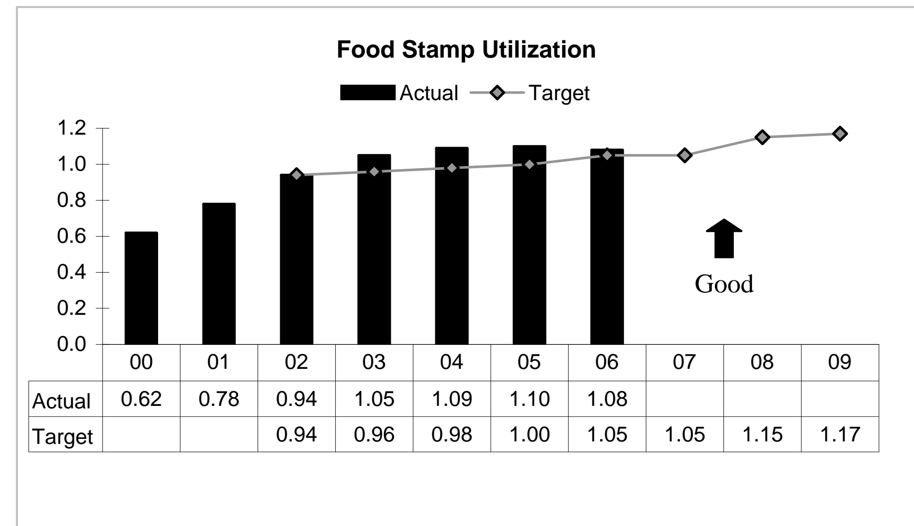
2006 data disaggregated:
(14.51 X 4.2) X 3.19 = $194

Full report Employment Outcomes Report is available at http://www.oregon.gov/DHS/spd/data/.

KPM #10	**FOOD STAMP UTILIZATION** **The ratio of Oregonians receiving food stamp assistance to the number of Oregonians living in poverty.**	**Measure since: 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 #57 and the DHS high-level outcome, "Percent of Oregon households that are food insecure as a percentage of the US."	
Data source	Food Stamp Management Information System and Census estimates.	
Owner	Children, Adults and Families Division, Belit Stockfleth (503) 947-5389	

1. **OUR STRATEGY**
   Our strategy is to 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.



	00	01	02	03	04	05	06	07	08	09
Actual	0.62	0.78	0.94	1.05	1.09	1.10	1.08			
Target			0.94	0.96	0.98	1.00	1.05	1.05	1.15	1.17

3. **HOW WE ARE DOING**
   Between June 2005 and June 2007, the Oregon food stamp caseload increased by 4.7% (219,316 households in 06/05 to 229,651 households in 06/07). Although the caseload increased between June '05 and June '07, the ratio of Oregonians receiving food stamp 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%.

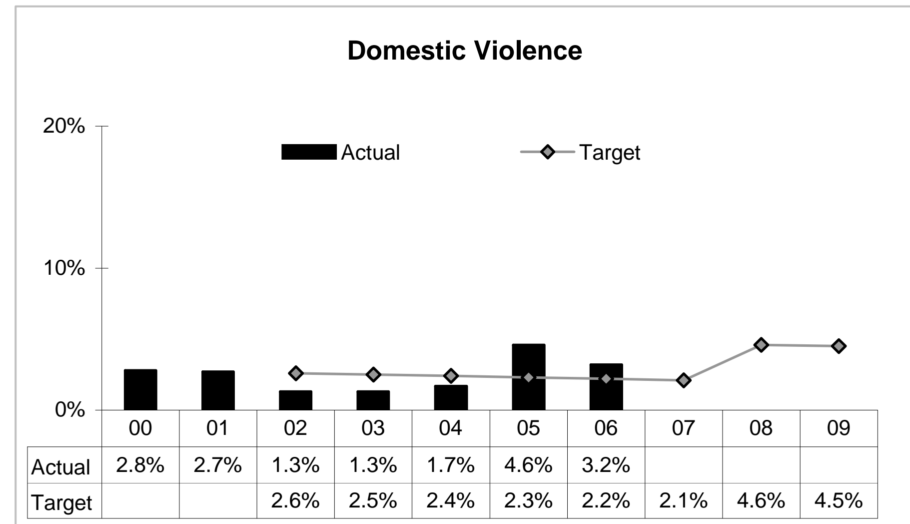
5. **FACTORS AFFECTING RESULTS**
   Nationwide, the elderly are recognized as the most under-served population. Oregon is pursuing a federal grant that would allow us to create a simplified on-line application process and expand outreach efforts to identify and neutralize barriers to food stamp participation.

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.

KPM #11	DOMESTIC VIOLENCE The percentage of women subjected to domestic violence in the past year.	Measure since: 2002
Goal	Safe & Healthy – People are safe. People are healthy.	
Oregon Context	This performance measure links to the DHS goals, “People are safe” and “People are healthy.” This measure also links to Oregon Benchmark #45 and the DHS high-level outcomes, “Premature death: years of life lost before age 70”, and “Decrease domestic violence.”	
Data source	Office of Disease Prevention & Epidemiology survey and database.	
Owner	Public Health Division, Lisa Millet (971) 673-1111	

1. **OUR STRATEGY**
   DHS provides financial support to families who are fleeing or need to stay free from domestic violence. DHS is one of the state agencies that pass state and federal funds to domestic violence service providers across the state. The DHS DV Council has developed “Quality Assurance Standards for DV Intervention and Prevention” 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. DHS has adopted workplace domestic violence policies and is currently participating on a DAS work group to develop policies for all state agencies. DHS supports a coordinated community response and is represented on the Governor’s Council on Domestic Violence as well as other local and statewide DV related committees, councils and task forces. DHS is represented on the AG’s Batterer Intervention Standards Advisory Committee.



	00	01	02	03	04	05	06	07	08	09
Actual	2.8%	2.7%	1.3%	1.3%	1.7%	4.6%	3.2%			
Target			2.6%	2.5%	2.4%	2.3%	2.2%	2.1%	4.6%	4.5%

2. **ABOUT THE TARGETS**
   Progress in reducing domestic violence will be reflected in decreasing incidence rates over time.

3. **HOW WE ARE DOING**
   Trend data are interrupted in 2005 by the introduction of a new risk behavior module in the Behavioral Risk Factor Surveillance Survey. The new module includes a series of new questions on interpersonal violence. Data for 2006 show an increase due to the new question module.

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

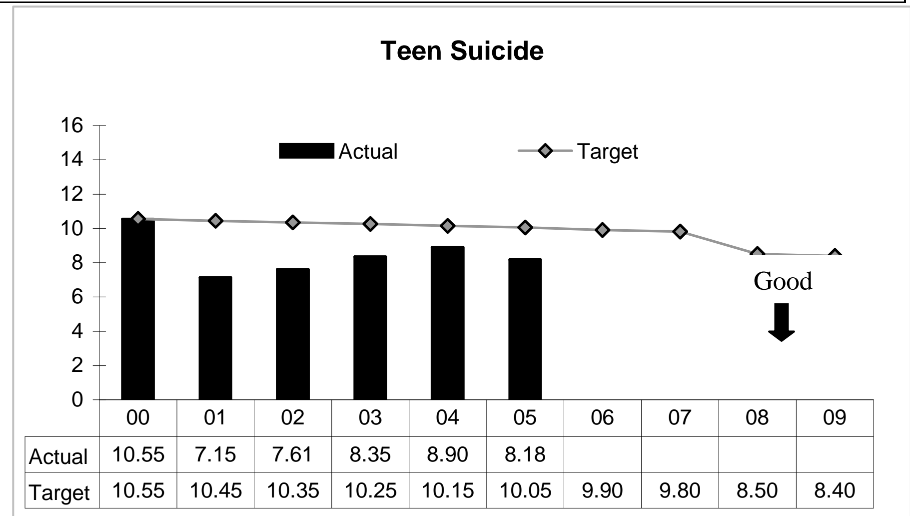
4. **HOW WE COMPARE**
   As yet there are no data that provide a way to measure Oregon's progress in response to violence or prevention efforts. There is no evaluation conducted of funds spent on response and there are no funds spent on primary prevention. Other states are also introducing primary prevention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

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

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

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

KPM #12	**TEEN SUICIDE** **The rate of suicides among adolescents per 100,000.**	**Measure since: 2002**
Goal	People are safe. People are healthy.	
Oregon Context	Preventable death	
Data source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Death Certificates) and Portland State University, Population Research Center (Population Estimates)	
Owner	Public Health Division, Office of Disease Prevention & Epidemiology, Injury Prevention & Epidemiology Program, Lisa Millet 971-673-1059	



	00	01	02	03	04	05	06	07	08	09
Actual	10.55	7.15	7.61	8.35	8.90	8.18				
Target	10.55	10.45	10.35	10.25	10.15	10.05	9.90	9.80	8.50	8.40

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

2. **ABOUT THE TARGETS**
   Reducing suicides among youth will occur over time. The long-range target of reducing deaths is dependent upon:
   - developing resources to fund prevention activities
   - increasing awareness of the problem
   - increasing community readiness to adopt suicide prevention strategies
   - increasing the number of people working with youth who can intervene in suicidal behavior
   - supporting parents in learning to monitor moods and communicate with youth
   - teaching youth to take suicide talk seriously and report it to an adult
   - establishing procedures and policies in schools
   - providing health education on depression and suicide to youth and families
   - providing bereavement support in communities
   - enhancing crisis response
   - increasing the number of school based health centers with enhanced ability to provide behavioral health services
   - providing teens with problem solving and coping skills
   - reducing the stigma associated with behavioral health care and with suicide

- improving screening and assessment that can identify youth at risk in all settings where youth are typically assessed
- providing training for professionals in health, behavioral health, and social services on suicide

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

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

4. **HOW WE COMPARE**
Oregon's youth suicide rate (ages 10-24) ranks 15th among states. The state rate of 9.4 per 100,000 (2004 national comparison data) is greater than the national rate of 7.32 per 100,000. The state rate of suicide among youth aged 10-24 in 2005 is xx 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.

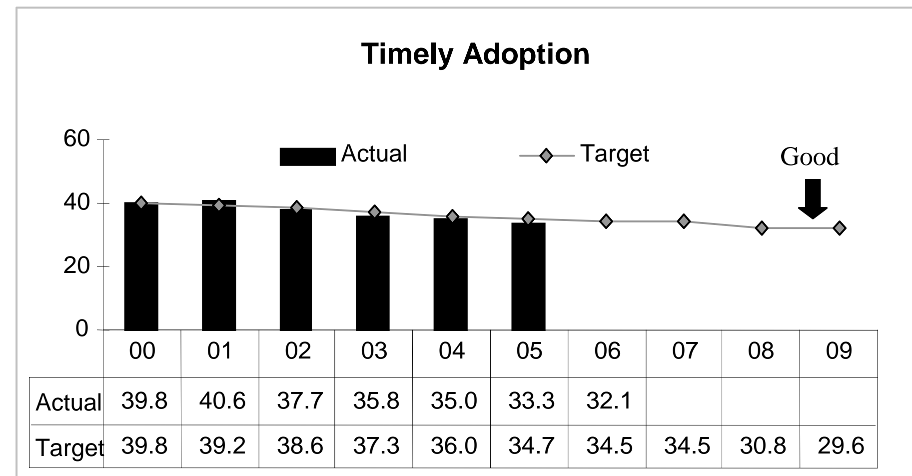
7. **ABOUT THE DATA**
Reporting cycle – calendar year. The data are provided by the Center for Health Statistics death certificate database. The data include youth aged 10-24 years of age. Some suicides may be excluded as local medical examiners may hesitate to rule a death a suicide due to stigma. Deaths are verified in two ways: through Oregon's Child Fatality Review system and through Oregon's Violence Death Reporting System.

