LFO Revised Budget Form #107BF04c

Oregon Department of Human Services
Annual Performance Progress Report (APPR)
for Fiscal Year 2005-06

Original Submission Date: September 29, 2006

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.	**5**
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)	**7**
3	OVRS CLOSED - EMPLOYED – The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.	**9**
4	SPD EMPLOYMENT – The percentage of Seniors and People with Disabilities (SPD) consumers with a goal of employment who are employed	**11**
5	TANF (WELFARE) EMPLOYMENT – The percentage of Temporary Assistance to Needy Families (TANF) adults placed for whom employment is a goal.	**13**
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.	**15**
7	TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.	**17**
8	ENHANCED CHILD CARE – The percentage of child care providers who are providing enhanced quality of care.	**19**
9	AVERAGE EARNINGS FOR SPD CLIENTS – Average monthly earnings for persons with developmental disabilities who receive Seniors and People with Disabilities (SPD) services.	**21**
10	FOOD STAMP UTILIZATION – The ratio of Oregonians receiving food stamp assistance to the number of Oregonians living in poverty.	**23**
11	DOMESTIC VIOLENCE – The percentage of women subjected to domestic violence in the past year.	**25**
12	TEEN SUICIDE – The rate of suicides among adolescents per 100,000.	**27**
13	TIMELY ADOPTION – The median number of months from date of latest removal from home to finalized adoption.	**29**

2005-07 KPM#	2005-07 Key Performance Measures (KPMs)	Page #
14	CHILD RE-ABUSE – The percentage of abused/neglected children who were re-abused within 6 months of prior victimization.	**31**
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).	**33**
16	INTENDED PREGNANCIES – The percentage of births where mothers report that the pregnancy was intended.	**37**
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.	**39**
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.	**41**
19	8TH GRADER RISK FOR ALCOHOL AND DRUG USE – Percentage of 8th graders at high risk for alcohol and other drug use.	**42**
20	TOBACCO USE – Tobacco use among: a) adults, b) youth, c) pregnant women.	**44**
21	CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.	**47**
22	CHILD IMMUNIZATIONS – The percentage of 24 – 35 month old children served by local health departments who are adequately immunized.	**49**
23	INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.	**51**
24	HIV RATE – The annual rate of HIV infection per 100,000 persons.	**53**
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	**55**
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.	**57**
27	SAFETY NET CLINIC USE – The number of uninsured Oregonians served by safety net clinics.	**60**
28	MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.	**62**
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.	**63**

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

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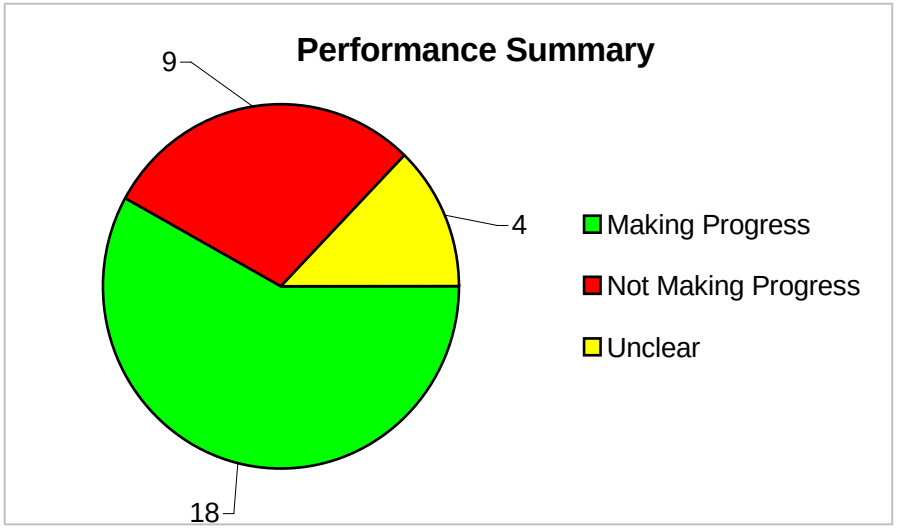
1. SCOPE OF REPORT

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

DHS is making progress on 18 of the key performance measures and not making progress on 9 of the key performance measures. For four of the measures, it is unclear as to whether or not progress is being made.

- IMPORTANT NOTE - KPM#15 reports 3 different populations. We are making progress with one of those populations. It is unclear if we are making progress yet with the other two populations. To determine performance, the measure is broken into three parts, therefore the numbers in the chart above will not add up to 29 – which is the total number of DHS Key Performance Measures.

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) appear to have an impact on whether or not we achieve our desired results. Budget constraints should be seen as a key driver for finding more efficient and effective ways to deliver services to vulnerable populations in Oregon.

Other challenges include the fact that the work of DHS is complex and requires coordinated efforts to see an impact in the results. Many of our outcomes are about human behavior changes, such as teen pregnancy and alcohol and drug use, 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. 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 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 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

Total DHS Fund = $9,807.1 million

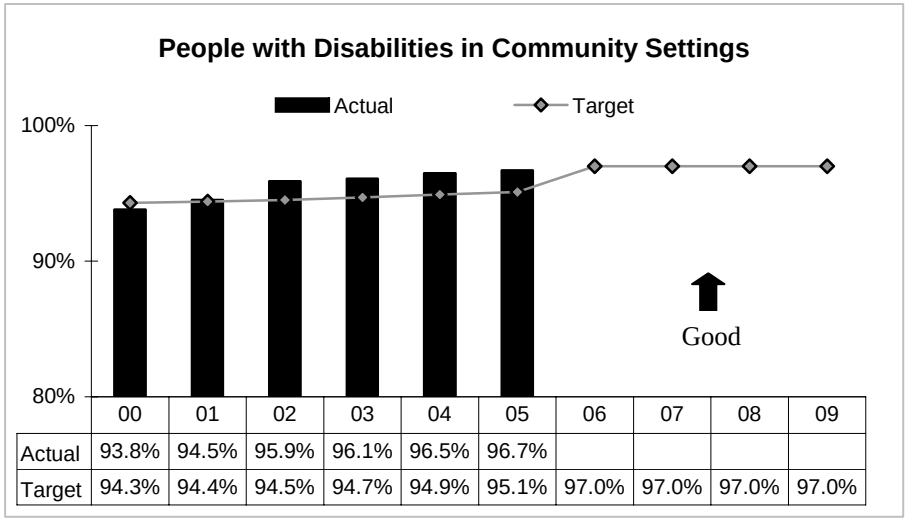
	% FTE	FTE	% Funds	Total Funds
CAF – Children, Adults and Families	43.9%	3,974.50	23.1%	$2,268.3
Health Services*	23.9%	2,163.80	47.6%	$4,671.7
SPD – Seniors and People with Disabilities	21.4%	1,939.58	25.3%	$2,480.7
DWSS – Department-Wide Support Services	10.9%	983.63	3.9%	$385.3
Capital Improvement			0.0%	$1.1
TOTAL	**100%**	**9,061.51**	**100%**	**$9,807.1**

*Includes Division of Medical Assistance Programs, Addictions and Mental Health Division and Public Health Division.

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	Independence – 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 Division, Julia S. Brown, (503) 947-5153	

1. **OUR STRATEGY**
Seniors and People with Disabilities Division (SPD) provides alternatives to services previously provided in large congregate care settings. Critical partners include County Community Mental Health 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 an environment that approximates those experienced by other Oregon citizens. Additionally people with developmental disabilities can take advantage of everyday community life and involvement and take advantage of the opportunities this offers.



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Actual	93.8%	94.5%	95.9%	96.1%	96.5%	96.7%				
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 five years.

4. **HOW WE COMPARE**
No data are available for comparison for 2005.

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 that level of care. 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/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 the age of 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 - fiscal 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.

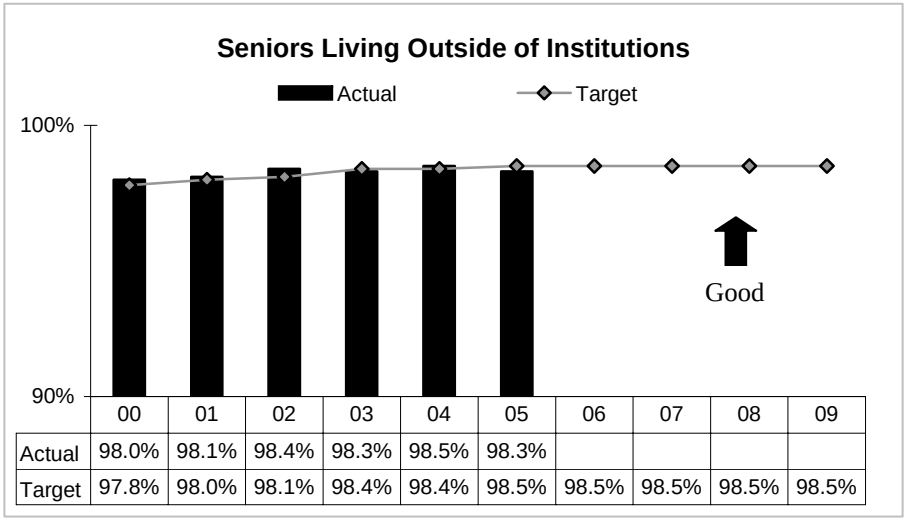
Formula used for this report is:
Fiscal Year (SE 48 Count – U of Minnesota Survey Count) / (SE 48 Count + EOTC Count)
where U of Minnesota Survey Count = # of residents in settings 7 or more

2005 data disaggregated:
Count of people receiving Case Management = 15,883
University of Minnesota Survey Count = 499
Eastern Oregon Training Center = 45

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

KPM #2	**SENIORS AND PEOPLE WITH DISABILITIES 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 – Seniors living independently	
Data source	Oregon Office of Health Policy and Research and Portland State University Population Research Center	
Owner	Seniors and People with Disabilities Division, Julia S. Brown, (503) 947-5153	

1. **OUR STRATEGY**
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%	98.3%				
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 Seniors and People with Disabilities Division (SPD) to track performance of 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 SPD 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. Projects like the collaboration between SPD and Addictions and Mental Health Division (AMH) on community resource development for seniors with mental health issues should be fostered.

7. **ABOUT THE DATA**
Reporting cycle - 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 2005 *Oregon Population Report (http://www.pdx.edu/media/p/r/prc_2005completed.pdf, p. 20)*

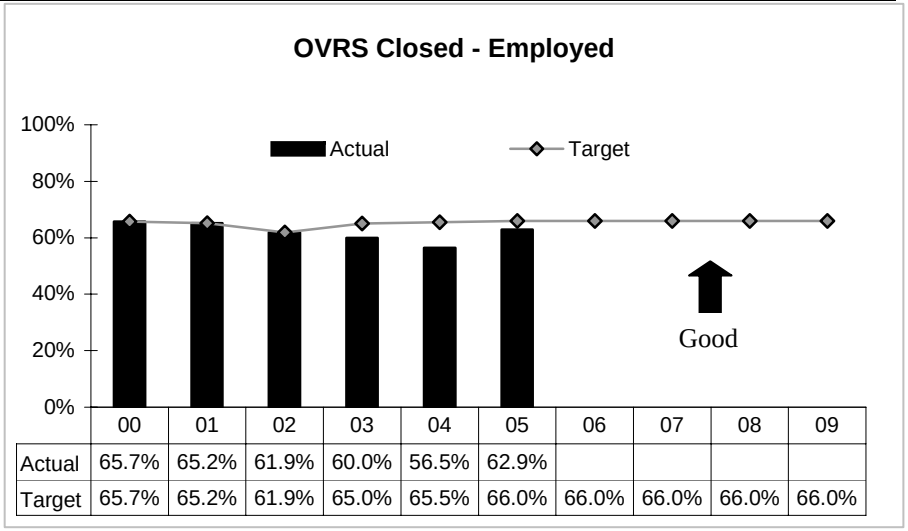
Formula:
100% - (OOHPR Nursing Facility resident days / Days in Year / 65+ Population)

2005 data disaggregated:
Population over 65: 455,980
Days in Year: 365
Nursing Facility resident days: 2,896,137 resident days
100% - (2,896,137/365/455,980) = 98.3%

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, Aaron Hughes, 503-945-6709	

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.

