Ways and Means

HUMAN SERVICES SUBCOMMITTEE

Oregon Benchmark and Key Performance Measure Data

January 2007

Key performance measures from these agencies link	… to these Oregon Benchmarks.
• Blind, Commission for the • Children and Families, State Commission on (OCCF) • Human Services, Department of (DHS) • Medical Examiners, Board of (BME) • Private Health Partnerships, Office of (PHP) formerly Insurance Pool Governing Board (IPGB) • Psychiatric Security Review Board (PSRB) There are no appropriate Oregon Benchmark linkages for the for the following Human Services Subcommittee agencies: Board of Nursing and the Long Term Care Ombudsman	14 Workers Above Poverty 18 Ready to Learn 22 High School Dropout Rate 32 Feeling of Community 39 Teen Pregnancy 40 Prenatal Care 42 Immunizations 43 HIV Diagnosis 44 Adult Non-Smokers 45 Preventable Death 46 Perceived Health Status 48 Child Care Availability 50 Teen Substance Abuse 51 Child Abuse and Neglect 53 Alcohol/Tobacco During Pregnancy 55 Health Insurance 58 Hunger 60 Working Disabled 61 Disabled Living in Poverty 62 Overall Crime 63 Juvenile Arrests 64 Students Carrying Weapons 65 Adult Recidivism 66 Juvenile Recidivism

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ALIGNMENT – HUMAN SERVICES SUBCOMMITTEE AGENCIES

***OREGON SHINES* – OREGON'S STRATEGIC VISION** "A prosperous Oregon that excels in all spheres of life."		
Goal 1 **Quality Jobs for All Oregonians**	**Goal 2** **Safe, Caring and Engaged Communities**	**Goal 3** **Healthy, Sustainable Surroundings**

OREGON BENCHMARKS & LINKED KEY PERFORMANCE MEASURES (KPMS) – ALL AGENCIES

Economy	Education	Civic Engagement	Social Support	Public Safety	Community Development	Environment
Benchmarks #1-17	Benchmarks #18-29	Benchmarks #30-38	Benchmarks #39-61	Benchmarks #62-67	Benchmarks #68-74	Benchmarks #75-91
73 KPMs	65 KPMs	44 KPMs	61 KPMs	39 KPMs	29 KPMs	72 KPMs

KEY PERFORMANCE MEASURES (KPMS) – HUMAN SERVICES AGENCIES

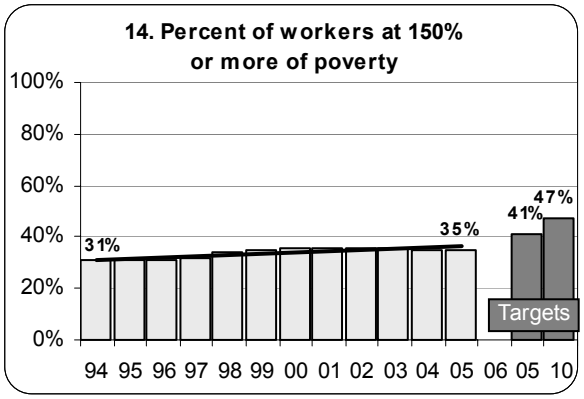
DHS 2 KPMs	OCCF 3 KPMs	OCCF 1 KPM	Blind Comm. 1 Performance Measure	OCCF 1 KPM
			PHP 9 KPMs	PSRB 1 KPM
			DHS 14 KPMs	
			OCCF 3 KPMs	
			BME 4 KPMs	

Oregon Benchmark #14 – Workers Above Poverty

Percent of covered Oregon workers with earnings of 150% or more of the poverty level for a family of four

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #5: The percentage of Temporary Assistance to Needy Families (TANF) adults placed for whom employment is a goal	28		No change
PM #6: The percentage of Temporary Assistance to Needy Families (TANF) cases who do not return, or are off cash assistance 18 months after exit due to employment	30	√	No change
Employment Department			