III. KEY MEASURE ANALYSIS

KPM #13	TIMELY ADOPTION The median number of months from date of latest removal from home to finalized adoption.	Measure since: 1997
Goal	People are safe.	
Oregon Context	This performance measure links to the DHS goal, "People are safe." It also links to the DHS high-level outcome "Increase the percentage of children living in safe, nurturing families." This measure focuses on timely achievement of adoption for children in foster care who are unable to return home.	
Data source	AFCARS database, which is derived from the State Child Welfare HS data system.	
Owner	Children Adults and Families Division, Lois Day, (503) 947-5358	

1. **OUR STRATEGY**
   Increased monitoring and support of cases and families as they move through the process to finalization.

2. **ABOUT THE TARGETS**
   Oregon has exceeded the benchmark for median time to adoption for Federal Fiscal Years 2002 through 2006. The data demonstrate that Oregon is making consistent and steady progress toward reducing the time to achieve adoption. 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.



	00	01	02	03	04	05	06	07	08	09
Actual	39.8	40.6	37.7	35.8	35.0	33.3	32.1			
Target	39.8	39.2	38.6	37.3	36.0	34.7	34.5	34.5	30.8	29.6

3. **HOW WE ARE DOING**
   The agency's progress toward meeting the annual goals has been 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. The continually decreasing rates achieved for this performance measure reflects this progress.

4. **HOW WE COMPARE**

   The agency's performance on the median time to adoption has exceeded the targets for 2002 through 2006. Oregon's performance is slightly better than the national median of 32.4 months.

5. **FACTORS AFFECTING RESULTS**

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

   Another example of a department activity is the creation of guidance on what activities constitute "concurrent planning," which is required if children are to move quickly toward adoption. Concurrent planning includes not only the identification of an alternate permanency plan for foster children whose permanency goal is "return home;" it also includes the achievement of concrete activities toward achieving the alternate permanency plan so that if the return home plan is not successful, the department can quickly move the child in accordance with the alternate permanency plan. The preferred alternate permanency plan is adoption for most children.

6. **WHAT NEEDS TO BE DONE**

   Oregon has made steady progress toward reducing the time to achieve adoption for children in its care and custody who are unable to live safely and permanently with their families of origin. Nonetheless, the department needs to further examine its practices through its performance and continue to streamline and adjust them to further reduce the timelines.

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).

AGENCY NAME Oregon Department of Human Services

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

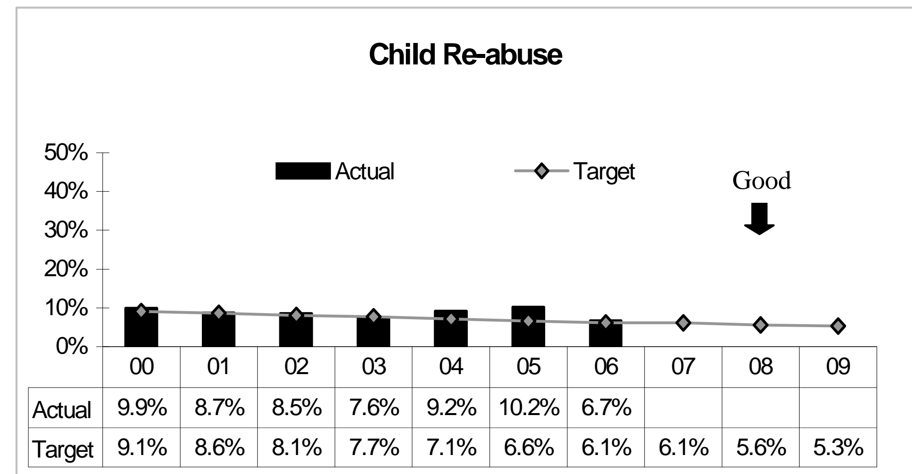
III. KEY MEASURE ANALYSIS

KPM #14	CHILD RE-ABUSE The percentage of abused/neglected children who were re-abused within 6 months of prior victimization.	Measure since: 1997
Goal	People are safe.	
Oregon Context	This performance measure links to the DHS goal, "People are safe." It also links to Oregon Benchmark #50 and the DHS high-level outcome, "Number of children per 1,000 persons under 18, who are: a) neglected/abused, b) at a substantial risk of being neglected/abused." This measure concerns children who are victims in founded cases of abuse. The term "founded" means that there is reasonable cause to believe that child abuse or neglect has occurred.	
Data source	State Child Welfare HS data system. State Child Welfare IIS data system.	
Owner	Child Protective Services Program, Children Adults and Families Division, Una Swanson (503) 945-6696	

1. **OUR STRATEGY**

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

- Define Child Welfare as the "safety expert" and assure that all child welfare staff receives training in child safety interventions.
- Assess allegations of child abuse in a timely manner and provide a comprehensive protective capacity assessment of caregiver's 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.



	00	01	02	03	04	05	06	07	08	09
Actual	9.9%	8.7%	8.5%	7.6%	9.2%	10.2%	6.7%			
Target	9.1%	8.6%	8.1%	7.7%	7.1%	6.6%	6.1%	6.1%	5.6%	5.3%

2. **ABOUT THE TARGETS**

The 2006 and 2007 targets were based on the national standard set by Health and Human Services, Administration for Children and Families. The decrease in the target for 2008 and 2009 is due to the change in the new national standard, which is <=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%).

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. Oregon achieved its lowest reabuse rate seen since 2000.

4. **HOW WE COMPARE**
   Oregon's repeat maltreatment rate is higher than the national standard.

5. **FACTORS AFFECTING RESULTS**
   The major factors affecting families of abused and neglected children are drug/alcohol abuse, parental involvement with law enforcement, domestic violence and unemployment. Often, there are several of these factors in families of child abuse/neglect victims. The addition of resources from the 2007 Legislature, in the child welfare staffing improvement package and the legal representation package, will further support achievement of the targets for this measure in 2008 and 2009.

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

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.

AGENCY NAME Oregon Department of Human Services

III. KEY MEASURE ANALYSIS

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

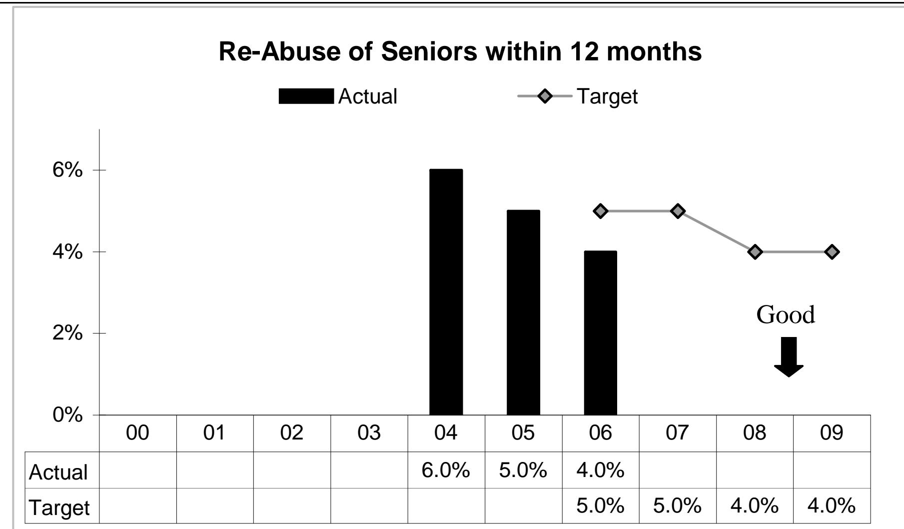
KPM #15	RE-ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES – The percentage of seniors and adults with disabilities who are re-abused within 12 months of first substantiated abuse: a) seniors, b) adults with disabilities, c) developmental disabilities	Measure since: 2002
Goal	People are safe.	
Oregon Context	Elder abuse	
Data source	Office of Licencing & Quality of Care Adult Protective Services and Office of Investigation and Training	
Owner	Seniors and People with Disabilities, Julia S. Brown, (503) 947-5153	

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

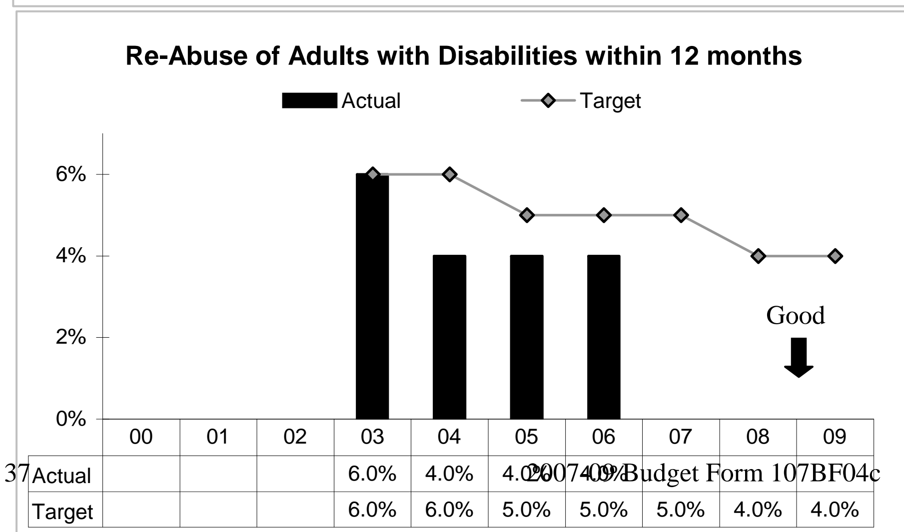
   Developmental disabilities: Increase training for local protective service investigators and collaboration with brokerages who serve people with developmental disabilities in their own home. Initiate a Prevention Initiative with a focus on clients, their family, providers and the community at large.