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.



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

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.

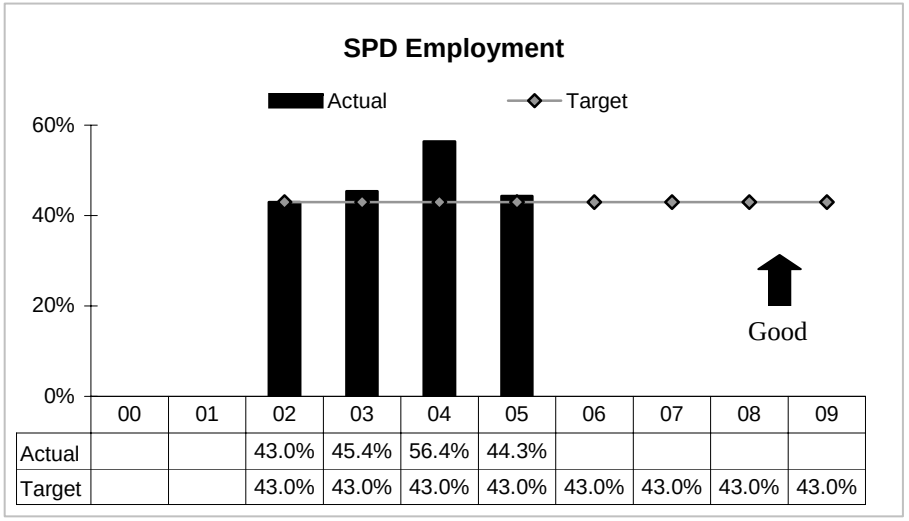
The VR relies on a state and federal relationship. Federal funding requires a state match of 21.3 percent and this has worked well for over 80 years but under the current appropriations, the VR program can meet the needs of only a small percentage of people with disabilities who live in Oregon. The VR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

KPM #4	**SPD EMPLOYMENT** **The percentage of Seniors and People with Disabilities (SPD) consumers with a goal of employment who are employed**	**Measure since: 2002**
Goal	Independence – 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 Division, Julia S. Brown, (503) 947-5153	

1. **OUR STRATEGY**

Seniors and People with Disabilities Division (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.



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

SPD, Office of Developmental Disability (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. The impact of SELN should be seen in 2007 and beyond.

2. **ABOUT THE TARGETS**

SPD is maintaining a target of 43% employment for 2008 and 2009. 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 43% 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 for 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.

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 is presently in process of completing an analysis and strategic plan for DD Supported Employment that is expected to be complete by January 2007.

7. **ABOUT THE DATA**

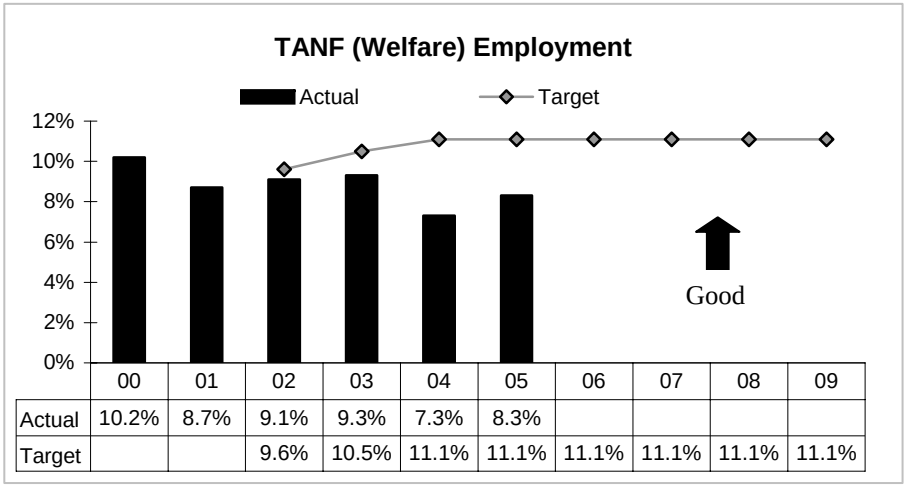
Reporting cycle is calendar year.

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

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	Self-Sufficient – 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 he 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 to Needy Families (TANF) program become employed. Most of these placements are 30 or more hours per week and result in families earning their way off monthly cash assistance. For most economically disadvantaged families, employment is the best avenue available for a better life.

2. **ABOUT THE TARGETS**
The original 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 before maintaining the 2004 target of 11.1% since then.



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

3. **HOW WE ARE DOING**
We increased performance by 1% from last year. 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 work. 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 four years. This may indicate an overly optimistic goal, given the general economic conditions and declining program resources. Although the economic picture is gradually improving and the unemployment rate has been going down, we were not able to reach the target, even though we improved by 1% since last year. In addition, 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. Some come in and are job ready, but there is a core group with significant barriers. We will continue to evaluate our JOBS program efforts to determine, coordinate, and provide services that will offer skills needed at each level of the work-ready continuum.

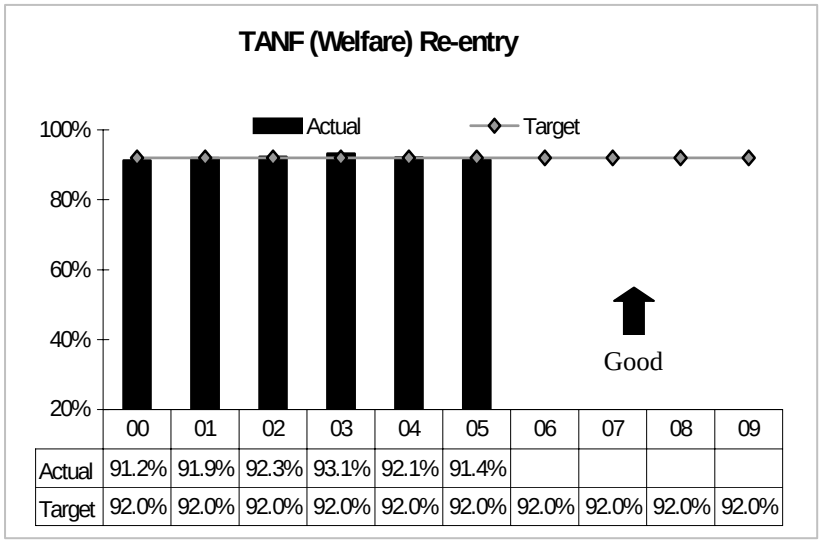
6. **WHAT NEEDS TO BE DONE**
We will continue to conduct program monitoring and implement any necessary program improvements based on data analysis and new TANF regulations enacted through the Deficit Reduction Act of 2005.

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	Self-Sufficient – 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 to 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%				
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 maintain the goal of former clients not requiring future TANF 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.

3. HOW WE ARE DOING
91.4% of TANF clients that leave public cash assistance due to employment are not receiving cash assistance 18 months later. This indicates that an overwhelming majority of TANF clients that leave 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. This is the first year since 2001 that DHS has not met its goal.

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

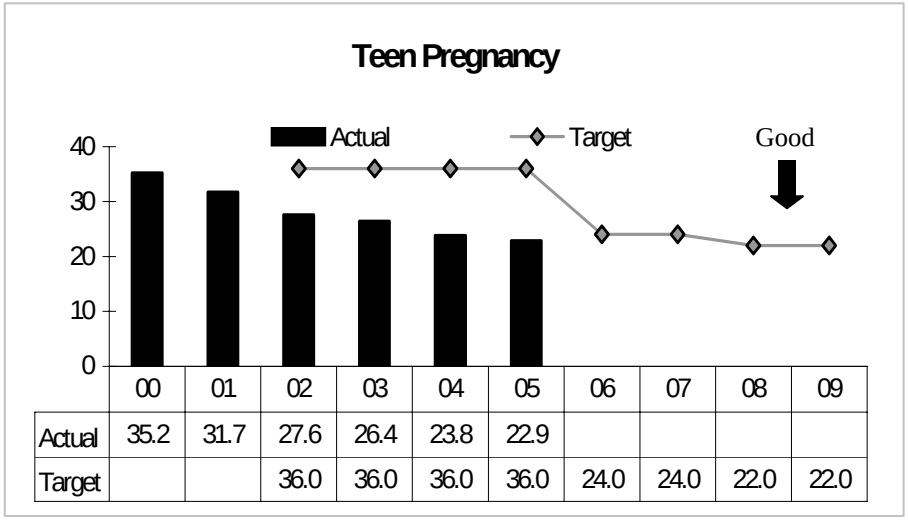
5. FACTORS AFFECTING RESULTS
This measure may be affected by several things, including the status of the labor market and industry, the effectiveness of the JOBS program that determines, coordinates, and provides services to assist TANF clients find and retain employment, and offer strategies to enhance wage gain efforts.

6. WHAT NEEDS TO BE DONE
The current trend of higher returns to TANF requires further analysis as it may be related to the changing characteristics of the existing client caseload. This outcome indicates lower performance in this area.

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

KPM #7	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. Enough description of data source/methodology to allow an auditor to validate the data. If desired, add detail under item #7, below.	
Owner	Children, Adults and Families Division, Carolyn Ross (503) 945-6074	

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	22.9				
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. Nationally, teen pregnancy numbers are usually presented for females age 15-19.

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

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

4. **HOW WE COMPARE**
The national teen birth rate is 41.2 for 2004 and the Oregon teen birth rate for 2004 is 23.8.

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

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

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

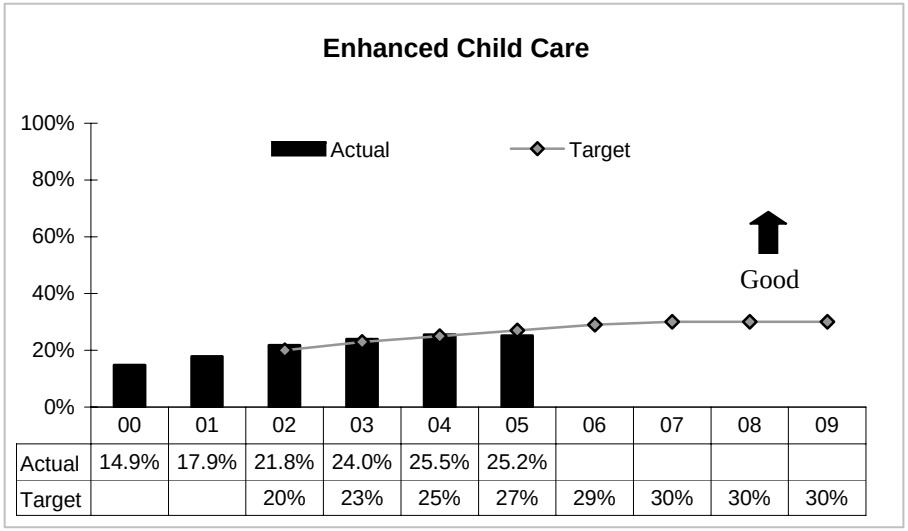
- Be long-term
- Be comprehensive
- Reach young people before they are sexually active and continue after they begin sexual activity
- Consider underlying risks and contributing factors, such as poverty and sexual abuse
- Utilize culturally sensitive approaches

7. **ABOUT THE DATA**
Reporting cycle - calendar year. The data are generally 1 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. It is important to understand that there is a difference between the pregnancy rate and the birth rate. There are pregnancies that end in abortion or miscarriage. Then there are also live births.

KPM #8	ENHANCED CHILD CARE The percentage of child care providers who are providing enhanced quality of care.	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." 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 basic training requirements. 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%				
Target			20%	23%	25%	27%	29%	30%	30%	30%

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 is below target.

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**
Due to low reimbursement rates, initially, the enhanced rate did encourage some providers to complete the training requirements. At this point, most providers receiving the enhanced rate are licensed. Since there has not been a meaningful rate increase since 1997, fewer licensed providers are willing to care for children whose parents receive a DHS subsidy. This has made it difficult to remain on target.