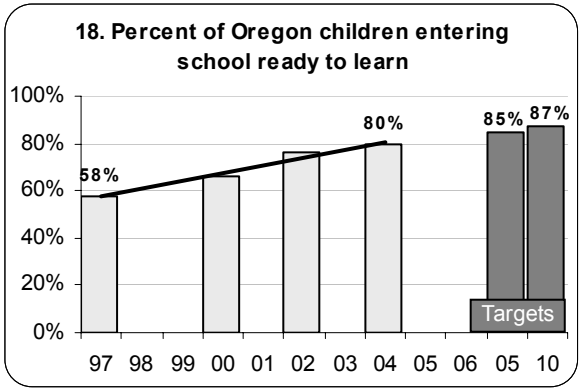


Oregon Benchmark #18 – Ready To Learn

Percent of children entering school ready to learn

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #1: Incidence rate of child maltreatment for children, aged 0 – 2 years, participating in Healthy Start compared to non-served families in the same counties	20	√	Modify
PM #2: Percent of all commission-funded activity outcomes that meet or exceed outcome targets as reported in the FMORS database in quarter 8 of the biennium	22	√	No change
Library, Oregon State			
Education, Oregon Department of			



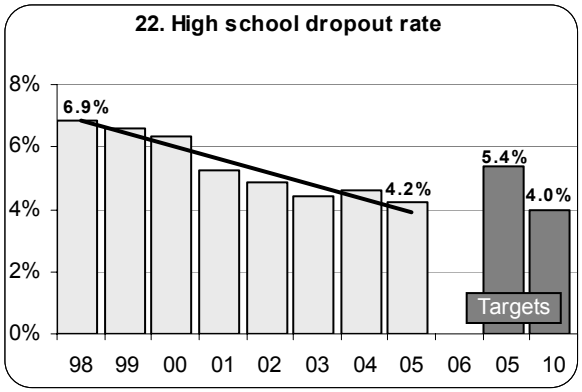
* Each agency self-links its key performance measures to Oregon Benchmarks.
** A "√" in the "Making Progress?" column means the agency indicated that actual data were at or trending toward target achievement in the most recent year shown in the 2006 Annual Performance Progress Report.

Oregon Benchmark #22 – High School Dropout Rate

Percent of students who drop out of grades 9 – 12 without receiving a high school diploma or equivalent

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #2: Percent of all commission-funded activity outcomes that meet or exceed outcome targets as reported in the FMORS database in quarter 8 of the biennium	22	√	No change
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change

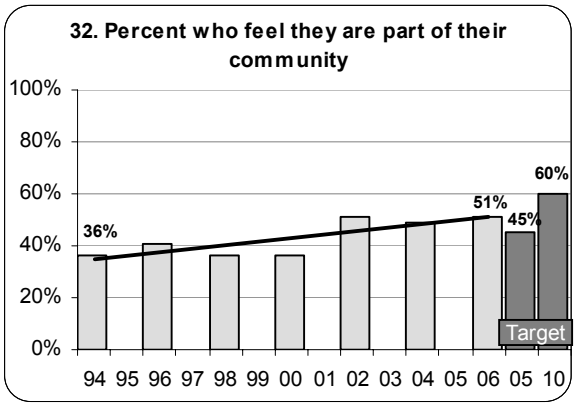


Oregon Benchmark #32 – Feeling of Community

Percent of Oregonians who feel they are a part of their community

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM# 3: Amount of leveraged funds reported biennially in the FMORS database at biennium end	24	√	No change
Land Use Board of Appeals (LUBA)			

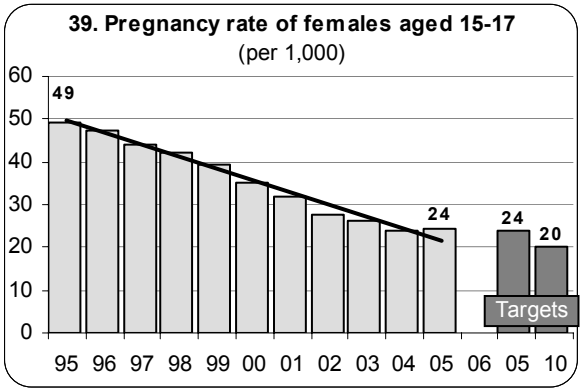


Oregon Benchmark #39 – Teen Pregnancy

Pregnancy rate per 1,000 females, age 15-17

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #7: The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant	32	√	No change
PM #16: The percentage of births where mothers report that the pregnancy was intended	42		Modify