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

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



	00	01	02	03	04	05	06	07	08	09
Actual					6.0%	5.0%	4.0%			
Target							5.0%	5.0%	4.0%	4.0%

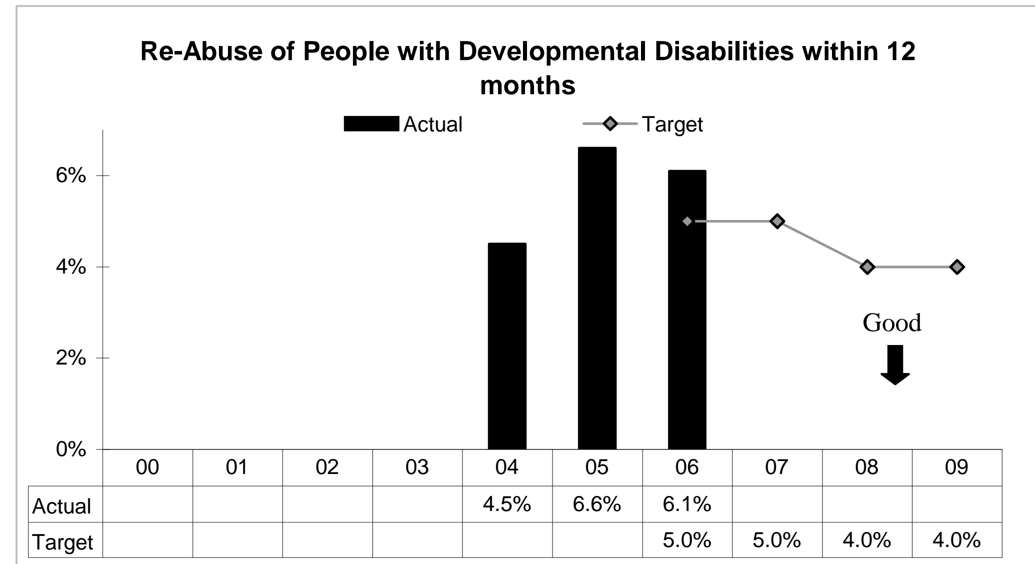


	00	01	02	03	04	05	06	07	08	09
Actual				6.0%	4.0%	4.0%	4.0%			
Target				6.0%	6.0%	5.0%	5.0%	5.0%	4.0%	4.0%

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

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

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



	00	01	02	03	04	05	06	07	08	09
Actual					4.5%	6.6%	6.1%			
Target							5.0%	5.0%	4.0%	4.0%

3. **HOW WE ARE DOING**

Insert an objective, stand-alone summary of agency progress on this measure, referring wherever possible to recent data and the trend.

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

Strategies to improve the department's performance include:

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

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

Developmental disabilities: Analysis of the 2006 abuse and neglect data included type of abuse, setting and review of individual allegations. It is believed that the number of clients being served and for whom mandatory reports are made has increased due to the Staley settlement where many individuals are receiving services in their own home, and have increased the overall re-abuse rate from 4.5 to 6.6 for this population. Overall, the numbers of abuse and neglect reports and subsequent investigations have ranged from 866 in 2004 to 994 in 2005 and 887 in 2006. The serious types of abuse (sexual and physical) have remained relatively low with significant increases in financial exploitation.

Strategies to improve performance on these measures include initiation of a prevention initiative which will increase training to providers consumers advocates and the public; leadership of an initiative to address sexual abuse of persons with developmental disabilities that is sponsored by the Attorney General's Sexual Assault Task Force' collaboration with community partners to solicit a grant that will expand local capacity of domestic violence and sexual assault programs to meet the needs of victims of abuse who are developmentally disabled

4. **HOW WE COMPARE**

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

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

5. **FACTORS AFFECTING RESULTS**

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

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

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

6. **WHAT NEEDS TO BE DONE**
Seniors and adults with disabilities:

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

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

7. **ABOUT THE DATA**
Reporting cycle is Calendar Year.

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

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

Additional and Disaggregated Data:
Data for 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*.

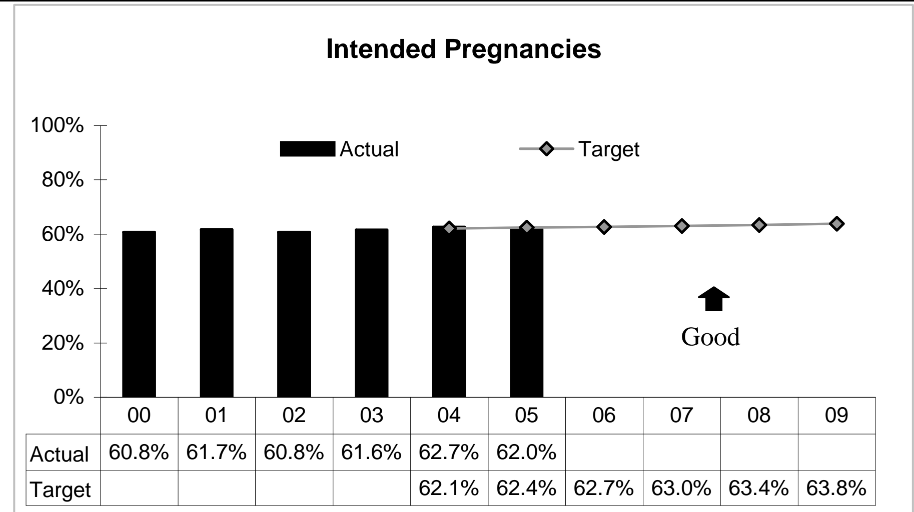
III. KEY MEASURE ANALYSIS

KPM #16	INTENDED PREGNANCIES The percentage of births where mothers report that the pregnancy was intended.*	Measure since: 2006
Goal	People are healthy.	
Oregon Context	Teen pregnancy	
Data source	Public Health Division, Office of Family Health, Pregnancy Risk Assessment Monitoring System (PRAMS) survey	
Owner	Public Health Division, Office of Family Health, Reproductive Health Program, Lisa Angus (971) 673-0358	

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

2. **ABOUT THE TARGETS**
   Modest targets have been set given limited program budget and the complex nature of pregnancy intent.

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



	00	01	02	03	04	05	06	07	08	09
Actual	60.8%	61.7%	60.8%	61.6%	62.7%	62.0%				
Target					62.1%	62.4%	62.7%	63.0%	63.4%	63.8%

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

5. **FACTORS AFFECTING RESULTS**
   One important obstacle to increasing intended pregnancy is the limited funding available for family planning programs. Title X—the federal grant program devoted to family planning and reproductive health care—has been flat-funded for several years, which translates to a decrease in funding when adjusted for inflation and the rising cost of providing medical care. Oregon also administers a Medicaid family planning waiver and clients of that program were adversely affected by Federal citizenship documentation requirements implemented in 2006. In its 2007 session, however, the Oregon Legislature authorized additional funds for the waiver, which may offset the losses due to Federal requirements. Finally, because pregnancy intent is influenced by an often complex mix of feelings about pregnancy, childbearing, intimate relationships and other issues, there is a limit to what state-level programs can do to increase the proportion of pregnancies that are intended. Comprehensive access to high-quality family planning services should be considered a necessary, but not sufficient, step toward achieving significant increases in intended pregnancy.

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

7. **ABOUT THE DATA**
   Reporting cycle - calendar year. The foremost strength of the data is that they directly reflect women's own reports of pregnancy intent; the population-based design and high response rate of the PRAMS survey are also strengths. The primary limitation of the data is that the complexity women's feelings about pregnancy and childbearing can make pregnancy intent difficult to measure accurately.

AGENCY NAME Oregon Department of Human Services

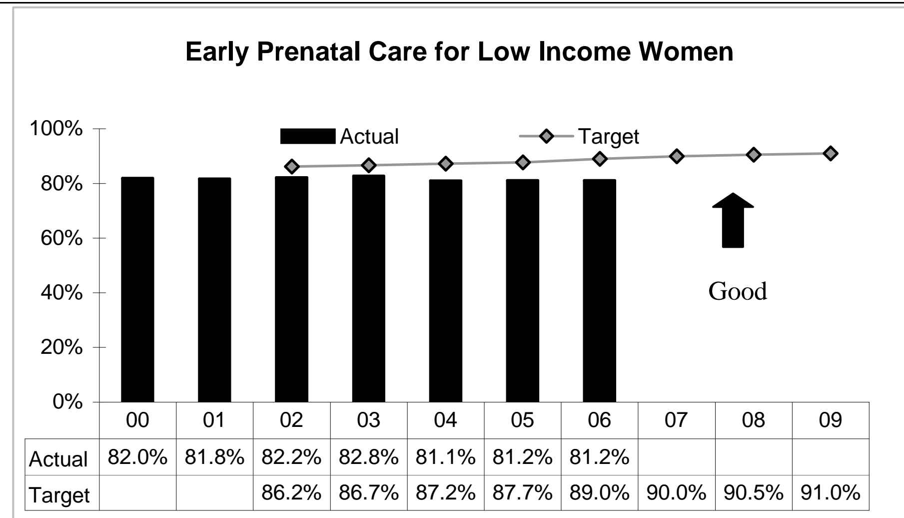
III. KEY MEASURE ANALYSIS

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

KPM #17	EARLY PRENATAL CARE FOR LOW INCOME WOMEN The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy.	Measure since: 2002
Goal	People are healthy.	
Oregon Context	Prenatal care	
Data source	Oregon DHS, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Birth Certificates)	
Owner	Public Health Division, Office of Family Health, Ruth Helsley 971-673-0345 / Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	

1. **OUR STRATEGY**
   Office of Family Health (OFH) is continuing to provide funding and technical support for Oregon MothersCare (OMC), a program that collaborates with 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 28 sites that served more than 5,300 women in 2006 with over 29,400 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.



	00	01	02	03	04	05	06	07	08	09
Actual	82.0%	81.8%	82.2%	82.8%	81.1%	81.2%	81.2%			
Target			86.2%	86.7%	87.2%	87.7%	89.0%	90.0%	90.5%	91.0%

2. **ABOUT THE TARGETS**
   The targets were developed for 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**
   There was a slight decline in ’01 and ‘04. Otherwise, the rates have remained stable from 2000 through 2006 with rates in the low 80s with less than a two percentage point difference (81.1 % - 82.8%).

4. **HOW WE COMPARE**

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 2006, approximately 84% of women receiving services through OMC during their first trimester entered prenatal care during the first trimester. This includes women who are low-income but ineligible for Oregon Health Plan (OHP) coverage. Among women who report OHP/Medicaid as their delivery payment source, the percent of first trimester care is consistenly 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 19.9% in '05. Investment in the OregonMothers 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 likely 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. Due to implementation of the federal Deficit Reduction Act (DRA) there may be a resulting delay in future OHP application processing as women wait to receive their birth certificate, now required as proof of citizenship to determine eligibility.

6. **WHAT NEEDS TO BE DONE**

OFH and DMAP will continue to collaborate through the Oregon Motherscare 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.