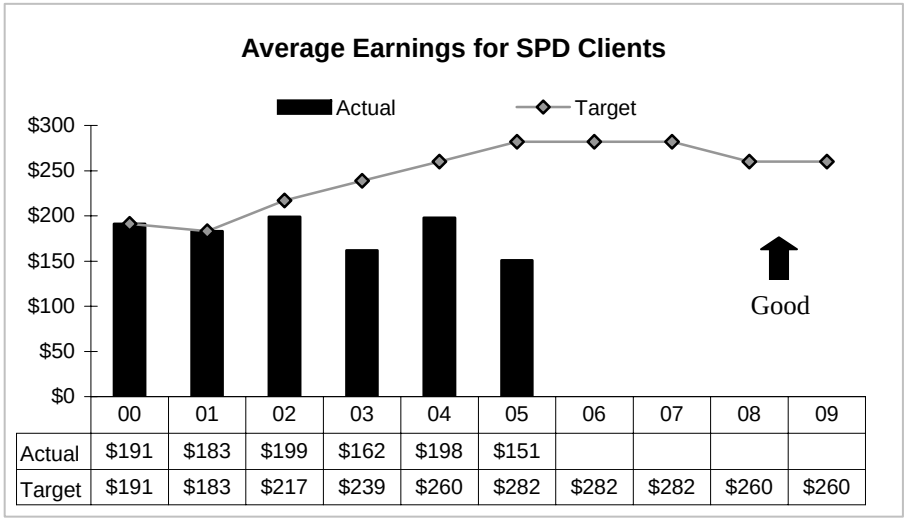
6. **WHAT NEEDS TO BE DONE**
Continued efforts to improve the quality of childcare provided to clients must occur. Aside from an increase in rates, the only remaining strategy is to step up efforts along with our partners to publicize training opportunities and the advantages of the enhanced rate.

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

KPM #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	Self-Sufficient – 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 Division, 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 currently included in available data sources.

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



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

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

4. **HOW WE COMPARE**
There are no current available data to make this comparison. However, communications with other states and national organizations indicate the lack of progress in obtaining competitive employment for persons with developmental disabilities is a nationwide concern. This concern has led to several new initiatives to address this concern. Most notable are initiatives by the Centers for Medicare and Medicaid Services (CMS) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). SPD is participating in both of these initiatives.

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 is 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, collaboration, and creating new employment opportunities. A more critical review of the available outcome data and performance measurement issues will continue in order to align agency performance with meaningful targets. Key to these continuing efforts is SPD's participation in the national initiatives identified in question #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 - 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)

2005 data disaggregated:
(14.18 X 4.2) X $2.54 = $151

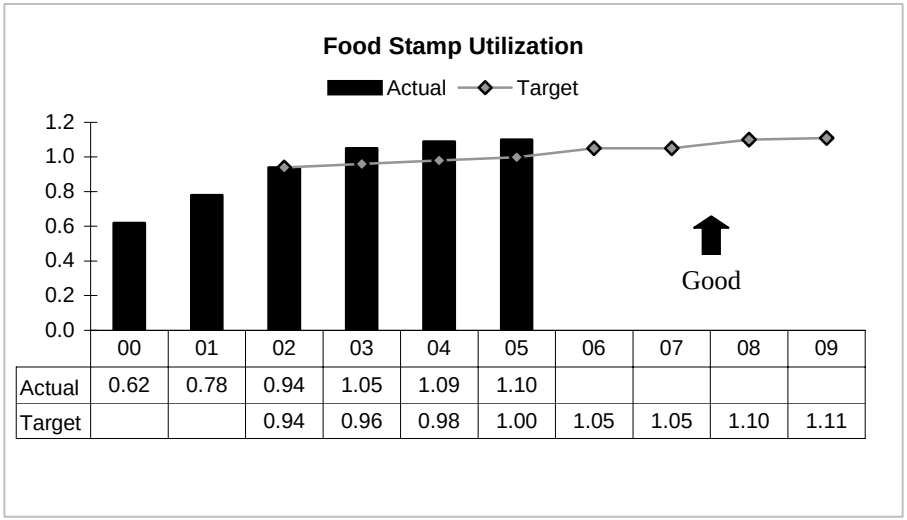
Full Employment Outcomes Report is available at http://www.oregon.gov/DHS/spd/data/.

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	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 #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. … Food Stamp Management Information system compared to Census estimates of Oregonians living at or below the federal poverty level.	
Owner	Children, Adults and Families Division, Carolyn Ross (503) 945-6074	

1. **OUR STRATEGY**
   Our strategy is to implement food stamp outreach in 4 counties in 2006 to increase the participation rate in underserved areas of the state. The main strategies are to have stuffers in grocery sacks at Food 4 Less and having applications submitted by fax.

2. **ABOUT THE TARGETS**
   It is possible for more than 100% of people living in poverty to receive food stamps because food stamp eligibility may be extended to those whose incomes reach up to 130% of the federally defined poverty level. Although we are currently at 110%, potential changes in Federal requirements for Food Stamp eligibility may cause eligibility rules to be stricter. This makes the targets chosen a challenging but attainable goal.

3. **HOW WE ARE DOING**
   We continue to stay flat in that we only served 434,514 people in May 2006 on a statewide basis. We have just started these strategies and are hopeful to see improvement by December 2006.



	00	01	02	03	04	05	06	07	08	09
Actual	0.62	0.78	0.94	1.05	1.09	1.10				
Target			0.94	0.96	0.98	1.00	1.05	1.05	1.10	1.11

4. **HOW WE COMPARE**
   Oregon leads the nation in Food Stamp participation and we are number one with highest percentage of eligible food stamp families that are accessing services. One of the reasons that we have seen very little increase in the last two years is that we had huge increases in 2000 and 2001 and we then have leveled off.

5. **FACTORS AFFECTING RESULTS**
   We believe that the people we are not serving are more of the working poor that do not want to come into branch offices and we believe that the fax process will increase their participation.

6. **WHAT NEEDS TO BE DONE**
Continue to capture the data as the projects continue.

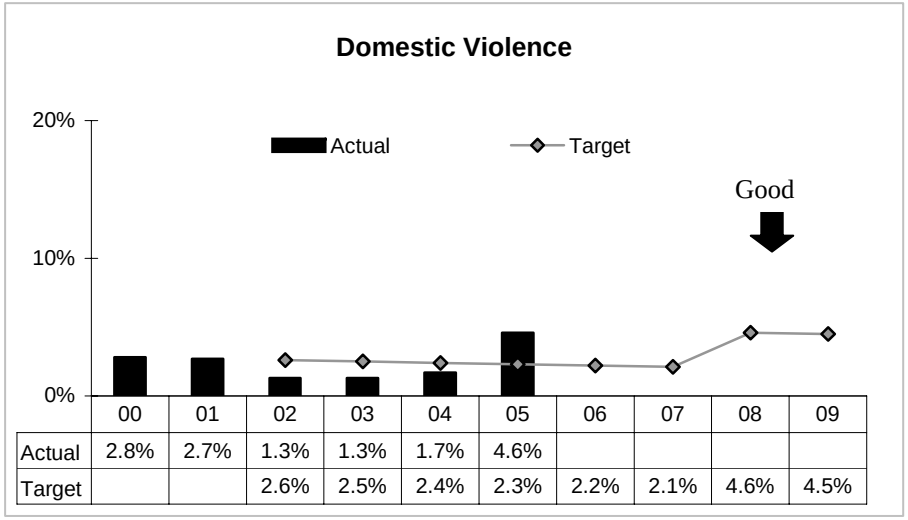
7. **ABOUT THE DATA**
Reporting cycle - federal fiscal year. The Food Stamp Management Information system is compared to Census estimates of Oregonians living at or below the federal poverty level.

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**
   Funding for the victims, Governor's Council on Domestic Violence (DV) promoting prevention and community involvement. The Agency provides training on new policies and procedures for staff. The DHS DV Council is promoting screening and referral in all DHS service deliveries. DHS has published the "Oregon Violence Against Women Prevention Plan**".**

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.



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

The introduction of a primary prevention plan is a first step for the state in addressing prevention. The dissemination of the plan and resources for implementing prevention practices will be a critical step for the state. As yet there are no state funds invested in primary prevention, public health data system, current program evaluation or research. 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.

4. **HOW WE COMPARE**
In years to come Oregon will be able to compare data with other states. 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.

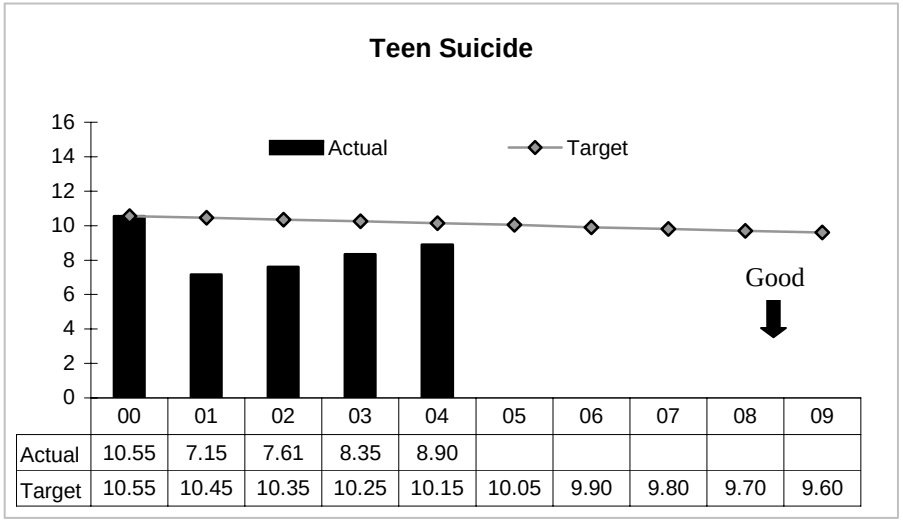
6. **WHAT NEEDS TO BE DONE**
The state needs funds to implement prevention activities as a means to reducing the incidence of violence. Responding alone will not reduce violence. The state needs to implement evaluation of existing response programs. A public health data system is necessary to better 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. Until this year comparisons were 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	TEEN SUICIDE: Safe & Healthy – People are safe. People are healthy.	
Oregon Context	Preventable death	
Data source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Death Certificates) and Portland State University, Population Research Center (Population Estimates)	
Owner	Public Health Division, Office of Disease Prevention & Epidemiology, Injury Prevention & Epidemiology Program, Lisa Millet 971-673-1059	

1. **OUR STRATEGY**

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



	00	01	02	03	04	05	06	07	08	09
Actual	10.55	7.15	7.61	8.35	8.90					
Target	10.55	10.45	10.35	10.25	10.15	10.05	9.90	9.80	9.70	9.60

2. **ABOUT THE TARGETS**

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

- 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**

Suicide attempts among youth treated in emergency rooms number approximately 2,000 per year in Oregon. Among these youth about 42% report a previous attempt and about 90% are reported to have a diagnosable mental health problem. These youth are at high risk for an additional attempt and death. The state has implemented pilot projects that enlist hospitals to report attempt cases to local health departments. The health department staff and hospitals in two counties have completed agreements to establish reporting. Health department staff have been trained in evidence based practice to support family and youth. These efforts will create outreach and services to reduce stigma, support the parental role in monitoring mood and in communication, and support the youth role in developing and carrying out health related goals for themselves. The work will also encourage entering behavioral healthcare.

4. **HOW WE COMPARE**

Oregon is a leader in public health surveillance of suicide. Oregon has over 5,000 adtults trained in suicide intervention skills. Only one county has completed implementation of comprehansive suicide prevention in schools. There is a statewide crisis hotline. About 50% of school based health centers have enhanced mental health services. Bereavement support is available in urban areas. Tribal suicide prevention has begun in the Confederated Tribes of Warm Springs Reservation. A consortium of eight universities has received a federal grant to develop suicide prevention. A community college has also received this grant. The Native American Rehabilitaion Association has received a grant to implement a program known as No More Fallen Feathers. The state has received a grant to implement a multifacted suicide prevention program in four regions of the state. These efforts are possible through state and local partnerships and support from the state and the federal governemt and foundations in Oregon.

5. **FACTORS AFFECTING RESULTS**

Presently there are not enough staff resources to implement statewide efforts. 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.