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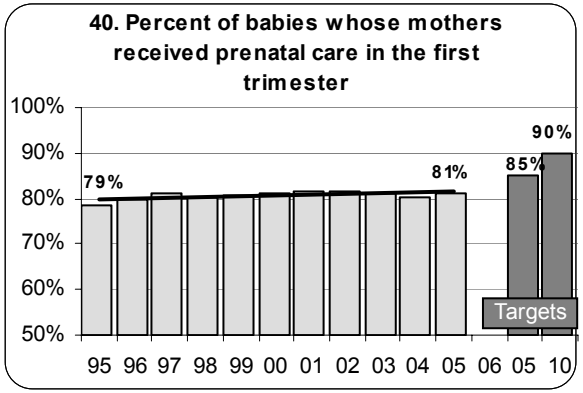
Oregon Benchmark #40 – Prenatal Care

Percent of babies whose mothers received prenatal care beginning in the first trimester

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #17: The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy	44		No change

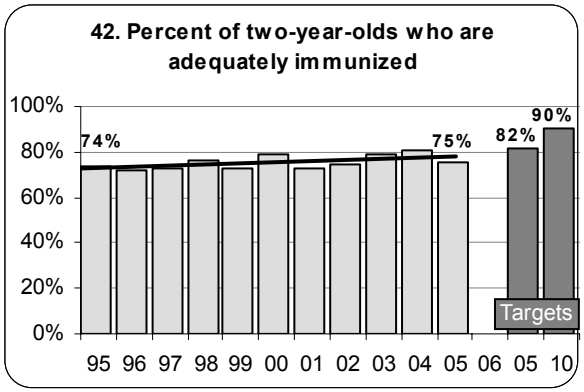


Oregon Benchmark #42 – Immunizations

Percent of two-year-olds who are adequately immunized

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #22: The percentage of 24 – 35 month old children served by local health departments who are adequately immunized	54		Modify



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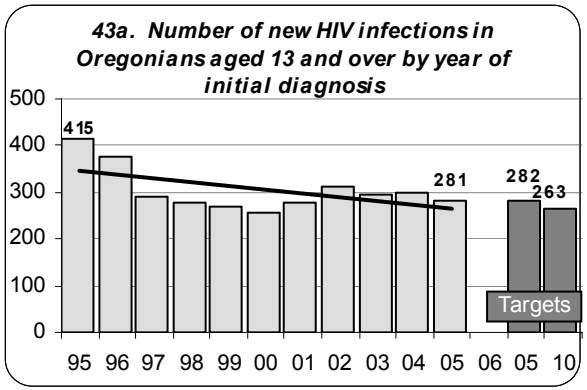
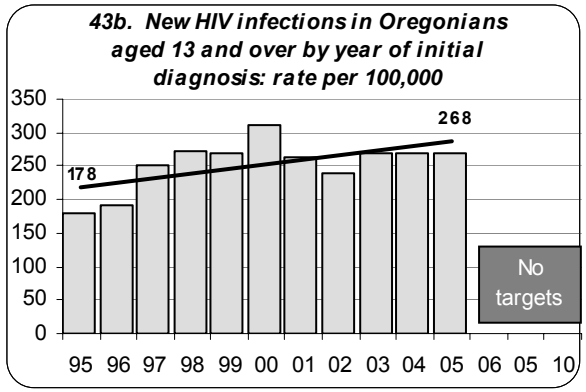
Oregon Benchmark #43 – HIV Diagnosis

Number of new HIV diagnoses among Oregonians aged 13 and older

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #24: Annual rate of HIV infection per 100,000 persons	58		Modify