7. **ABOUT THE DATA**

Birth certificate data were used to calculate early prenatal care during months 1 through 4. Income data not available; OHP/Medicaid as a source of payment for delivery was used as a surrogate for "low income." The data for 2006 are preliminary. At the time of updating the data in July 2007, it was found that the data presented in the graph were correctly computed for all previous years but improperly translated into the graph. The graph reflects now correct actual and target values

AGENCY NAME Oregon Department of Human Services

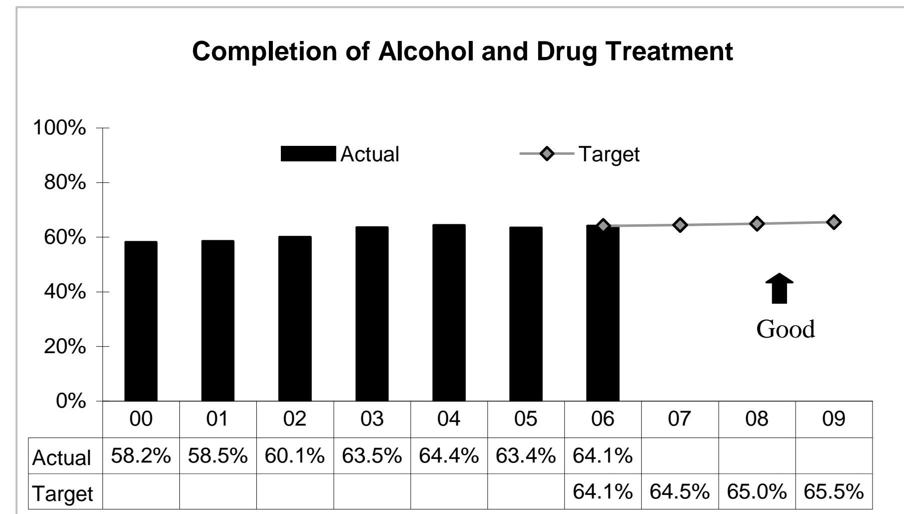
III. KEY MEASURE ANALYSIS

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

KPM #18	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.*	Measure since: 2002
Goal	People are healthy	
Oregon Context	Teen substance abuse, alcohol/tobacco use during pregnancy, alcohol/drug abuse	
Data source	Addictions and Mental Health Division, Client Process Monitoring System database	
Owner	Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	

*Data correction

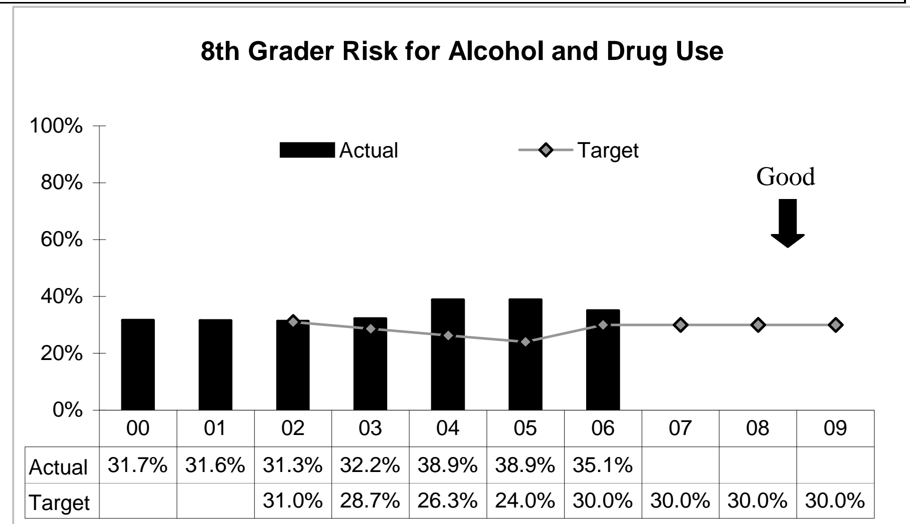
1. **OUR STRATEGY**
   Completion of treatment services leads to better outcomes for the client.
2. **ABOUT THE TARGETS**
   The higher the completion rate the better.
3. **HOW WE ARE DOING**
   The completion rate for clients has been steadily increasing for the past seven years. The Division is working with providers to continue this trend through a quality improvement process and by incorporating this measure into performance based contracting.
4. **HOW WE COMPARE**
   Nationally the completion rate was 51% in 2003, according to reports available from the Substance Abuse and Mental Health Services Administration Office of Applied Studies.



	00	01	02	03	04	05	06	07	08	09
Actual	58.2%	58.5%	60.1%	63.5%	64.4%	63.4%	64.1%			
Target							64.1%	64.5%	65.0%	65.5%

5. **FACTORS AFFECTING RESULTS**
   There are a number of factors affecting this measure including referral source (legal referrals are more likely to complete), type of service being delivered (residential compared to outpatient completion), and the quality of services (varies by provider and by type of service delivered). Methadone clients and clients receiving detoxification services are not included in this measure, as it is inappropriate for this type of measure.
6. **WHAT NEEDS TO BE DONE**
   The Division will continue quality improvement and process improvement efforts to improve completion rates.
7. **ABOUT THE DATA**
   Data is extracted from the Division's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. The Division produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate/accurate data are submitted to the CPMS. Data were corrected since the FY 2006 annual performance progress report. Targets were adjusted based on the corrected data.

KPM #19	8TH GRADER RISK FOR ALCOHOL AND DRUG USE Percentage of 8th graders at high risk for alcohol and other drug use.	Measure since: 2002
Goal	People are healthy	
Oregon Context	Teen substance abuse	
Data source	Addictions and Mental Health Division/Office of Disease Prevention & Epidemiology, Oregon Health Teens Survey	
Owner	Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



	00	01	02	03	04	05	06	07	08	09
Actual	31.7%	31.6%	31.3%	32.2%	38.9%	38.9%	35.1%			
Target			31.0%	28.7%	26.3%	24.0%	30.0%	30.0%	30.0%	30.0%

1. **OUR STRATEGY**

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

AMH currently funds a statewide public education effort, which focuses primarily on radio and television advertising. Youth written and produced spots target messages to parents encouraging them to provide clear messages to youth regarding underage drinking, family expectations, and not providing alcohol to those under 21.

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

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

2. **ABOUT THE TARGETS**

The lower the rate the better.

3. **HOW WE ARE DOING**

The percent of 8th graders at risk of alcohol or drug use declined in 2006, but still exceeds the target.

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

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

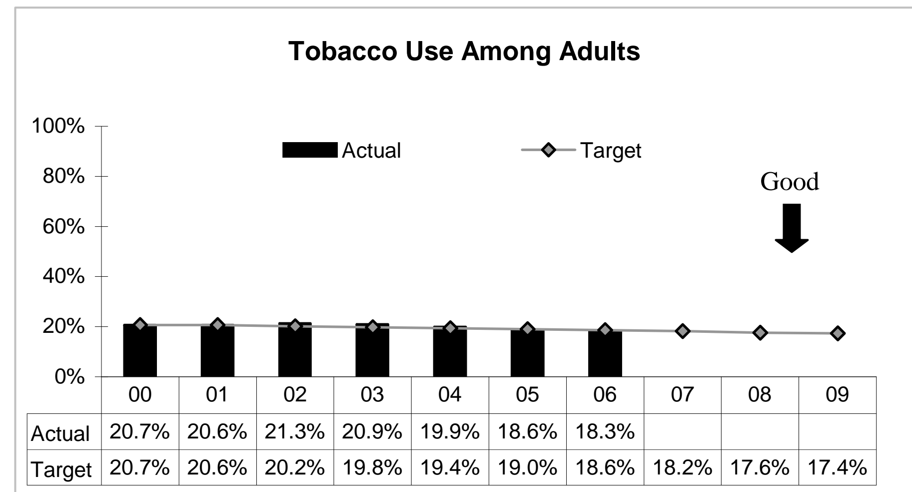
6. **WHAT NEEDS TO BE DONE**
Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol and other drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those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

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

III. KEY MEASURE ANALYSIS

KPM #20	TOBACCO USE Tobacco use among: a) adults, b) youth, c) pregnant women	Measure since: 2002
Goal	People are healthy.	
Oregon Context	Adult non-smokers, Preventable death, Teen substance abuse, Alcohol / tobacco use during pregnancy	
Data source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099.	

1. **OUR STRATEGY**
The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach to effectively decrease tobacco use.



	00	01	02	03	04	05	06	07	08	09
Actual	20.7%	20.6%	21.3%	20.9%	19.9%	18.6%	18.3%			
Target	20.7%	20.6%	20.2%	19.8%	19.4%	19.0%	18.6%	18.2%	17.6%	17.4%

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

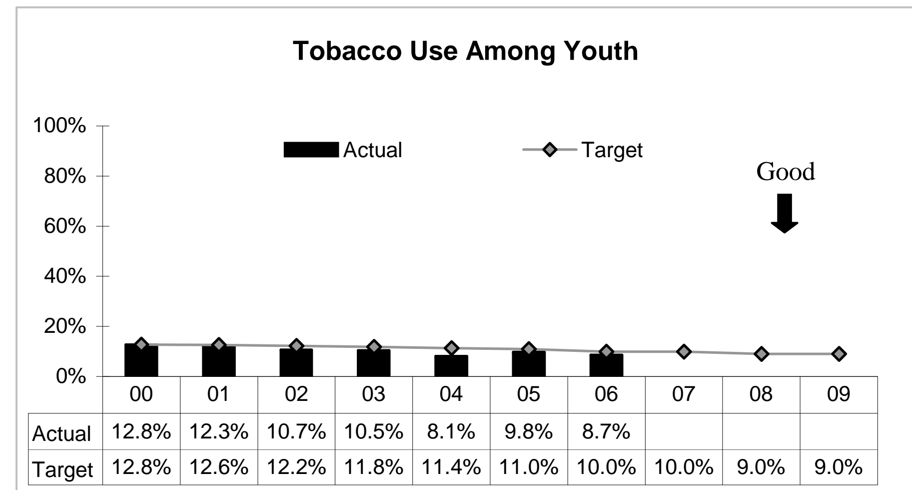
3. **HOW WE ARE DOING**
In 2006, the prevalence of smoking in Oregon was 18.3% for the general adult population, 8.7% among 8th grade adolescents, and 12.3% among pregnant women. For the general population of adults and for 8th graders, these measures were slightly better than targeted levels, while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

4. **HOW WE COMPARE**

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

Healthy People 2010 has a target of 16% for the smoking rate among high school students. The Department's performance measure is for 8th graders, but the 11th grade-smoking rate is currently 15.4% in Oregon. If this success continues, Oregon's 11th grade smoking rates should meet the 16% target for 2010.

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



	00	01	02	03	04	05	06	07	08	09
Actual	12.8%	12.3%	10.7%	10.5%	8.1%	9.8%	8.7%			
Target	12.8%	12.6%	12.2%	11.8%	11.4%	11.0%	10.0%	10.0%	9.0%	9.0%

5. **FACTORS AFFECTING RESULTS**

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the minimum recommended funding for tobacco prevention is $6.51 per capita, which is more than $24 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.

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.

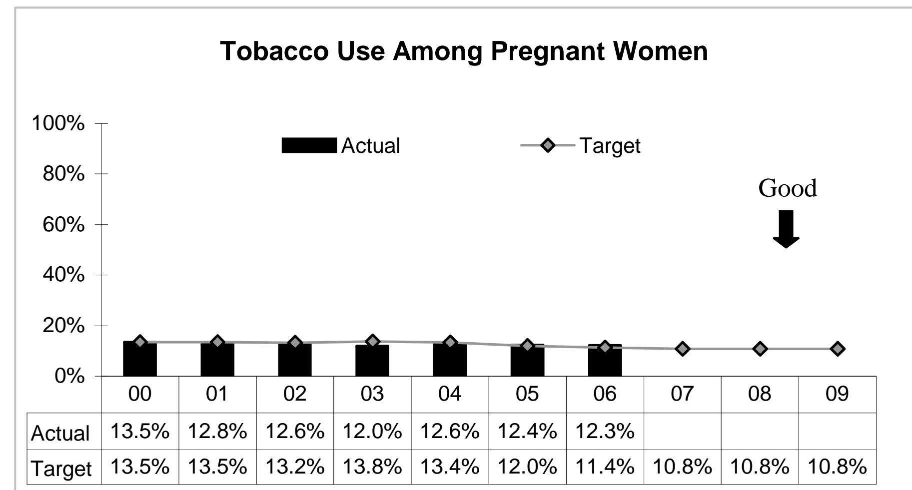
7. **ABOUT THE DATA**

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 Oregon's annual data report, Tobacco Facts.