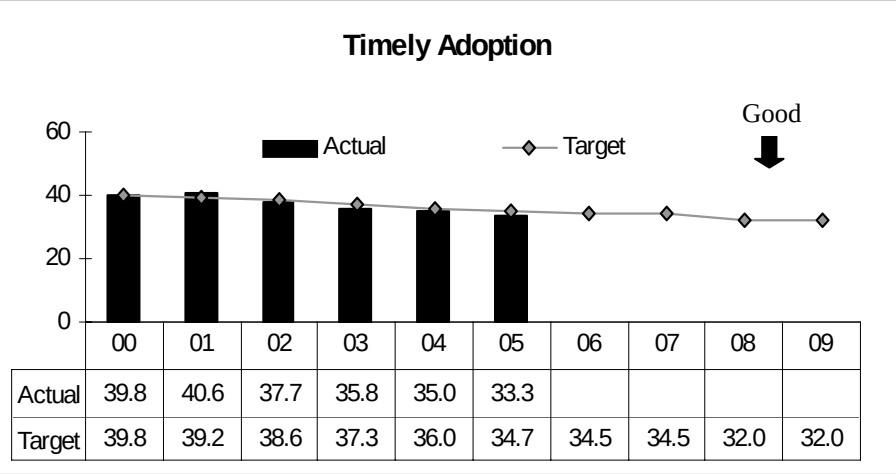
7. **ABOUT THE DATA**

Reporting cycle – calendar year. The data are provided by the Center for Health Statistics death certificate database. Some suicides may be excluded as local medical examiners may hesitate to rule a death a suicide due to stigma. Deaths are verified in two ways: through Oregon's Child Fatality Review system and through Oregon's Violence Death Reporting System.

KPM #13	**TIMELY ADOPTION** **The median number of months from date of latest removal from home to finalized adoption.**	**Measure since: 1997**
Goal	Safety – 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 2005. 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				
Target	39.8	39.2	38.6	37.3	36.0	34.7	34.5	34.5	32.0	32.0

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 2005.

5. **FACTORS AFFECTING RESULTS**
The agency negotiated with the Region X office of the Department of Health and Human Services, Administration for Children and Families (DHHS, ACF) a goal of 36 months for the median time to adoption for all children who exit foster care to adoption. This is a secondary adoption goal, which was negotiated as an interim step toward the federal standard of 32% of children for whom adoption is achieved exiting to finalized adoptions in 24 months or less from date of last removal from home. When Oregon had its onsite federal Child and Family Services Review in 2001, approximately 12% of foster children exiting care to a finalized adoption reached this goal in 24 months or less. This performance has steadily increased since that time. While Oregon's performance against this measure falls short of the federal standard, the agency has demonstrated steady progress toward achieving both this goal and the interim adoption goal of 36 months as the median time to adoption.

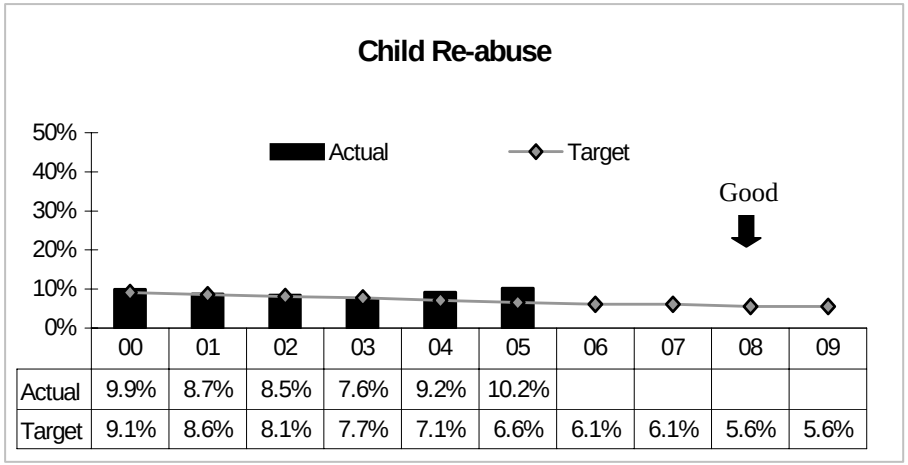
6. **WHAT NEEDS TO BE DONE**
Oregon has made steady progress toward reducing the time to achieve adoption for children in its care and custody who are unable to live safely and permanently with their families of origin. Nonetheless, the department needs to further examine its practices through its performance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

7. **ABOUT THE DATA**
Reporting cycle - federal fiscal year. 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 2005 the agency continued to streamline rules and processes related 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.

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	Safety – 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. The Safety Intervention Model includes all actions and decisions required throughout the life of a case to:
   - Define Child Welfare as the "safety expert" and assure that all child welfare staff receive training in child safety interventions.
   - Assess allegations of child abuse in a timely manner and provide 4a 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%				
Target	9.1%	8.6%	8.1%	7.7%	7.1%	6.6%	6.1%	6.1%	5.6%	5.6%

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 <=5.6%, 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 5.6%).

3. **HOW WE ARE DOING**
   In 2005, the child repeat maltreatment rate for children in Oregon was 10.2 percent. This measure was below target in 2003. The trend between 2003 and 2005, however, shows a worsening.

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.

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.

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	Safety – 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 Division, 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.

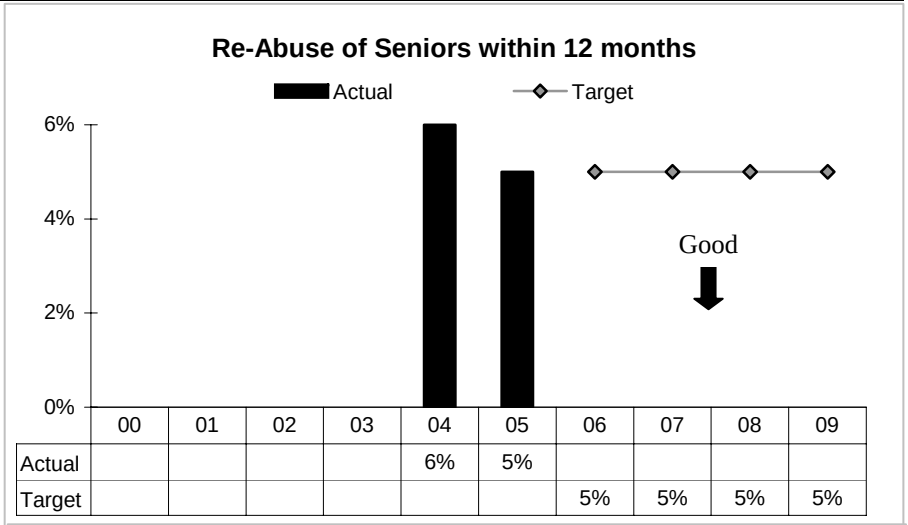
Developmental disabilities: Increase training for local protective service investigators and collaboration with brokerages who serve people with developmental disabilities in their own home.

2. **ABOUT THE TARGETS**
All targets for 2005 were changed from 6.0 to 5.0 at the request of the Oregon State Legislature.

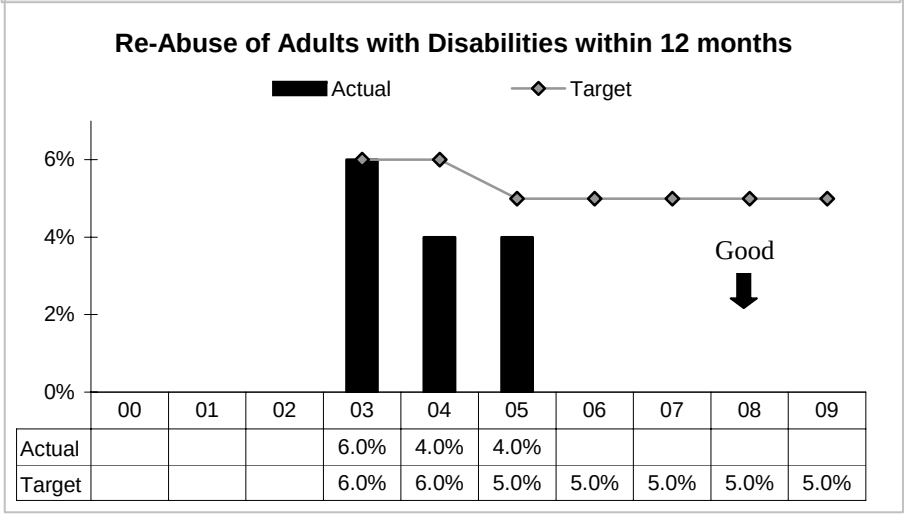
Seniors and adults with disabilities: In order to measure success in reducing re-abuse, in the community, SPD in agreement with the legislature selected the target of 5% for tracking victims who have been reabused within 12 months of the first reported abuse incident.

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 principle for the Seniors and Adults with Disabilities' protective service model is to balance our obligation to protect older adults and adults with disabilities with their rights to self-determination. Independent adults can make decisions about their own life and the course of action to be taken in abuse situations. This individual decision-making is factored into our reabuse rate.

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



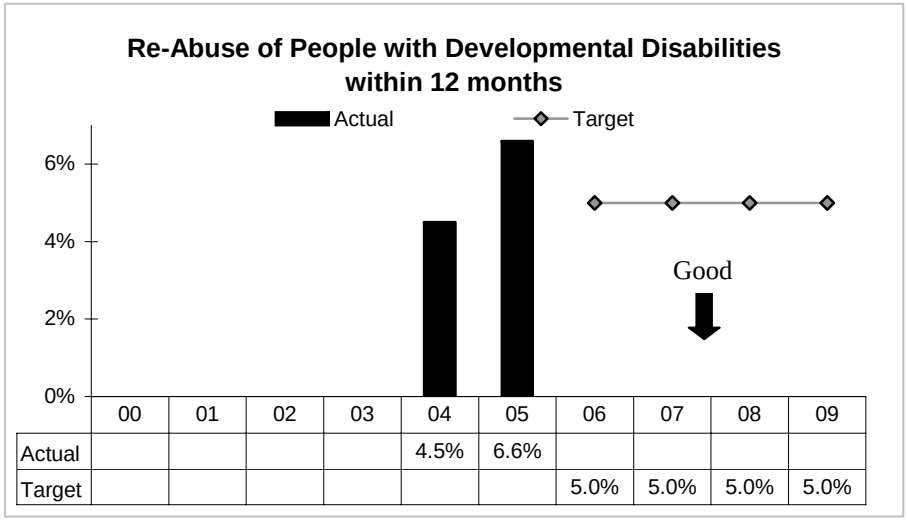
	00	01	02	03	04	05	06	07	08	09
Actual					6%	5%				
Target							5%	5%	5%	5%



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

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

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



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

3. **HOW WE ARE DOING**

Seniors and adults with disabilities: Since our Department currently meets or is below the current benchmark of 5% for the percentage of seniors, adults with disabilities who are re-abused within 12 months, it appears that we are meeting the goals of our intervention model described above. However, reabuse in the community can be difficult to lower due to the individual's right to make decisions about their own life and the course of action. Additionally, as public awareness of the signs of abuse increases so do the number of abuse reports received by the department resulting in more investigations and interventions. The department wants to encourage individuals to report 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 2005 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 resulting in an increase of the

re-abuse rate from 4.5 to 6.6 for this population. Overall, the numbers of abuse and neglect reports and subsequent investigations has increased from 866 in 2004 to 994 in 2005. The serious types of abuse (sexual and physical) have remained relatively low with significant increases in financial exploitation, though of small dollar amounts.

4. **HOW WE COMPARE**

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

Developmental disabilities: There are no national prevalence/incidence studies for abuse of individuals with developmental disabilities. The limited research available shows extremely high rates of abuse for individuals with developmental disabilities. For example, the World Health Organization has stated sexual violence is experienced by 90-95% of individuals with developmental disabilities. They are identified as experiencing the highest rate of abuse of all vulnerable populations.

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 Specialists;
- Response of the criminal justice system;
- Development and understanding of intra-agency functions;
- Self-neglect: The re-abuse data figures include those clients that are categorized under self-neglect. This could be interpreted to mean that it may be an 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.

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 the brokerages who are serving people in their own homes. Research and program development focusing on prevention of abuse such as the Attorney General's Sexual Assault Task Force Developmental Disability Initiative.

7. **ABOUT THE DATA**
Reporting cycle - calendar year.