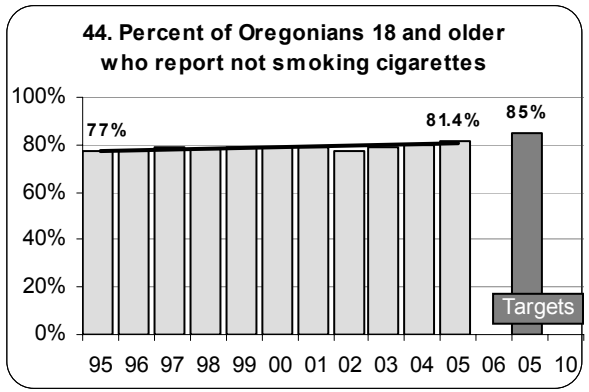


Oregon Benchmark #44 – Adult Non-Smokers

Percent of Oregonians 18 and older who report that they do not currently smoke cigarettes

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM# 18: The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD	46	√	Modify
PM# 20: Tobacco use among: a) adults, b) youth, c) pregnant women	49	√	No change
PM #21: Number of cigarette packs sold per capita	52	√	No change



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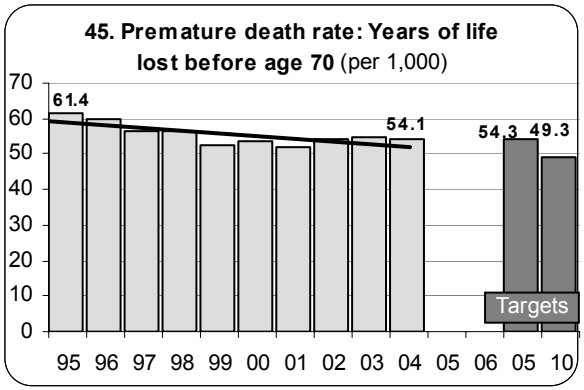
Oregon Benchmark #45 – Preventable Death
Years of life lost before age 70 (rate per 1,000)

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM# 11: Percentage of women subjected to domestic violence in the past year	38		No change
PM# 12: Rate of suicides among adolescents per 100,000	40	√	No change
PM# 20: Tobacco use among: a) adults, b) youth, c) pregnant women	49	√	No change
PM #21: Number of cigarette packs sold per capita	52	√	No change
PM #23: The percentage of adults aged 65 and over who receive an influenza vaccine	56		No change
Medical Examiners, Board of (BME)			
PM# 3: Percentage of disciplinary actions not overturned by appeal	61	√	No change
PM# 4: Percentage of licensees voluntarily entering treatment for substance abuse who meet the terms of the aftercare agreement	62	√	No change
PM # 5: Percentage of total probationers who re-offend within 3 years	63		No change
Police, Department of State			
Transportation, Oregon Department of (ODOT)			



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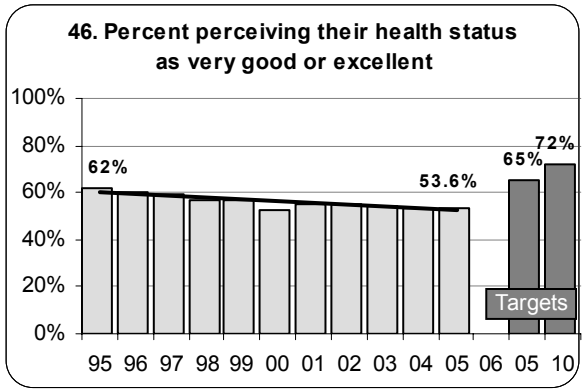
Oregon Benchmark #46 – Perceived Health Status

Percent of adults whose self-perceived health status is very good or excellent

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Medical Examiners, Board of (BME)	Page	Making Progress?**	Proposed change in 2007-09
PM #2: Percentage of forms requesting services that were generated from the web site	60	√	Delete
PM #3: Percentage of disciplinary actions not overturned by appeal	61	√	No change
PM #4: Percentage of licensees voluntarily entering treatment for substance abuse who meet the terms of the aftercare agreement	62	√	No change
PM #5: Percentage of total probationers who re-offend within 3 years	63		No change