Smoking prevalence among 8th graders in Oregon is on an annual reporting cycle, computed once per calendar year. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper survey administered to students at school. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.

Smoking prevalence among pregnant women is on an annual reporting cycle, computed once per calendar year. These data come from the birth certificates issued to all newborns in Oregon, which include parental demographic information, conditions of the newborn, and medical factors during the pregnancy (including mothers' smoking status). Advantages of these data are that they represent a census of information (that is, all births) and are not prone to sampling error, as are surveys. Additional years of data are available via our website by downloading the latest version of Oregon's annual data report, Tobacco Facts.



	00	01	02	03	04	05	06	07	08	09
Actual	13.5%	12.8%	12.6%	12.0%	12.6%	12.4%	12.3%			
Target	13.5%	13.5%	13.2%	13.8%	13.4%	12.0%	11.4%	10.8%	10.8%	10.8%

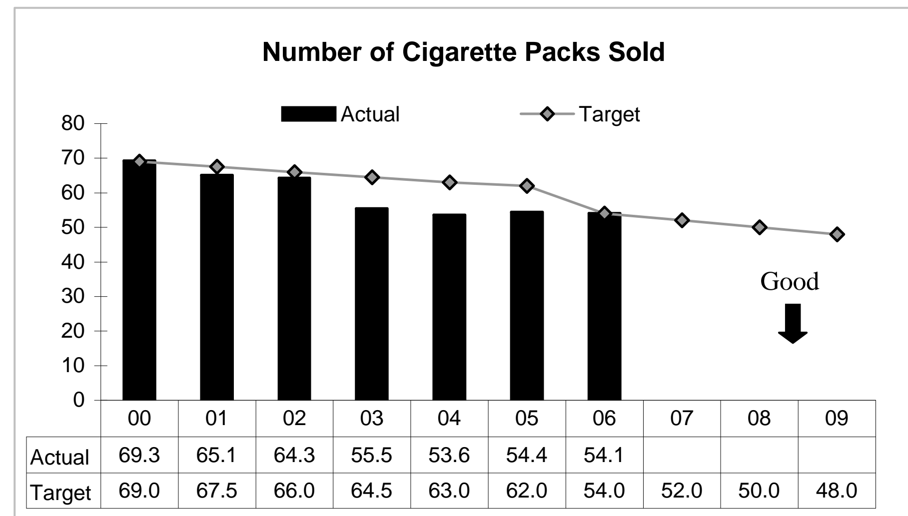
AGENCY NAME Oregon Department of Human Services

III. KEY MEASURE ANALYSIS

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

KPM #21	CIGARETTE PACKS SOLD Number of cigarette packs sold per capita.	Measure since: 2002
Goal	People are healthy.	
Oregon Context	Adult non-smokers, Preventable death, Teen substance abuse, Alcohol / tobacco use during pregnancy	
Data source	Oregon Department of Revenue (Cigarette Tax Receipts); Portland State University, Population Research Center (Population Estimates)	
Owner	Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099.	

1. **OUR STRATEGY**
   One of the main goals of the Tobacco Prevention and Education Program (TPEP) is to reduce tobacco use by adults. This goal is accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing per capita cigarette consumption – it takes a comprehensive approach to effectively decrease tobacco use.



	00	01	02	03	04	05	06	07	08	09
Actual	69.3	65.1	64.3	55.5	53.6	54.4	54.1			
Target	69.0	67.5	66.0	64.5	63.0	62.0	54.0	52.0	50.0	48.0

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

3. **HOW WE ARE DOING**
   In 2006, the number of cigarette packs sold in Oregon was 54.1 packs per capita. Although this measure is only slightly higher than the desired target for 2006, this measure has leveled off since 2003. These data points are of concern because they represent a deviation from the previous, desirable trend.

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

5. **FACTORS AFFECTING RESULTS**
   The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the minimum recommended funding for tobacco prevention is $6.51 per capita, which is more than $24 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.

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

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

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

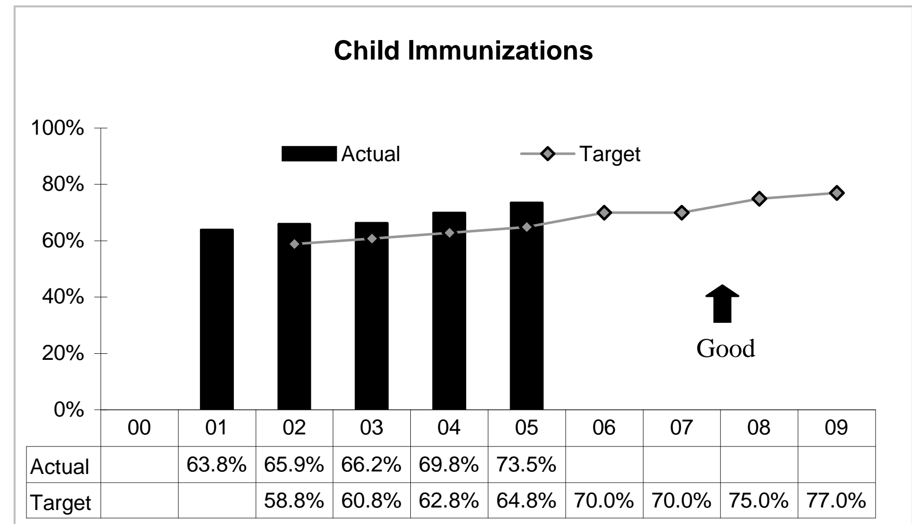
AGENCY NAME Oregon Department of Human Services

III. KEY MEASURE ANALYSIS

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

KPM #22	CHILD IMMUNIZATIONS The percentage of 24-35 month old children served by local health departments who are adequately immunized.*	Measure since: 2002
Goal	People are healthy.	
Oregon Context	Immunizations, Child mortality	
Data source	Public Health Division, Office of Family Health (ALERT Registry)	
Owner	Public Health Division, Office of Family Health, Immunization Program, Martha P. Skiles, 971-673-0304	

* The wording of this measure was corrected last year to accurately reflect the data. It captures 24-35 month old children, not 19-35 months.



	00	01	02	03	04	05	06	07	08	09
Actual		63.8%	65.9%	66.2%	69.8%	73.5%				
Target			58.8%	60.8%	62.8%	64.8%	70.0%	70.0%	75.0%	77.0%

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%. In 2006-07 the methods for calculating this rate will change. Currently the CDC-supplied software simply counts the number of each shot found in the ALERT Registry. Starting with 2006 data, the software will count only valid doses, meaning it will discount any doses that do not meet minimum spacing or minimum age requirements. This will result in a drop in the calculated rates.

3. **HOW WE ARE DOING**
   In 2005, the percent of children immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps, rubella (MMR); three or more doses of *Haemophilus Influenzae* type b; and three or more doses of hepatitis B (4:3:1:3:3) reached 73.5% for those children served by local health departments. This up-to-date rate continues to steadily increase.

4. **HOW WE COMPARE**
   This KPM reflects children 24-35 months olds, served in the public sector based on data reported to the statewide registry. A national comparison is difficult because national data is based on a phone survey of a selected sample of Oregon residents 19-35 months of age, regardless of where they seek care. However the national rate for 4:3:1:3:3 in 2004 (last data point available) was 80.9% and 78.9% 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. Additionally, vaccine shortages in 2003-04 were a barrier that all children in Oregon may have faced in receiving timely immunizations.

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**

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

AGENCY NAME Oregon Department of Human Services

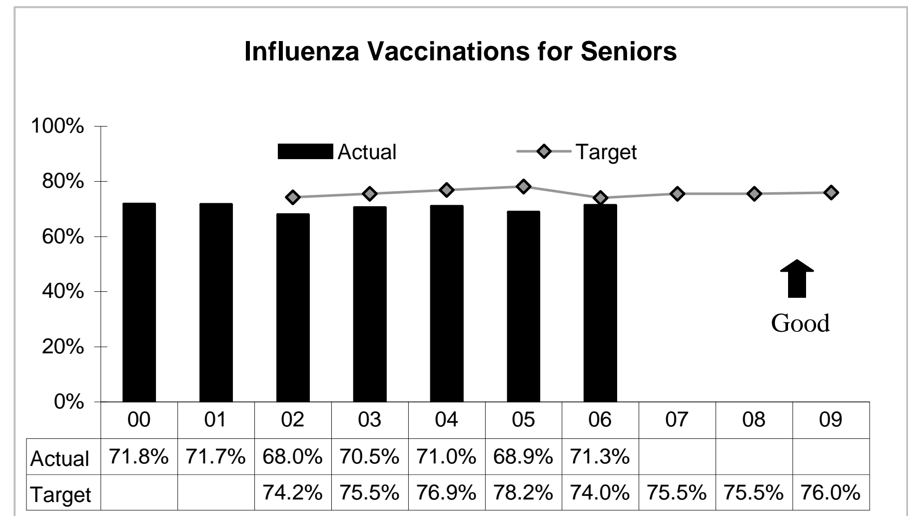
III. KEY MEASURE ANALYSIS

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

KPM #23	INFLUENZA VACCINATIONS FOR SENIORS The percentage of adults aged 65 and over who receive an influenza vaccine.	Measure since: 2002
Goal	People are healthy	
Oregon Context	Preventable death	
Data source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS)	
Owner	Public Health Division, Office of Family Health, Immunization Program, Martha P. Skiles (971) 673-0304	

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.



	00	01	02	03	04	05	06	07	08	09
Actual	71.8%	71.7%	68.0%	70.5%	71.0%	68.9%	71.3%			
Target			74.2%	75.5%	76.9%	78.2%	74.0%	75.5%	75.5%	76.0%

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 2006, the national immunization rate for persons 65 and older was 69.6%, with state rates ranging from 75.9% in Colorado to 57.7% in Nevada. Oregon ranked 19th in rates nationally, with a rate improvement from 68.9% to 71.3%.

5. **FACTORS AFFECTING RESULTS**

The slight dip in 2005 rates due to vaccine shortages has been corrected in 2006. In general the flat rates are influenced by public's perception of need and efficacy of the vaccine, absence of policies in place that motivate health systems to routinely vaccinate all clients, lack of funding for adult immunizations, and access to Immunization ALERT, the statewide immunization registry that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB2188 passed, expanding ALERT to a lifespan registry. Over the next few years as the registry collects and processes data, this information will be available to healthcare providers, helping them identify candidates for vaccine and could be used for sending out reminders to clients to seek out immunization every year. 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 4th Annual Flu Summit to promote influenza vaccination strategies to providers; and
- Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or tetanus/diphtheria vaccine, in all health care settings.