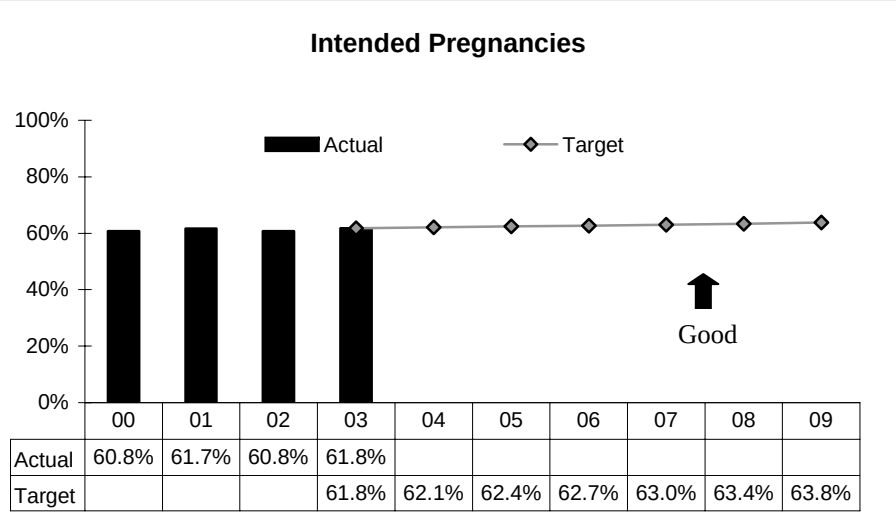
Seniors and Adults with Disabilities – Data is maintained by the Office of Licensing and Quality of Care, Quality Assessment and Monitoring Unit. Original data source is Oregon ACCESS. Since Lane County does not use Oregon Access, abuse data is sent in via paper forms and then appended to the abuse data.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

Developmental Disabilities – Data is maintained by the Office of Investigation and Training (OIT). Data source is the *2005 Abuse/ReAbuse Data for Developmental Disability Clients* yearly report from OIT Abuse database. Initial data entry into the database goes through a quality assurance process where paper forms are entered and then re-checked in the database. However, at the time of performance measure submission, not all data have been through the final quality assurance process. OIT believes that the final quality assurance process will have little impact on the actual data. Further, data for performance measure was checked for duplication.

Additional and Disaggregated Data:
Data for Seniors and Adults with Disabilities can be obtained by contacting the *Office of Licencing & Quality of Care Adult Protective Services.*
Data for People with Developmental Disabilities can be obtained by contacting the *Office of Investigation and Training*.

KPM #16	INTENDED PREGNANCIES The percentage of births where mothers report that the pregnancy was intended.*	Measure since: 2006
Goal	INTENDED PREGNANCY: Healthy – 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	

* JLAC-approved measure – July 2006



	00	01	02	03	04	05	06	07	08	09
Actual	60.8%	61.7%	60.8%	61.8%						
Target				61.8%	62.1%	62.4%	62.7%	63.0%	63.4%	63.8%

1. **OUR STRATEGY**
   Through a network of approximately 160 county health departments and other local agencies, the state family planning 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**
   As this measure was just developed and approved in July 2006, it is not possible to compare performance to previously set targets. However, the trend between 2000 and 2003 (the most recent year for which data are available) is a slight increase, as desired.

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. In addition, anything that constitutes a barrier for clients trying to access family planning services will reduce the state's ability to increase intended pregnancies. For example, new citizenship documentation requirements imposed by the Deficit Reduction Act of 2005 may result in delays or denial of services for clients who need birth control. Finally, because pregnancy intent is influenced by an often complex mix of feelings about pregnancy, childbearing, intimate relationships and other issues, state programs can only go so far 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.

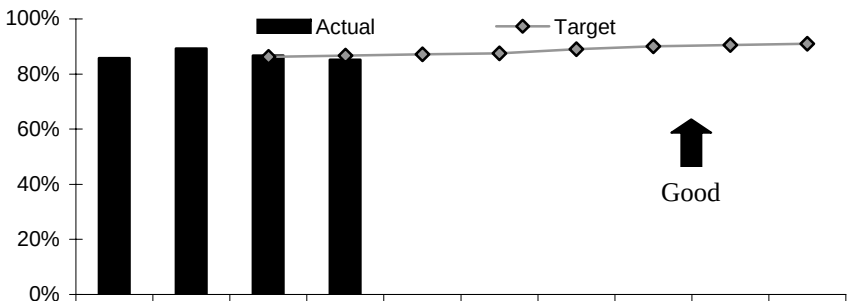
KPM #17	EARLY PRENATAL CARE FOR LOW INCOME WOMEN The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy.	Measure since: 2002
Goal	EARLY PRENATAL CARE FOR LOW INCOME WOMEN: Healthy – People are healthy.	
Oregon Context	Prenatal care	
Data source	Public Health Division, Office of Family Health (PRAMS survey) and ORDHS, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Birth Certificates)	
Owner	Public Health Division, Office of Family Health, Pat Westling, 971-673-0341 / 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 OMAP, the agency that administers the Oregon Health Plan (OHP), to assist pregnant women in entering early prenatal care.

2. **ABOUT THE TARGETS**
   The target for 2007 is 90.0%. Although there was a slight decline in '02 the numbers have remained stable since. The OMC program is also expanding.

3. **HOW WE ARE DOING**
   The OMC program has expanded from five sites serving fewer than 1,000 low-income women in 2000 to 26 sites that served more than 4,200 women in 2005 with over 21,000 referrals to prenatal care and other services.

Early Prenatal Care for Low Income Women



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Actual	85.8%	89.2%	86.7%	85.2%						
Target			86.2%	86.7%	87.1%	87.5%	89.0%	90.0%	90.5%	91.0%

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 and OHP clients in general might be helpful. Approximately 80% of women receiving services through OMC during their first trimester entered prenatal care during the first trimester. This includes women who are low-income but ineligible for Oregon Health Plan (OHP) coverage. Among OHP clients overall, the percent of first trimester care is consistenly slightly less than 70%.

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 19.4% in 04. Another factor may be that a large number of people have been eliminated from OHP standard so there are far fewer low-income women who are already covered by Medicaid when they become pregnant so must apply after they find out they're pregnant. It is possible that some of them do not know immediately that they can now qualify because they are pregnant, especially if they were recently told they were ineligible for OHP due to income.

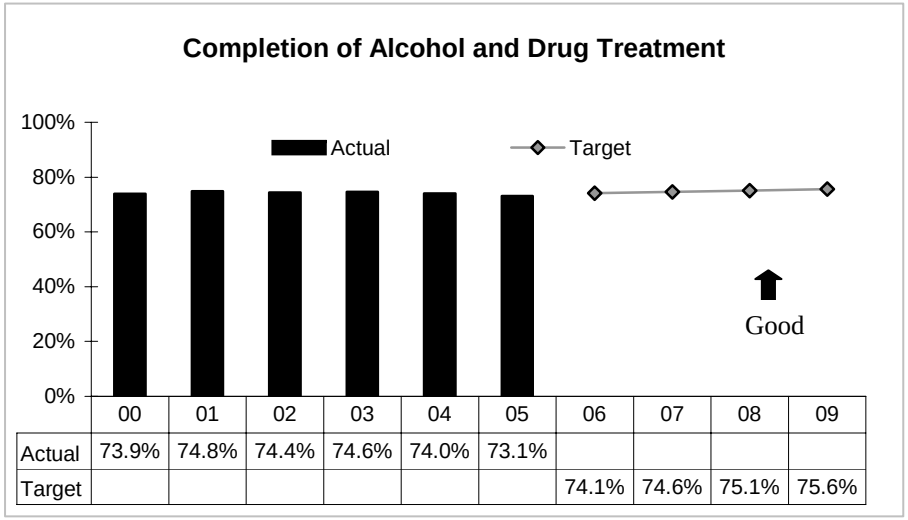
6. **WHAT NEEDS TO BE DONE**
Trends will continue to be tracked, comparing low-income Medicaid and non-Medicaid women for the entire state as well as by county and will likely use several measures including birth certificate data and perhaps birth record data linked to Medicaid-OMAP data.

7. **ABOUT THE DATA**
Reporting cycle - calendar year. The population-based design and high response rate of the PRAMS survey are both strengths. Self-reported data, like the PRAMS data, have both strengths and weaknesses. In this case, it is possible that some women may not be able to recall accurately at which week of their pregnancy they began prenatal care. Note also that timely entry into prenatal care does not guarantee that a woman will receive an adequate amount of prenatal care.

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**
   There has not been much variation for this measure during the past several years. The Office is working with providers to increase this through a quality improvement process and by incorporating this measure into performance based contracting.
4. **HOW WE COMPARE**
   There are no national data to compare.
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, and the quality of services.



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Actual	73.9%	74.8%	74.4%	74.6%	74.0%	73.1%				
Target							74.1%	74.6%	75.1%	75.6%

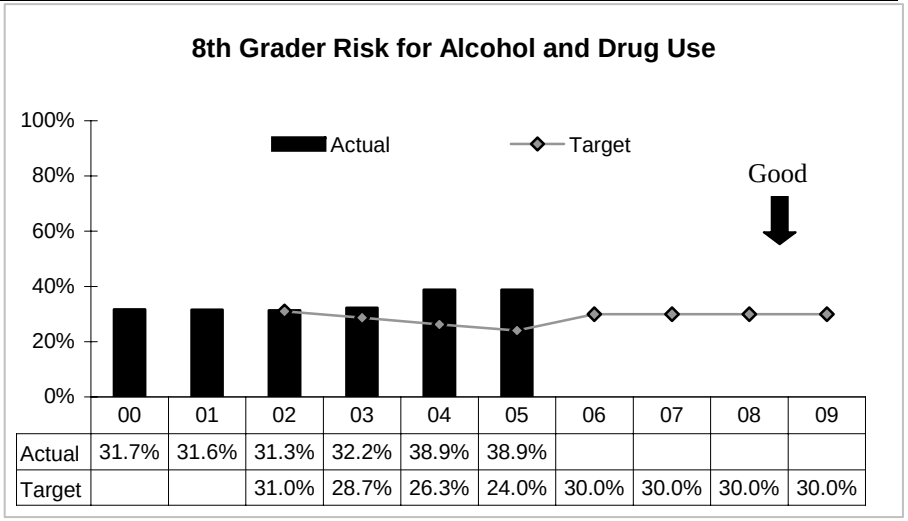
6. **WHAT NEEDS TO BE DONE**
   The Office will continue quality improvement efforts and the encouragement of the use of evidence-based practices.
7. **ABOUT THE DATA**
   Data is extracted from the Office's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. The Office produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate/accurate data are submitted to the CPMS.

KPM #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	

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.

2. **ABOUT THE TARGETS**
   The lower the rate the better.

3. **HOW WE ARE DOING**
   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.



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

   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, three pilot sites will receive extensive training and technical assistance to implement this evidence-based prevention program. Target areas will be determined by utilizing data from the Oregon Healthy Teens survey.

   In addition, each county in the state currently receives 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.

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. Only 18% of Washington 8th graders reported using alcohol in the past 30 days, while 31.8% of Oregon 8th graders did.

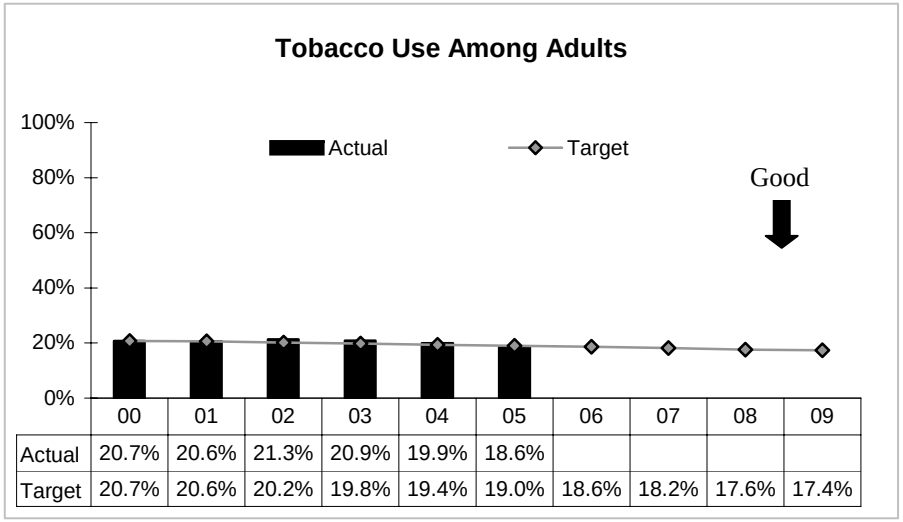
5. **FACTORS AFFECTING RESULTS**
Perceptions of youth to being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use has a tremendous effect on youth use. Youth whose parents feel that alcohol use is a "rite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

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

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

KPM #20	TOBACCO USE Tobacco use among: a) adults, b) youth, c) pregnant women	Measure since: 2002
Goal	TOBACCO USE: Healthy – 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%				
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 DHS Tobacco Prevention and Education Program (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.