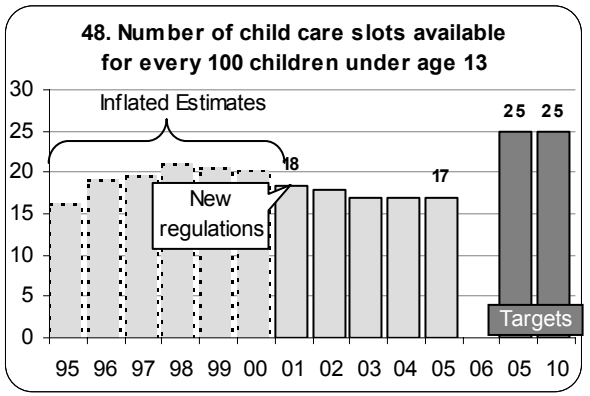


Oregon Benchmark #48 – Child Care Availability

Number of child care slots available for every 100 children under age 13

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #2: Percent of all commission-funded activity outcomes meeting targets as reported in the Fiscal, Monitoring & Outcomes Reporting System database	22	√	No change
Employment Department			



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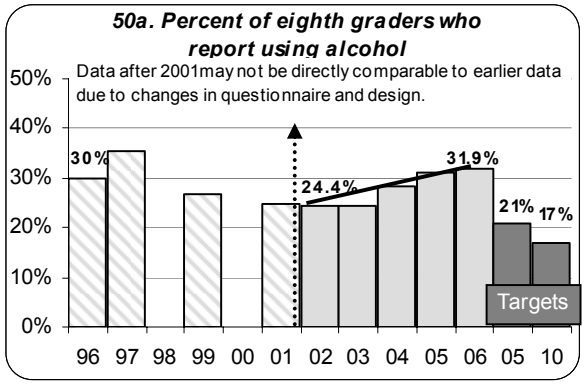
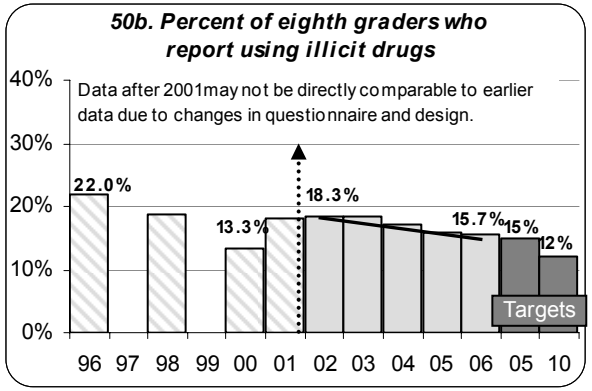
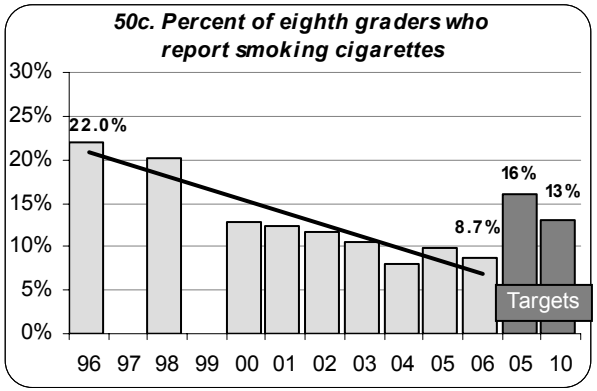
Oregon Benchmark #50 – Teen Substance Abuse
Percent of 8th grade students who report using in the previous month: a. alcohol, b. illicit drugs, c. cigarettes

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #18: The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD	46	√	Modify
PM #19: Percentage of 8th graders at high risk for alcohol and other drug use	47		No change
PM #20b:Tobacco use among youth	49	√	No change
PM #21: Number of cigarette packs sold per capita	52	√	No change
Children and Families, State Commission on (OCCF)			
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change
Liquor Control Commission (LCC)			