7. **ABOUT THE DATA**

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

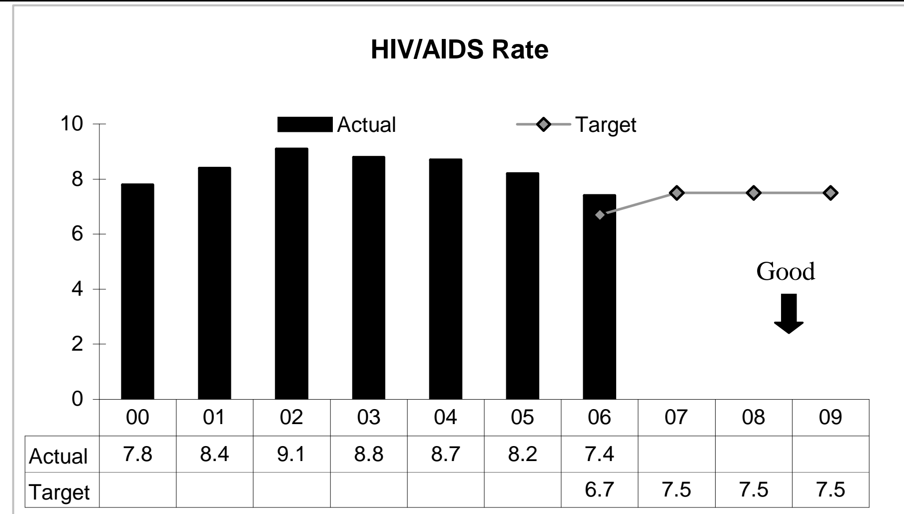
AGENCY NAME Oregon Department of Human Services

III. KEY MEASURE ANALYSIS

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

KPM #24	HIV/AIDS RATE The annual rate of newly acquired HIV/AIDS infections per 100,000 persons.	Measure since: 2000
Goal	People are healthy.	
Oregon Context	HIV diagnosis, Communicable disease	
Data source	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/AIDS Reporting Systems (HARS) database & PSU Census	
Owner	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/STD/TB Program, DHS, Jeff Capizzi, 971-673-0182	

* The data and targets reflect a correction to prior calculations in order to be consistent with the original intent and definition of this measure.



	00	01	02	03	04	05	06	07	08	09
Actual	7.8	8.4	9.1	8.8	8.7	8.2	7.4			
Target							6.7	7.5	7.5	7.5

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

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

3. **HOW WE ARE DOING**
   Slight declines in new case rates have occurred since 2002. This has occurred despite the fact that increasing survival with HIV infection means that the pool of people who might infect others increases continuously. This implies that the average person with HIV/AIDS infects fewer new persons each year and that prevention and care programs have been effective in curtailing the epidemic. Meeting optimistic targets of a further 20% reduction for 2006 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 2005 rate of 8.2 cases per 100,000 residents is well below that level.

5. **FACTORS AFFECTING RESULTS** DHS invests several million dollars each year in care for persons with HIV and AIDS and in prevention of new infections. The HIV Care Program provides case management services to over 2000 persons with HIV in Oregon each year, helping them sustain access to medical care and treatment. These services extend life expectancy among people with HIV and AIDS and reduce risk of subsequent HIV transmission. The HIV Prevention Program invests over a million dollars annually in HIV testing and counseling. These efforts detect newly infected persons early, leading to treatment and prevention of new cases. In addition the HIV Prevention Program makes large annual investments in counseling partners of persons newly diagnosed with HIV infection and in numerous social marketing campaigns to reduce behaviors that lead to reduction in HIV transmission.

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

7. **ABOUT THE DATA**
Reporting cycle – calendar year. Currently, the median delay between diagnosis and inclusion in the HIV case reporting system is approximately 2 months. 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 25% of people infected with HIV are unaware of their infection. In addition, about 10% of diagnosed cases are not captured by the reporting system. Therefore, reported rates probably represent less than 75% of the true number of new infections. As outlined above, changes in HIV case reporting rules were implemented during 2006. These include increased laboratory reporting requirements and a switch to named HIV case reporting. These changes have made case reporting more complete, and comparison with earlier years somewhat misleading. For interested readers, the HIV/STD/TB program publishes an annual epidemiologic profile for HIV. It is available at http://egov.oregon.gov/DHS/ph/hiv/data/docs/final.pdf.DHS APPR Revised Template_107BF04a.doc.

AGENCY NAME Oregon Department of Human Services

III. KEY MEASURE ANALYSIS

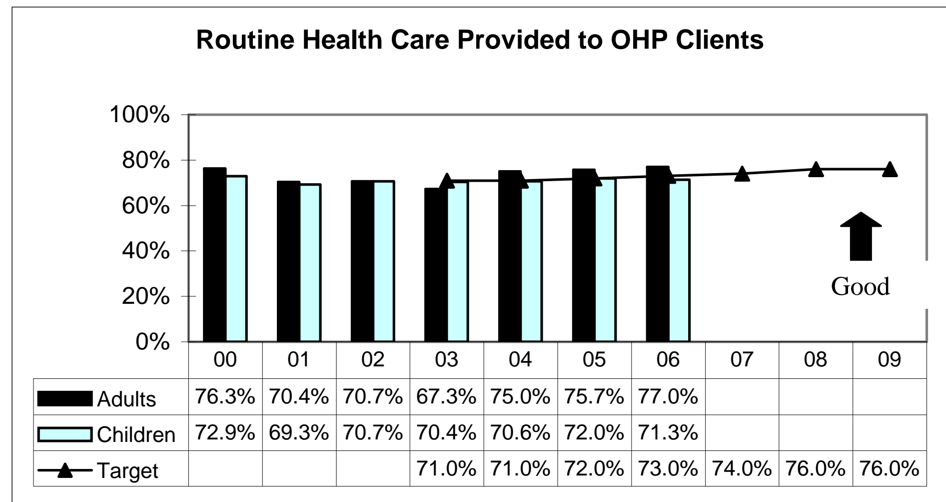
Agency Mission: Assisting people to become independent, healthy and safe.

KPM #25	ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS The proportion of Oregon Health Plan (OHP) clients who receive routine health care services annually: a) adults, b)children*	Measure since: 2002
Goal	People are healthy	
Oregon Context	Health Care Access – DHS High Level Outcome	
Data source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	

1. **OUR STRATEGY**

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

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



	00	01	02	03	04	05	06	07	08	09
Adults	76.3%	70.4%	70.7%	67.3%	75.0%	75.7%	77.0%			
Children	72.9%	69.3%	70.7%	70.4%	70.6%	72.0%	71.3%			
Target				71.0%	71.0%	72.0%	73.0%	74.0%	76.0%	76.0%

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

2. **ABOUT THE TARGETS**
DMAP chose targets that 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 2006 and is above the 2006 target. The rate for children dropped in 2006 by less than a percentage point and is slightly below the 2006 target. These rate changes may be attributed to the decreased number of adults in the measure from 2005 to 2006 and the increased number of children in the measure from 2005 to 2006. Since 2001, 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 2001 to 2006, the rate for adults increased 6.6 percentage points from 70.4% to 77.0% and the rate for children increased 2.0 percentage points from 69.3% to 71.3%.

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

5. **FACTORS AFFECTING RESULTS**
Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. 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.

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 2006, clients must be on OHP for at least six months between August 1, 2005 and December 31, 2006. 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.

KPM #26	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS The proportion of Oregon Health Plan (OHP) clients who receive routine health care services annually: a) African Americans, b) Native Americans, c) Asian/Pacific Islanders, d) Hispanic, e) White	Measure since: 2002
Goal	People are healthy	
Oregon Context	Health Care Access and Racial /ethnic Health Status – DHS High Level Outcomes	
Data source	Oregon MMIS (Medicaid Management Information System)	
Owner	Division of Medical Assistance Programs, Susan Arbor 503-945-5958	

1. **OUR STRATEGY**

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

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

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

   The Division of Medical Assistance Programs (DMAP), in collaboration with 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 is part of a state team working with the federal AHRQ (Agency for Healthcare Research and Quality) that has developed a state plan that aims to reduce pediatric asthma health care disparities. 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 2006 rates remained steady compared to 2005 rates – all changes were within a half of a percentage point or less. The Asian and Pacific Islander category increased by a fraction of percentage point from 2005 to 2006, while all other categories decreased by a half of a percentage point or less from 2005 to 2006. All race/ethnic categories were within a fraction of a percentage point of their 2006 targets. Native Americans, Hispanics, and whites categories were slightly above their 2006 targets while the African American and Asian and Pacific Islander categories were slightly below their 2006 targets. Since 2001, for all race/ethnic categories, the general trend shows a favorable increase in the proportion of OHP clients who receive routine health care services. From 2001 to 2006, the increased rates for all categories were between 3 and 4 percentage points.

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

5. **FACTORS AFFECTING RESULTS**

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

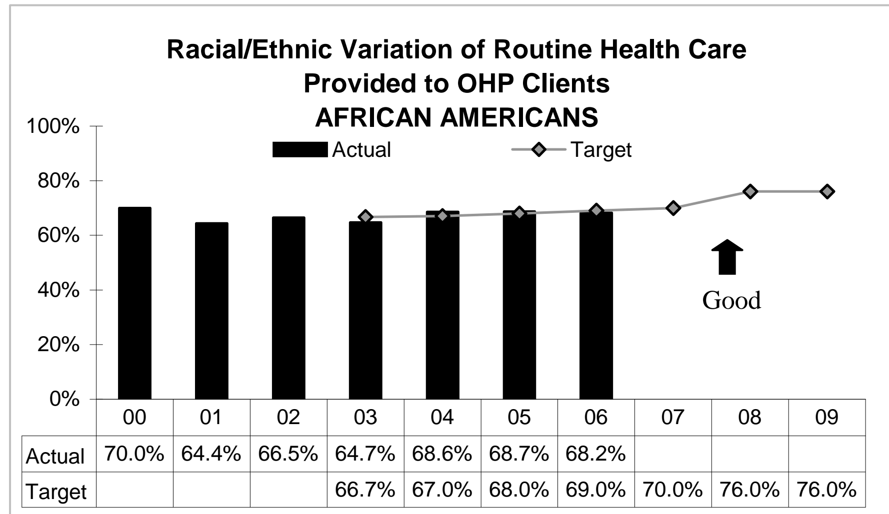
6. **WHAT NEEDS TO BE DONE**

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.

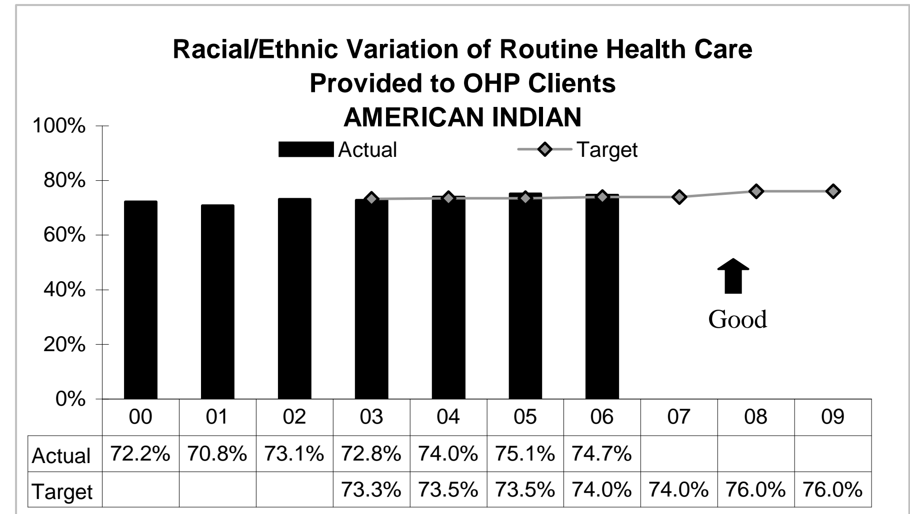
7. **ABOUT THE DATA**

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 2006, clients must be on OHP for at least six months between August 1, 2005 and December 31, 2006. 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.