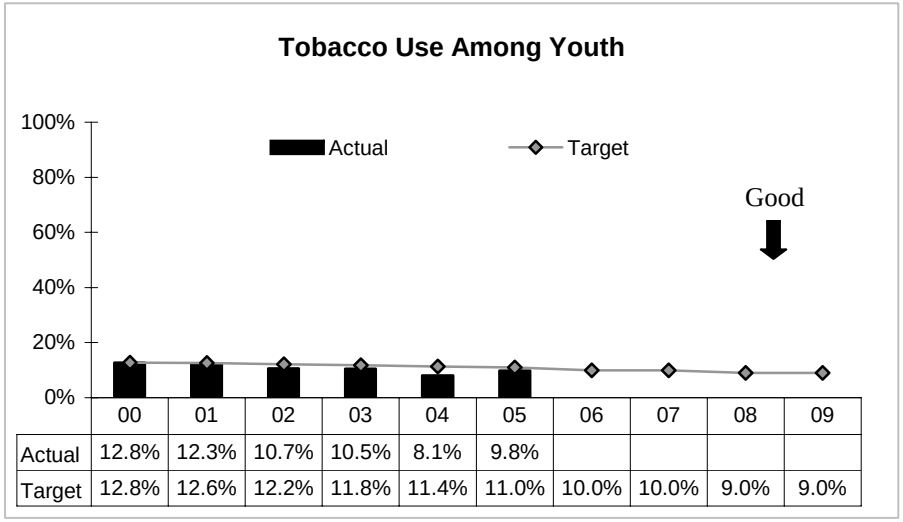
3. **HOW WE ARE DOING**
In 2005, the prevalence of smoking in Oregon was 18.6% for the general adult population, 9.8% among 8th grade adolescents, and 12.4% among pregnant women. For the general population of adults and for 8th graders, these measures were slightly better than targeted levels, while for pregnant women, this figure was slightly worse than the target. Although all measures are lower than their 2000 values, smoking rates for 8th graders have increased slightly over the past year, while smoking rates among pregnant women have remained about the same.

4. **HOW WE COMPARE**

For adult smoking prevalence, the Healthy People 2010 target for this performance measure is 12%. Without new resources dedicated to tobacco prevention, it is unlikely that Oregon will meet this target by 2010.

Healthy People 2010 has a target of 16% for the smoking rate among high school students. The Department's performance measure is for 8th graders, but the 11th grade-smoking rate is currently 16.9% in Oregon. If our past 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 slightly worse than target for 2005. Oregon's rate of smoking during pregnancy has historically been higher than the national rate, although national data for 2005 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%				
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 nearly $24 million annually. This is a fraction of the cost of tobacco use, however, with more than $2 billion lost to medical care and diminished productivity annually in Oregon. Despite the recommendation, Oregon currently receives $1.24 per capita for tobacco prevention from all funding sources, which is a sharp decrease from previous years. For most of the 2001-2003 biennium, the TPEP received approximately $3.14 per capita per year. However, in April 2003, the Legislature stopped funding the TPEP for the remainder of that biennium, and funding has not been returned to previous levels. Since the funding decrease, smoking among pregnant women and adolescents has stopped decreasing, and per capita consumption of cigarettes has 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.

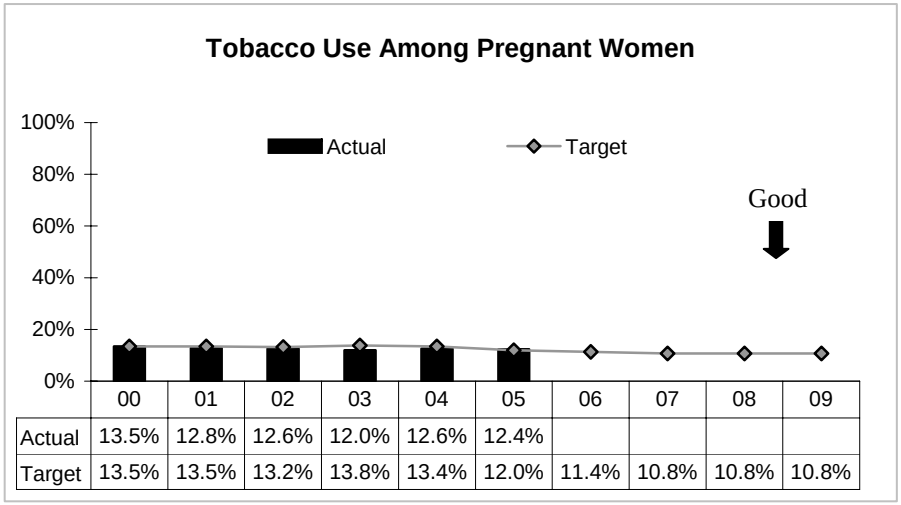
7. **ABOUT THE DATA**

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. 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.

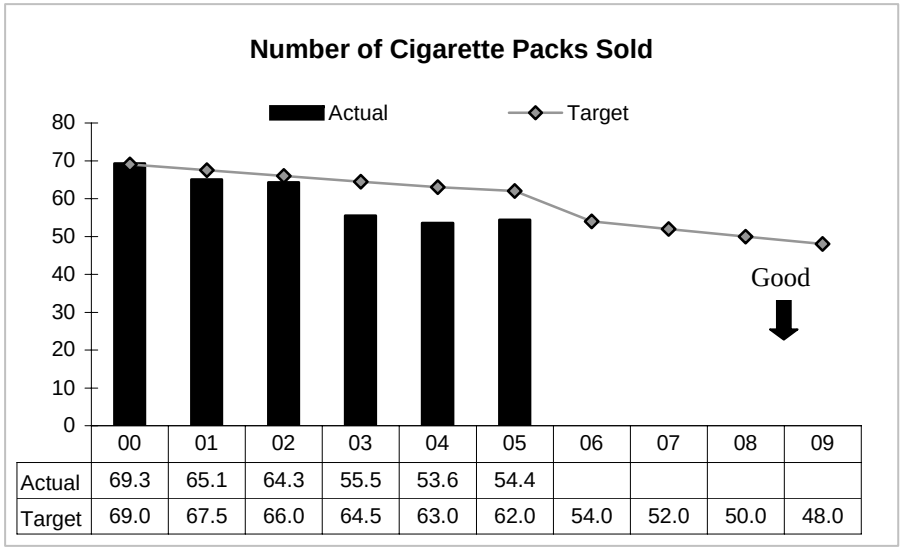
Smoking prevalence among pregnant women is on an annual reporting cycle, computed once per calendar year. These data come from the birth certificates issued to all newborns in Oregon, which include parental demographic information, conditions of the newborn, and medical factors during the pregnancy (including 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%				
Target	13.5%	13.5%	13.2%	13.8%	13.4%	12.0%	11.4%	10.8%	10.8%	10.8%

KPM #21	CIGARETTE PACKS SOLD Number of cigarette packs sold per capita.	Measure since: 2002
Goal	CIGARETTE PACKS SOLD: Healthy – 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				
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 2005, the number of cigarette packs sold in Oregon was 54.4 packs per capita. Although this measure was better than the targeted level for 2005, there was a leveling off in 2003 and 2004, and a slight increase between 2004 and 2005. 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 nearly $24 million annually. This is a fraction of the cost of tobacco use, however, with more than $2 billion lost to medical care and diminished productivity annually in Oregon. Despite the recommendation, Oregon currently receives $1.24 per capita for tobacco prevention from all funding sources, which is a sharp decrease from previous years. For most of the 2001-2003 biennium, the TPEP received approximately $3.14 per capita per year. However, in April 2003, the Legislature stopped funding the TPEP for the remainder of that biennium, and funding has not been returned to previous levels. Since the funding decrease, smoking among pregnant women and adolescents has stopped decreasing, and per capita consumption of cigarettes has 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.

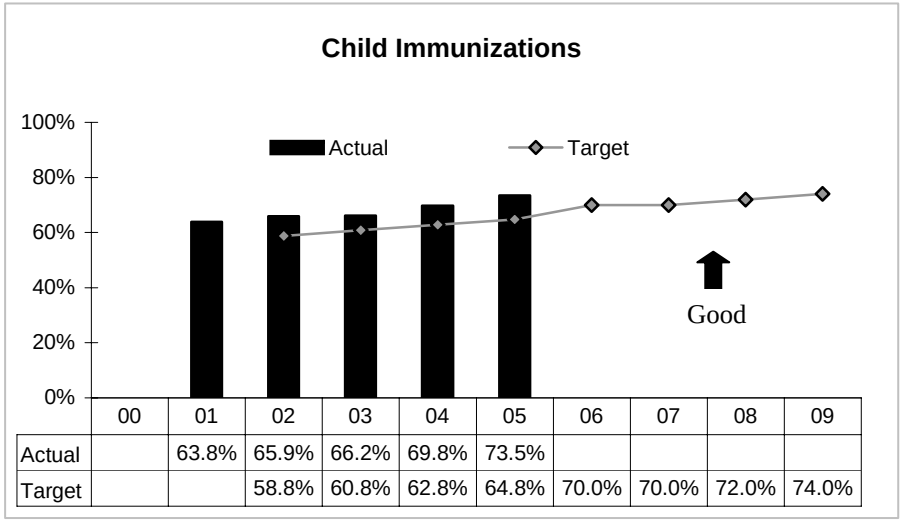
Advantages associated with these data are that they allow comparisons with national and other state estimates of consumption, which similarly rely on tax revenue data and population estimates. In addition, this estimator does not depend upon accurate self-reporting of smoking behavior. A disadvantage 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. The TPEP estimates that untaxed cigarettes represent a small fraction of the cigarettes Oregon smokers consume.

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	CHILD IMMUNIZATIONS: Healthy – 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	

* Correction to wording of measure. No change to data.

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.



	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%	72.0%	74.0%

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.

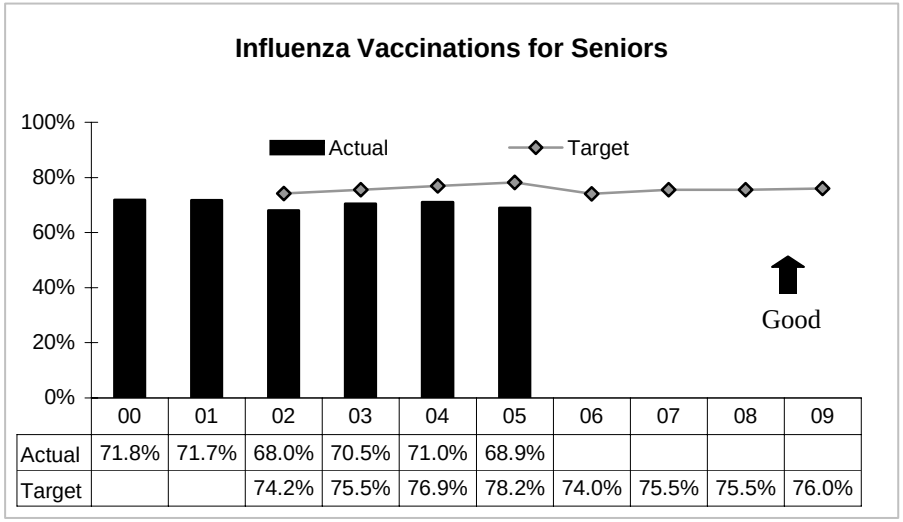
6. **WHAT NEEDS TO BE DONE**
To continue our success, DHS needs to:
- Continue to provide funding, vaccines, and consultation to all local health departments.
- Maintain the new computerized record system for the public sector, which includes reminder postcards for overdue shots.
- Increase private provider 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.