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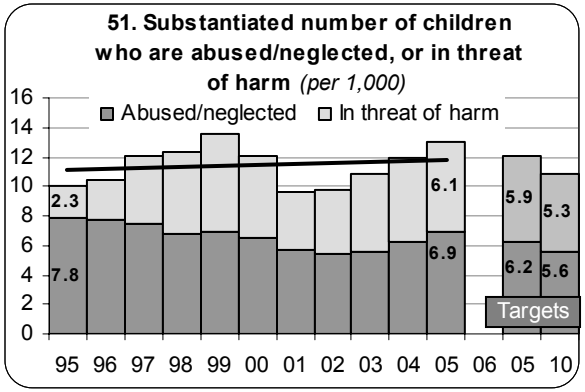
Oregon Benchmark #51 – Child Abuse and Neglect

Substantiated number of children, per 1,000 persons under 18, who are: a. neglected/abused, b. at a substantial risk of being neglected or abused

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #1: To have the incidence rate of child maltreatment lower for children, aged 0 - 2 years, participating in Healthy Start than for non-served families in the same counties	20	√	Modify
PM #2: Percent of all commission-funded activity outcomes meeting targets as reported in the Fiscal, Monitoring & Outcomes Reporting System database	22	√	No change
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change

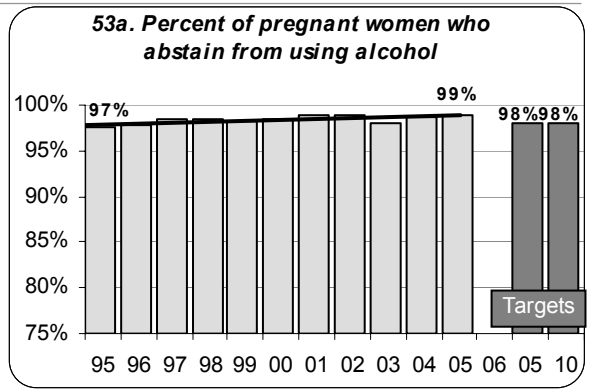


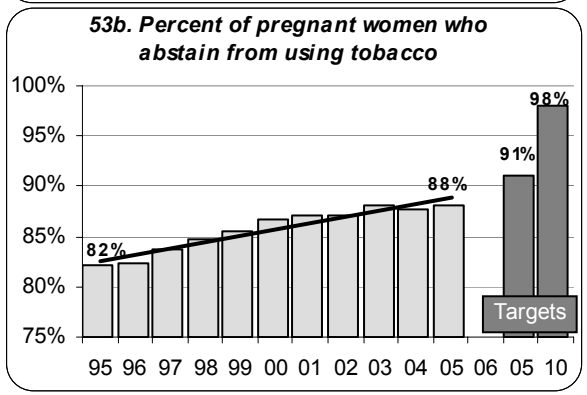
Oregon Benchmark #53 – Alcohol/Tobacco Use During Pregnancy

Percent of pregnant women who report not using: a. alcohol, b. tobacco

Human Services Subcommittee agencies are in bold.
All agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #18: The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD	46	√	Modify
PM #20c:Tobacco use among pregnant women	49	√	No change
PM #21: Number of cigarette packs sold per capita	52	√	No change





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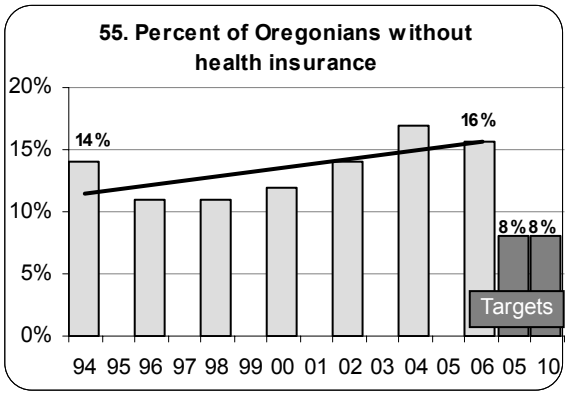
Oregon Benchmark #55 – Health Insurance
Percent of Oregonians without health insurance