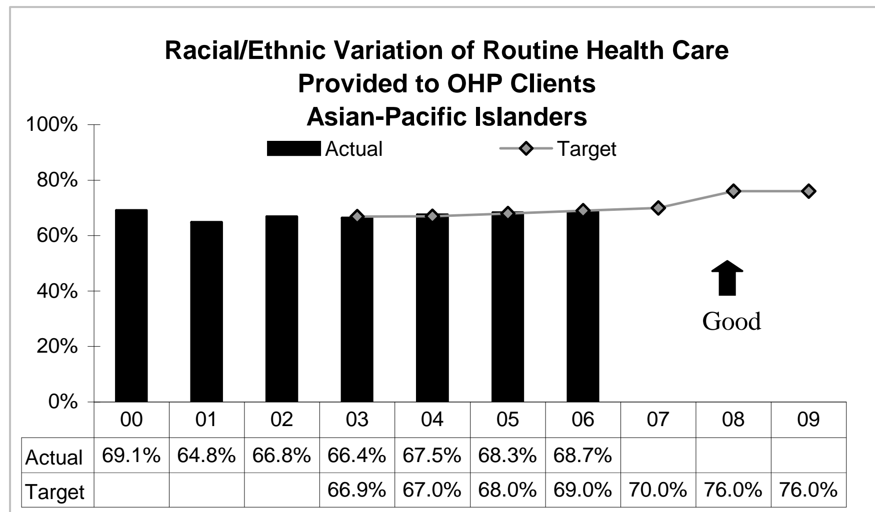
III. KEY MEASURE ANALYSIS



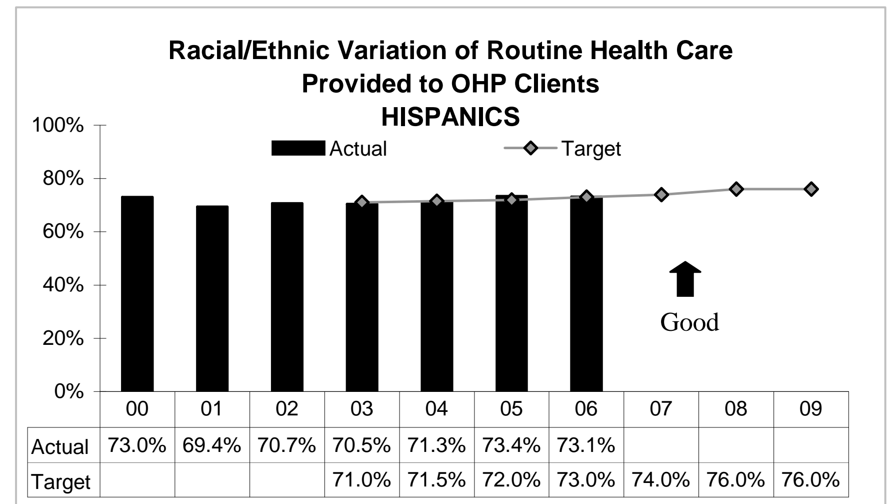
	00	01	02	03	04	05	06	07	08	09
Actual	70.0%	64.4%	66.5%	64.7%	68.6%	68.7%	68.2%			
Target				66.7%	67.0%	68.0%	69.0%	70.0%	76.0%	76.0%



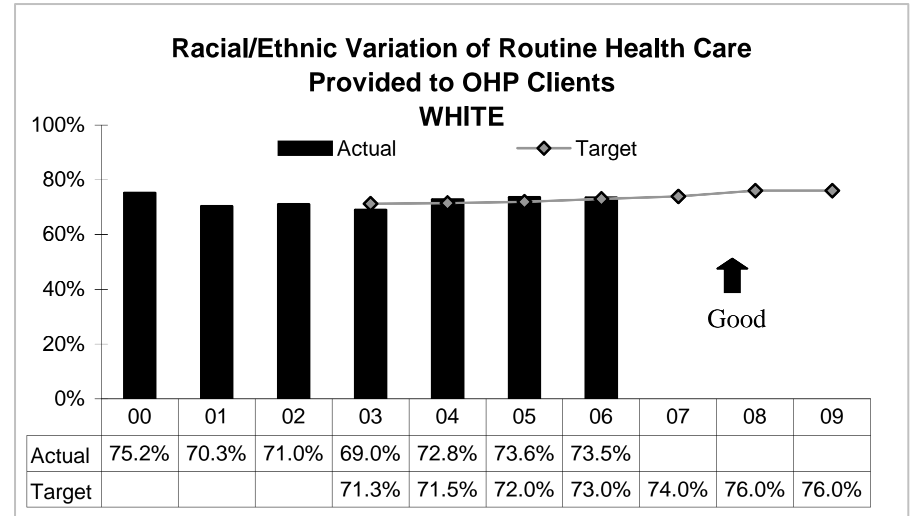
	00	01	02	03	04	05	06	07	08	09
Actual	72.2%	70.8%	73.1%	72.8%	74.0%	75.1%	74.7%			
Target				73.3%	73.5%	73.5%	74.0%	74.0%	76.0%	76.0%



	00	01	02	03	04	05	06	07	08	09
Actual	69.1%	64.8%	66.8%	66.4%	67.5%	68.3%	68.7%			
Target				66.9%	67.0%	68.0%	69.0%	70.0%	76.0%	76.0%



	00	01	02	03	04	05	06	07	08	09
Actual	73.0%	69.4%	70.7%	70.5%	71.3%	73.4%	73.1%			
Target				71.0%	71.5%	72.0%	73.0%	74.0%	76.0%	76.0%



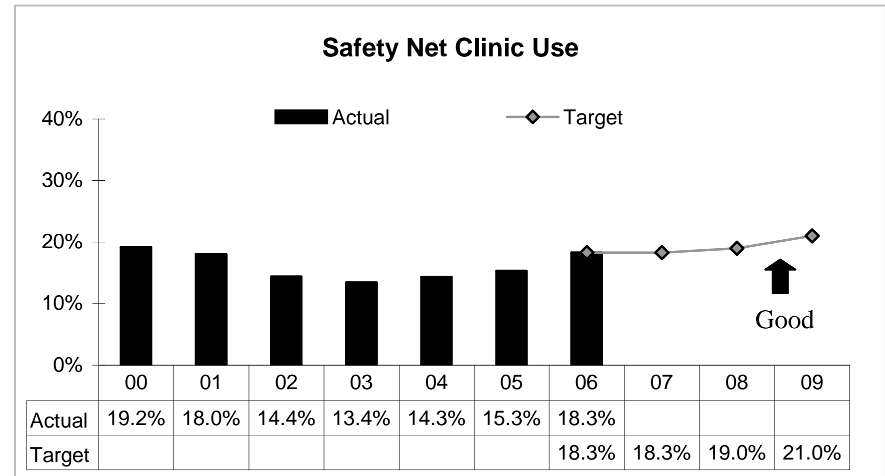
	00	01	02	03	04	05	06	07	08	09
Actual	75.2%	70.3%	71.0%	69.0%	72.8%	73.6%	73.5%			
Target				71.3%	71.5%	72.0%	73.0%	74.0%	76.0%	76.0%

KPM #27	SAFETY NET CLINIC USE The percentage of uninsured Oregonians served by safety net clinics.	Measure since: 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	

* See narrative under question #7 to description of data and target changes.

1. **OUR STRATEGY**

Safety Net clinics provide health care to Medicaid clients, Medicare, and uninsured clients. This has been a critical role as the Oregon Health Plan (OHP) has shrunk and the number of uninsured has increased. Health Systems Planning (HSP) monitors policy implications and staffs the Safety Net Advisory Council. HSP determines health professional shortage areas and areas of unmet need and makes that information available to communities. HSP provides technical assistance to communities and sites interested in establishing or expanding sites. HSP assists communities with workforce needs in underserved areas of the state.



	00	01	02	03	04	05	06	07	08	09
Actual	19.2%	18.0%	14.4%	13.4%	14.3%	15.3%	18.3%			
Target							18.3%	18.3%	19.0%	21.0%

2. **ABOUT THE TARGETS**

We originally assumed that using percentages of uninsured served would quantify the work of the safety net and that increasing percentages would further indicate both the needs of the uninsured and the role of the safety net. However with the diminishing size of OHP enrollment and the increasing number of uninsured the OHP percentage served by the safety net declined even though in absolute numbers the safety continued to see more and more uninsured in addition to the Medicaid and Medicare clients in their patient load. In 2000, the safety net served over 80,000 uninsured Oregonians. By 2006 that number had risen to over 105,000. The targets for 07, 08, and 09 assume that additional children and perhaps some adults will be covered through the implementation of Healthy Kids (if Oregonians approve the referral) and therefore the percentage of uninsured Oregonians served by the safety net will decline although actual numbers served may remain high because they will continue to serve many OHP patients among the newly covered.

3. **HOW WE ARE DOING**

Percentages served by the safety net have remained high since 2000 reflecting an economic downturn, some level of recovery between 2002 and 2005 and then a subsequent increase in the percentage in 2005 with an even greater increase in 2006 bringing the safety percentage back to numbers more like those of 2000. With the referral of Healthy Kids to Oregonians for a vote in November these percentages will likely drop if the measure is approved. It would add as many as 100,000 or more children to coverage if outreach is successful. It is possible a much smaller number of adults could be added as well. SB 329 was approved by the legislature and its future implementation may also have some significant impact on the number of uninsured Oregonians and the percentage served by the safety net. That impact would not likely be visible until 2009 or after. This is, of course, barring another downturn in the economy. If we

assume that the purpose of the safety net is to enable the state to provide care to a significant number of uninsured whatever the barriers they face then we would have to assume that the safety net is doing its job. This is especially true when we consider that safety net providers also serve Medicaid and Medicare patients and are part of the capacity equation for these populations. Of some concern from a policy perspective is the fact that the safety net has served increasing numbers of uninsured without corresponding increases in revenue. We are also aware that there are capacity needs in the current Medicare and Medicaid programs and that capacity will be strained as baby boomers retire. The likely shortage of providers will have a significant impact on the safety net unless it is addressed.

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

5. **FACTORS AFFECTING RESULTS**
Factors have been noted above in #2 and #3.

6. **WHAT NEEDS TO BE DONE**

Targets need to be changed to absolute numbers rather than percentages or at least both need to be included to document the role of the safety net and to highlight capacity needs and challenges for serving the increasing number of uninsured individuals and the burden that places on safety net providers who continue to serve Medicaid and Medicare individuals. SB 329 passed in the recent session provides an opportunity to develop a roadmap to covering most Oregonians. The DHS director, OHPR director, and the new Health Fund Director, and the legislature will be key to facilitating the development and implementation of that roadmap. Understanding the shifting payer source for safety net providers will be important to understanding the role the safety net can and should play in an environment where many more people are covered. In that light we will need to especially understand the relative proportions of uninsured, Medicaid, and Medicare served by the safety net. Medicare access is increasingly problematic in Oregon and Fully Capitated Health Plans depend to a good extent on the safety net as part of their panel to assure access. Until or unless fee-for service rates improve the safety net is likely to remain a critical part of this access piece. Workforce shortages will also play a part in understanding both the contribution of the safety net and the challenges its faces. It is important to understand the role the safety net plays as a part of total health system capacity to provide care to both those who are uninsured (assuming there will always be some) and those who are covered by Medicare or Medicaid.