KPM #23	INFLUENZA VACCINATIONS FOR SENIORS The percentage of adults aged 65 and over who receive an influenza vaccine.	Measure since: 2002
Goal	INFLUENZA VACCINATIONS FOR SENIORS: Healthy – 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%				
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 2005, the national immunizatin rate for persons 65 and older was 65.7%, with state rates ranging from 78% in Minnesota to 53% in Nevada. Oregon ranked 16th in rates, an improvement over 2004.

5. **FACTORS AFFECTING RESULTS**
The slight dip in 2005 rates may be attributed to the vaccine shortage during the 2004-05 season, which would be collected in the 2005 BRFSS. However the dip was slight because of the substantial efforts on the part of DHS and the local health departments to prioritize vaccine for the populations at highest risk, such as the elderly. 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 legal constraints that presently do not allow providers to access Immunization ALERT, the statewide immunization registry that could provide immunization information for providers about their adult populations. A lifespan registry would help providers identify candidates for vaccine and could be used for sending out reminders to clients to seek out immunization every year.

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 3rd Annual Flu Summit to promote influenza vaccination strategies to providers; and
- Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or tetanus/diphtheria vaccine, in all health care settings.

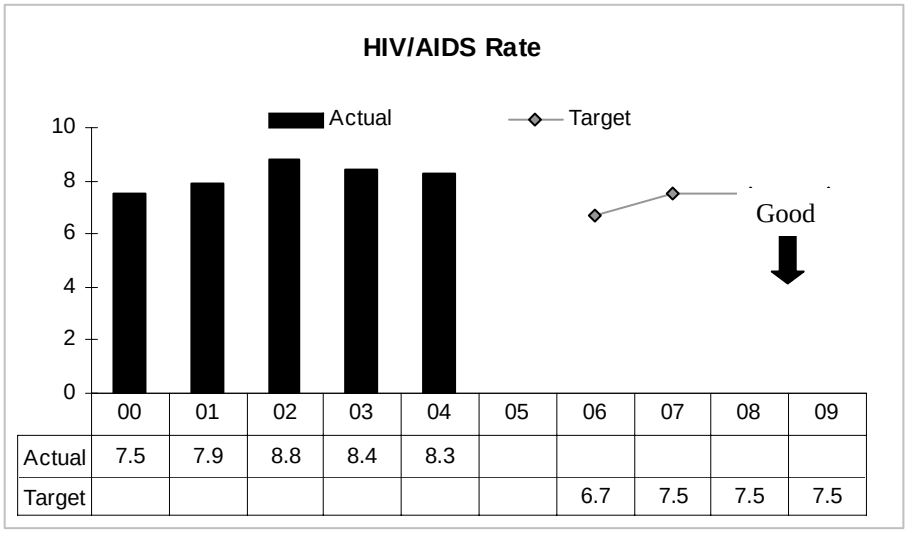
7. **ABOUT THE DATA**
Reporting period - calendar year. This measures the percent of adults, 65 years and older, which reported receiving an influenza vaccination in the previous 12 months as reported on the Behavioral Risk Factor Surveillance survey (BRFSS). [Survey question: During the past 12 months,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

KPM #24	**HIV/AIDS RATE** **The annual rate of newly acquired HIV/AIDS infection per 100,000 persons.**	**Measure since: 2000**
Goal	HIV/AIDS RATE: Healthy – 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 estimates	
Owner	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/STD/TB Program, ORDHS, 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.

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.



	00	01	02	03	04	05	06	07	08	09
Actual	7.5	7.9	8.8	8.4	8.3					
Target							6.7	7.5	7.5	7.5

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 20.7 HIV infections were diagnosed per 100,000 people during 2004 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 2004 rate of 8.3 cases per 100,000 residents is well below that level.

5. **FACTORS AFFECTING RESULTS**
As outlined above (question #2), changes in HIV case reporting rules have been implemented during 2006. These include increased laboratory reporting requirements and a change to named HIV case reporting. Even if underlying rates of new infections are unchanged, these changes in case reporting will likely lead to increases in the measured rate of new infections because of more complete case reporting.

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. 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.

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	ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – 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	

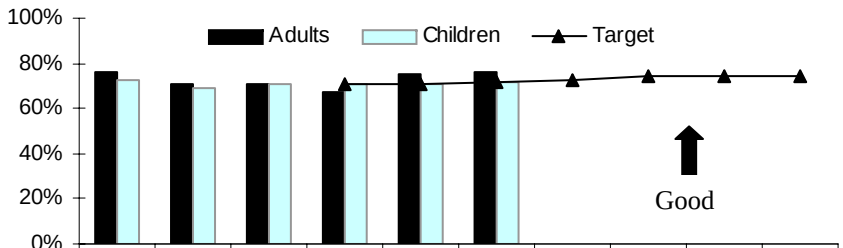
* Wording change for clarification. No data change.

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.

Routine Health Care Provided to OHP Clients



	00	01	02	03	04	05	06	07	08	09
Adults	76.3%	70.4%	70.7%	67.3%	75.0%	75.7%				
Children	72.9%	69.3%	70.7%	70.4%	70.6%	72.0%				
Target				71%	71%	72%	73%	74%	74%	74%

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, and childhood immunizations. 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 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.

3. **HOW WE ARE DOING**

The rates for adults and children increased in 2005 and are above the 2005 targets. 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 2005, the rate for adults increased 5.3 percentage points from 70.4% to 75.7% and the rate for children increased 2.7 percentage points from 69.3% to 72.0%.

4. **HOW WE COMPARE**

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

5. **FACTORS AFFECTING RESULTS**

Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Barriers include health care providers that do not accept Medicaid clients and a lack of knowledge among some clients that routine health visits are necessary and important.

6. WHAT NEEDS TO BE DONE

DMAP is adding more explicit standards to the managed care organization contracts to make certain there is adequate network capacity to provide routine and preventive services. OMAP 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 2005, clients must be on OHP for at least six months between August 1, 2004 and December 31, 2005. 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	RACIAL/ETHNIC VARIATION OF ROUTINE HEALTH CARE PROVIDED TO OHP CLIENTS – 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	

* Wording change for clarification. No data change.

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) to develop 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 rates for all race/ethnic categories increased in 2005 and all are above their 2005 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. The increased rates from 2001 to 2005 were 3.3 percentage points for whites (70.3% to 73.6%), 3.5 percentage points for Asian/Pacific Islanders (64.8% to 68.3%), 4 percentage points for Hispanics (69.4% to 73.4.%), and 4.3 percentage points for African Americans (64.4% to 68.7%) and Native Americans (70.8% to 75.1%).

4. **HOW WE COMPARE**

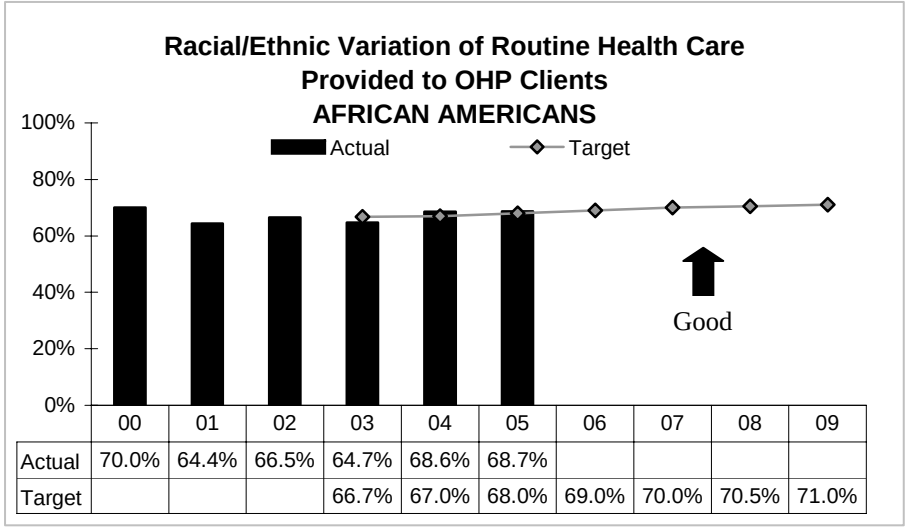
There are no public or private industry standards to compare to this performance measure. This measure separates KPM #25 into five racial/ethnic categories combining adults and children.

This measure was designed to measure OMAP'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.

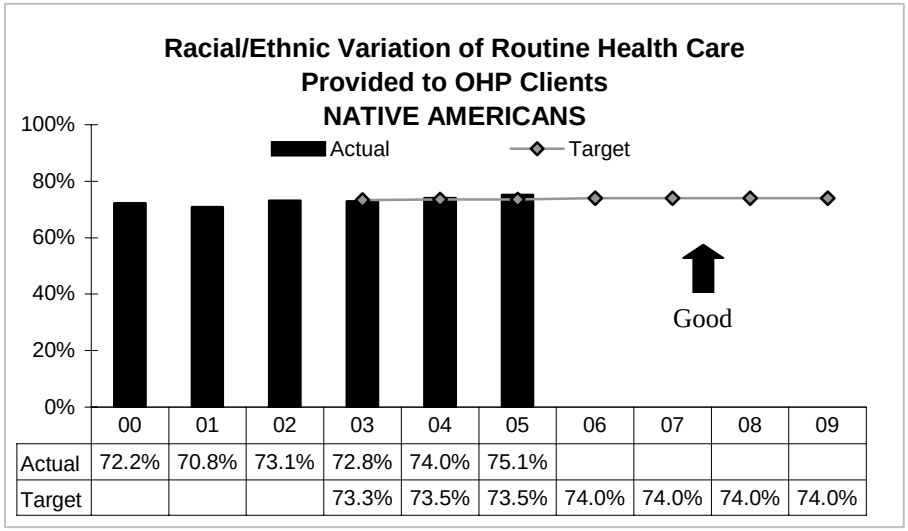
5. **FACTORS AFFECTING RESULTS**
Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Another facilitator is the number of clients whose medical home is a Federally Qualified Health Clinic or a Rural Health Clinic, as these clinics have a high level of cultural competence. Barriers are health care providers that do not accept Medicaid clients and a lack of knowledge 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 2005, clients must be on OHP for at least six months between August 1, 2004 and December 31, 2005. 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 Race/ethnic categories (African American, Native American, Asian American, 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.