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

The Uniform Data System (UDS) collects data on all clinics in the U.S. receiving federal funds through section 330 of the Public Health Service (PHS) Act and administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). These clinics are known as Federally Qualified Health Centers (FQHC's). The Oregon Primary Care Association (OPCA) provides annual calendar year figures of the total number of uninsured persons in Oregon served by these clinics. For more information about the UDS see http://bphc.hrsa.gov/uds/. In the calculation of this measure FQHC's are used as a proxy for the entire safety-net clinic system in Oregon. However, this undercounts the number of people served by the safety-net

because it does not include some other types of safety-net clinics such as: community sponsored clinics, Indian/Tribal clinics, rural health clinics, and school based health centers. Unfortunately, a comparable data system does not exist for these other types of clinics.

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

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

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

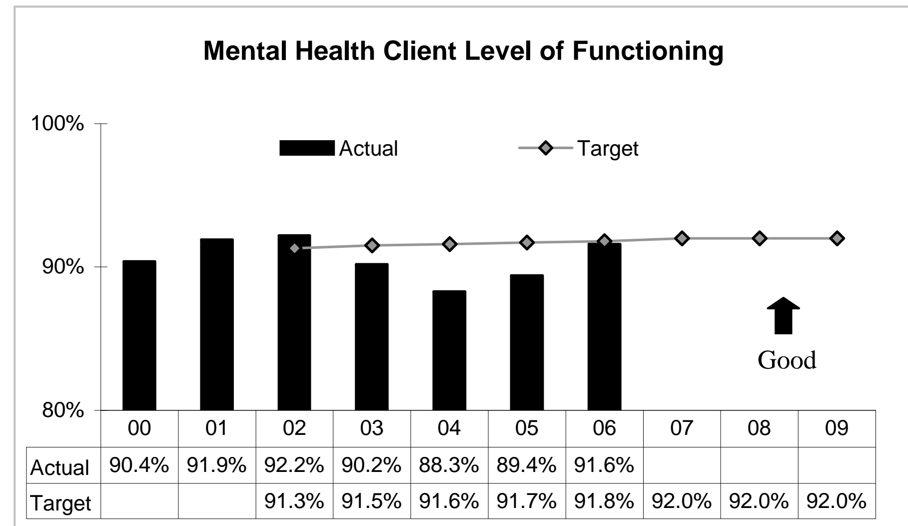
AGENCY NAME Oregon Department of Human Services

III. KEY MEASURE ANALYSIS

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

KPM #28	MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING The percentage of mental health clients who maintain or improve level of functioning following treatment.	Measure since: 2002
Goal	People are healthy	
Oregon Context	Mental health consumer activities	
Data source	Addictions and Mental Health Division, Client Process Monitoring System database	
Owner	Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	

1. **OUR STRATEGY**
   To deliver services that promote recovery.
2. **ABOUT THE TARGETS**
   The higher the rate the better.
3. **HOW WE ARE DOING**
   It appears that many people are benefiting from mental health services. One concern is that this measure is not sensitive enough to truly assess improvement.
4. **HOW WE COMPARE**
   We don't have any national data to compare.
5. **FACTORS AFFECTING RESULTS**
   The tool used to measure level of functioning is not particularly sensitive. Addictions and Mental Health Division (AMH) is exploring the use of an alternative means to assess this measure.
6. **WHAT NEEDS TO BE DONE**
   AMH will continue quality improvement efforts and the encouragement of the use of evidence-based practices.



	00	01	02	03	04	05	06	07	08	09
Actual	90.4%	91.9%	92.2%	90.2%	88.3%	89.4%	91.6%			
Target			91.3%	91.5%	91.6%	91.7%	91.8%	92.0%	92.0%	92.0%

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

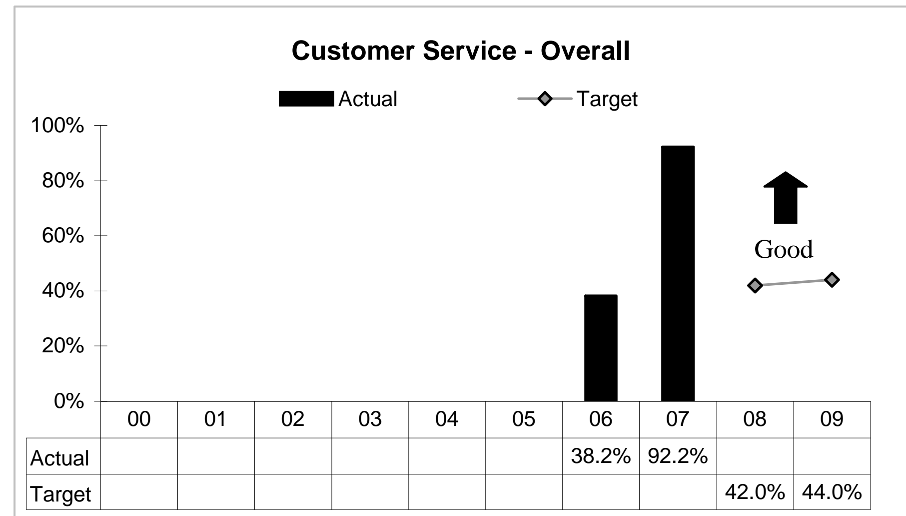
KPM #29	CUSTOMER SERVICE Percentage of customers rating their satisfaction with DHS' customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.	Measure since: 2005
Goal	People are independent. People are self-sufficient. People are safe. People are healthy.	
Oregon Context	DHS Mission – Assisting people to become independent, healthy and safe.	
Data source	Customer service mail surveys	
Owner	Administrative Services Division, Cathy Iles, 503-945-5855	

1. **OUR STRATEGY**

   Our strategy around customer service has been to initially focus on the methodology used to gather feedback. We are attempting to reach as many different populations groups as is feasible.

   In 2006 we reported on one population, those receiving medical cards, although we know that many people who receive medical cards also receive other DHS services. Over the past year, we have targeted the senior population, Food Stamp and Child Welfare customers.

   In the fall of 2007 we will have results of the Consumer Assessment of Health Plans Survey (CAHPS), which is conducted by the Division of Medical Assistance Programs (DMAP) on a biennial basis. These results will be included in our 2008 Annual Performance Progress Report.



	00	01	02	03	04	05	06	07	08	09
Actual							38.2%	92.2%		
Target									42.0%	44.0%

2. **ABOUT THE TARGETS**

   Based on last year's results, LFO set our 2008 and 2009 targets to 42% and 44% respectively. Until we have collected more data, we are reluctant to make changes to the targets at this time.

3. **HOW WE ARE DOING**

   This is only our second year reporting customer service. While we did see a huge jump from last year's results to this year's, we can only attribute that to reaching a broader and more diverse customer base. Until we get to the point of gathering consistent and comparable data each year, we won't be able to adequately analyze any type of trends. We expect to continue seeing variation in our results over the next year or two.

4. **HOW WE COMPARE**

   At this time, we are unable to compare our results to other agencies, organizations or jurisdictions. We can't even compare our 2007 results to last year's results due to the difference in methodology. In 2006, we conducted a web survey and invited customers receiving a medical card to complete the survey. Out of approximately 240,000 customers, only 200 completed the survey.

5. **FACTORS AFFECTING RESULTS**

At this point, we are still focusing on our 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 lowering our response rates even more.

6. **WHAT NEEDS TO BE DONE**

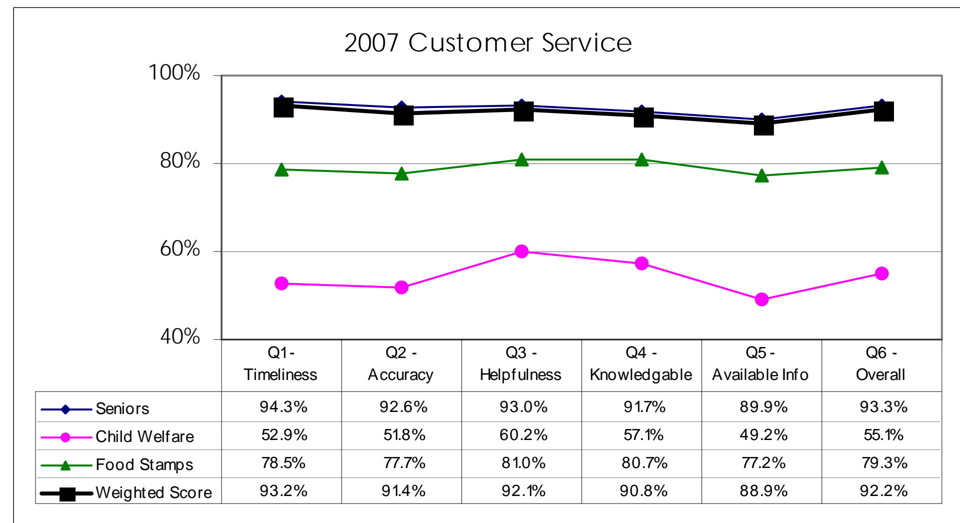
We need to continue looking at viable ways to gather feedback from our customers, including providers and stakeholders. This may include other ways of obtaining this kind of information – not just limited to traditional surveys.

7. **ABOUT THE DATA**

Reporting cycle - fiscal year. This is our second year reporting customer service. Our objective has been to find viable methodologies for surveying our diverse customer groups. We have focused on customers receiving direct services from DHS. However, it should be noted that this year we sampled child welfare customers – foster parents and biological parents. Based on the customer service guidelines, many biological parents would fit into the "compelled" customer group.

For purposes of reporting one number for customer service, scores were weighted by multiplying the percentage of "excellent" or "good" responses by the total number of respondents. This shows the effect of the number of respondents for each of the three surveys.

The senior survey was a paper survey included with their farm nutrition vouchers in the summer of 2006. Respondents were asked to complete the survey and mail it back - providing their own postage. Surveys were sent to approximately 40,000 seniors. We received just over 10,300 responses for a 26% response rate. Including farmer's market vouchers along with a customer survey could be considered a type of incentive, which may have had an impact on the response rate. However, we typically get a good response from the senior population, even without any incentive.



	Q1 - Timeliness	Q2 - Accuracy	Q3 - Helpfulness	Q4 - Knowledgable	Q5 - Available Info	Q6 - Overall
Seniors	94.3%	92.6%	93.0%	91.7%	89.9%	93.3%
Child Welfare	52.9%	51.8%	60.2%	57.1%	49.2%	55.1%
Food Stamps	78.5%	77.7%	81.0%	80.7%	77.2%	79.3%
Weighted Score	93.2%	91.4%	92.1%	90.8%	88.9%	92.2%

The other surveys were mail surveys sent to randomly selected Child Welfare customers and non-Medicaid Food Stamp customers. We sampled 1,155 in Child Welfare, receiving 195 (16.9% response rate). We sampled 1,414 in Food Stamps, receiving 284 (20.1% response rate).