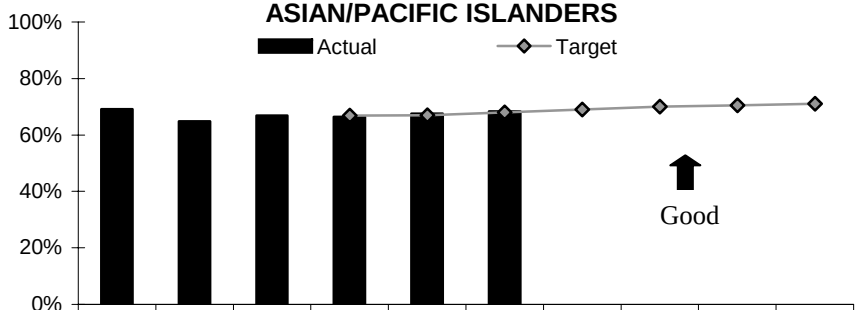


	00	01	02	03	04	05	06	07	08	09
Actual	70.0%	64.4%	66.5%	64.7%	68.6%	68.7%				
Target				66.7%	67.0%	68.0%	69.0%	70.0%	70.5%	71.0%



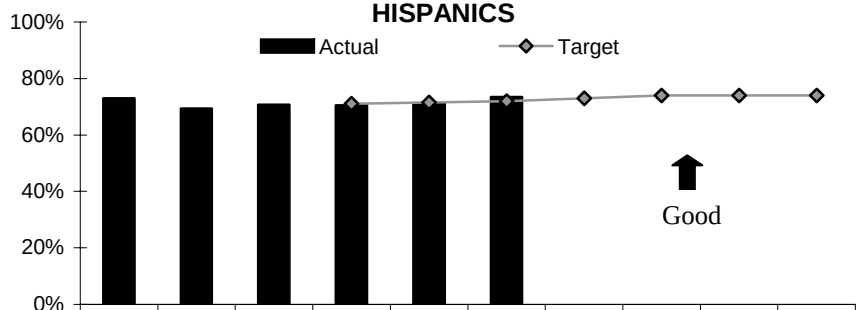
	00	01	02	03	04	05	06	07	08	09
Actual	72.2%	70.8%	73.1%	72.8%	74.0%	75.1%				
Target				73.3%	73.5%	73.5%	74.0%	74.0%	74.0%	74.0%

Proportion of OHP clients who receive routine health care services annually
ASIAN/PACIFIC ISLANDERS



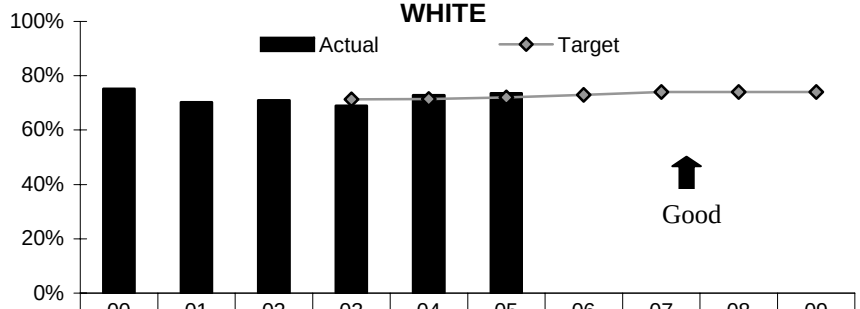
	00	01	02	03	04	05	06	07	08	09
Actual	69.1%	64.8%	66.8%	66.4%	67.5%	68.3%				
Target				66.9%	67.0%	68.0%	69.0%	70.0%	70.5%	71.0%

Racial/Ethnic Variation of Routine Health Care Provided to OHP Clients
HISPANICS



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

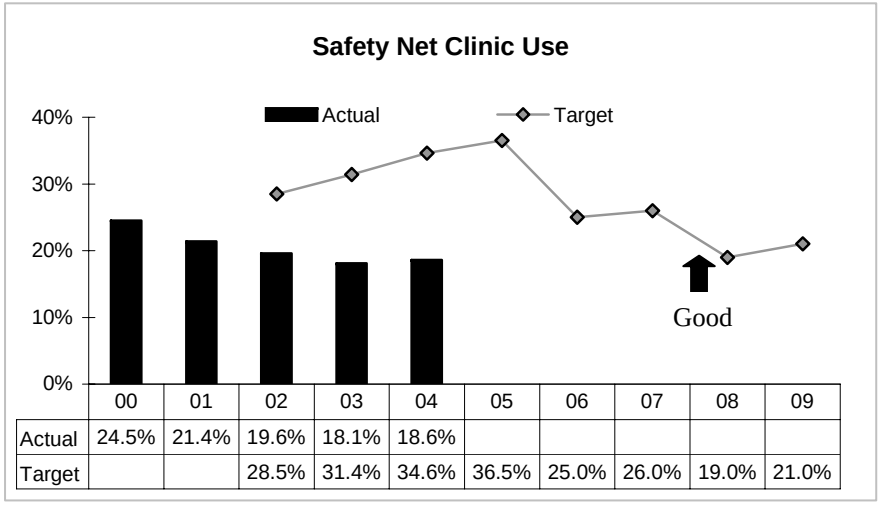
Racial/Ethnic Variation of Routine Health Care Provided to OHP Clients
WHITE



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

KPM #27	SAFETY NET CLINIC USE The number of uninsured Oregonians served by safety net clinics.	Measure since: 2002
Goal	SAFETY NET CLINIC USE: Healthy – People are healthy	
Oregon Context	Health care access	
Data source	Oregon Primary Care Association, Oregon Population Survey and Portland State University	
Owner	Public Health Division, Office of Community Health and Health Systems, Health Systems Planning, Juanita Heimann 971-673-1267	

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



	00	01	02	03	04	05	06	07	08	09
Actual	24.5%	21.4%	19.6%	18.1%	18.6%					
Target			28.5%	31.4%	34.6%	36.5%	25.0%	26.0%	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 declines even though in absolute numbers the safety continues to see more and more uninsured in addition to the Medicaid and Medicare clients in their patient load. We plan to transition in the next reporting cycle to numbers of uninsured seen to provide a clearer picture of need and safety net response.

3. **HOW WE ARE DOING**
Our comments are similar to the previous annual report. We do not yet have estimates of the uninsured to enable us to project the total number of uninsured and therefore the percentage of uninsured served for 2005 and beyond. For the data we do have we can say that the annual target was not met due to changes that were not anticipated when the targets were set in 2002. For the years of data we have high unemployment and the downturn in the economy contributed to an increase in the number of uninsured and underinsured Oregonians. Reductions to OHP also contributed to this outcome. Therefore the percentage of safety net served declines while the absolute number served increased. The 05, 06, and 07 targets are no longer good estimates for the reasons noted above. More accurate targets would be as follows 05 – 18%, 06 – 17.5%, 07 – 17%, 08 – 19%, and 09 – 21%. The 08 and 09 targets are higher because we anticipate some increase in OHP or other coverage in the next legislative session that would mean a decline in the number of uninsured and a commensurate increase in the percentage served by the safety net.

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.

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 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.

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))

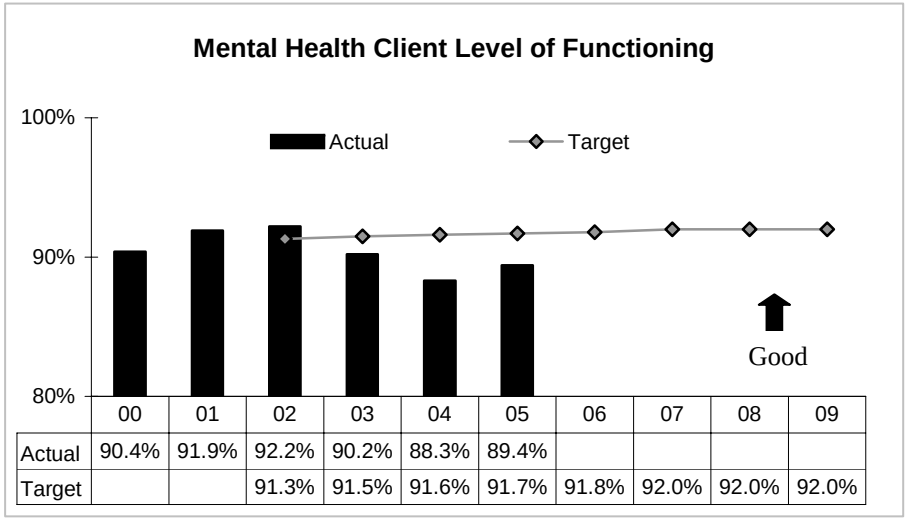
The Uniform Data System (UDS) collects data on all clinics in the U.S. receiving federal funds through section 330 of the Public Health Service (PHS) Act and administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). These clinics are known as Federally 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.

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. In the calculation of this measure FQHC clinics 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.

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.



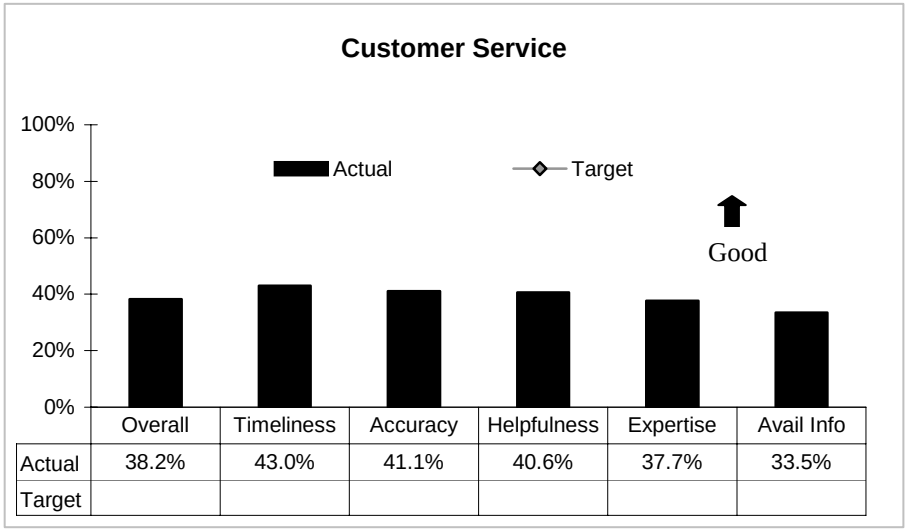
	00	01	02	03	04	05	06	07	08	09
Actual	90.4%	91.9%	92.2%	90.2%	88.3%	89.4%				
Target			91.3%	91.5%	91.6%	91.7%	91.8%	92.0%	92.0%	92.0%

6. **WHAT NEEDS TO BE DONE**
   AMH will continue quality improvement efforts and the encouragement of the use of evidence-based practices.
7. **ABOUT THE DATA**
   Reporting cycle – calendar year. Data is extracted from AMH's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. AMN 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	Client web survey	
Owner	Department Wide Support Services, Cathy Iles, 503-945-5855	

1. **OUR STRATEGY**
   As this is a new measure for DHS, the strategy addresses our survey methodology, rather than program efforts.

   We intend to continue focusing on DHS clients receiving services as our primary audience. We are currently surveying our senior population through a paper survey, which accompanied the Farm Direct Nutrition Program vouchers that were sent to approximately 40,000 seniors at the end of March 2006. Results will be reported in FY 2007. Other customer feedback surveys are being pursued as well, such as an internal customer survey for DHS employees to evaluate the quality of service provided by administrative offices within the agency (e.g. procurement, human resources, facilities, etc). In the next phase of gathering customer feedback, the project team is looking at ways to expand the client population receiving the survey and increase the response rate.



	Overall	Timeliness	Accuracy	Helpfulness	Expertise	Avail Info
Actual	38.2%	43.0%	41.1%	40.6%	37.7%	33.5%
Target						

2. **ABOUT THE TARGETS**
   Baseline data were collected in 2006, therefore no targets have been set.
3. **HOW WE ARE DOING**
   At this time we only have baseline data.
4. **HOW WE COMPARE**
   No comparisons can be made at this time.
5. **FACTORS AFFECTING RESULTS**
   Not available at this time.
6. **WHAT NEEDS TO BE DONE**
   Our strategy will focus on enhancing the survey methodology over the next year.

7. **ABOUT THE DATA**
Reporting cycle - fiscal year. DHS conducted its first client survey in March and April of 2006, in response to new DAS requirements around customer service. Due to time and budget constraints, the agency-wide project team recommended a web survey. DHS designed and administered this initial survey both to generate data to respond to DAS' mandatory questions and to test the web survey methodology. Survey notification was provided to clients receiving a medical card. A convenience sample of approximately 240,000 clients were invited to complete the web survey. The number of responses was extremely low, just over 200 limiting how the results can be analyzed and used.

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.
2 MANAGING FOR RESULTS How are performance measures used for management of the agency? What changes have been made in the past year?	The DHS performance measurement framework (Appendix A) outlines the different levels of performance measures and how they are connected to each other. At the highest level are the DHS goals, high-level outcomes and Oregon Benchmarks. They serve as tools for collaboration, motivation and leadership. The next level contains the key performance measures (intermediate-level outcomes). These types of measures serve as tools for collaboration, accountability, reporting, management, program improvement and stewardship. The foundation of the framework, contains program-specific measures, which may include other intermediate-level outcomes as well as caseload information and other outputs. These also serve as tools for accountability, reporting, management, program improvement and stewardship. Over the past year, the administrative offices within DHS have been developing a performance management system, which includes strategic planning and performance measurement. This is driving more informed decision-making for managing department-wide support services, such as human resources, contracts and procurement, document management and facilities.
3 STAFF TRAINING What training has staff had in the past year on the practical value and use of performance measures?	In the course of developing the Administrative Services performance management system, staff have received training in logic models, development of effective performance measures and the use of those measures for managing the work and decision-making.

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. 1. 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. 2. Stakeholders: Results are posted online and used for information sharing 3. Citizens: Results are posted online and used for information sharing.