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Private Health Partnerships, Office of (PHP)	Page	Making Progress?**	Proposed change in 2007-09
PM #1: Number of referrals made to insurance agents involved in the Agent Referral Program	64	√	Delete
PM #2: Number of training sessions or presentations made to insurance agents, community partners, and stakeholders	66	√	Delete
PM #3: Number of insurance agents, community partners, and stakeholders trained	68	√	Modify
PM #4: Number of Oregonians enrolled in the Family Health Insurance Assistance Program (FHIAP) for health insurance subsidies	70	√	Modify
PM #5: Percent of Oregonians deemed eligible for FHIAP who are enrolled in health insurance	72	√	Delete
PM #6: FHIAP administrative expenses as a percentage of total cost	74	√	Modify
PM #8: Number of businesses who purchase an OPHP certified plan	76		Delete
PM #9: Number of children enrolled in an OPHP Children's Group Plan	78		Delete
PM #10: Percent of customers rating their overall satisfaction with the agency "good" or "excellent" for: Timeliness, accuracy, helpfulness, expertise, and information availability	80	√	Modify
Administrative Services, Department of (DAS)			
Consumer and Business Services, Department of (DCBS)			



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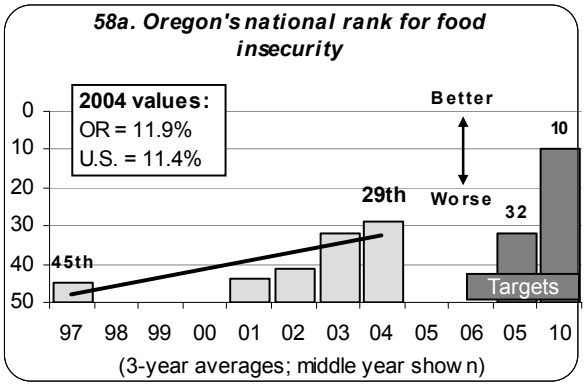
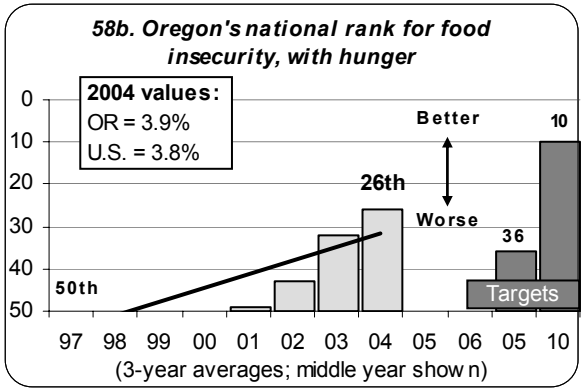
Oregon Benchmark #58 – Hunger
Oregon's national rank for percent of households that are: a. food insecure (limited access to enough food for all household members to live a healthy, active life), b. Food insecure with hunger (at least one member has experienced hunger within the last year)

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #10: The ratio of Oregonians receiving food stamp assistance to the number of Oregonians living in poverty	36		No change
Housing and Community Services, Oregon Department of (OHCS)			





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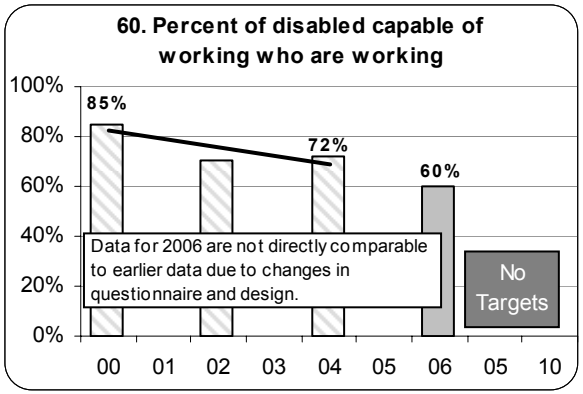
Oregon Benchmark #60 – Working Disabled

Percent of adults with lasting, significant disabilities who are capable of working who are employed

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Blind, Commission for the	Page	Making Progress?**	Proposed change in 2007-09
PM #1: Percentage of individuals who enter into individualized plans for employment in the vocational rehabilitation program who are successful in reaching their outcome	18	√	No change
Transportation, Oregon Department of (ODOT)			

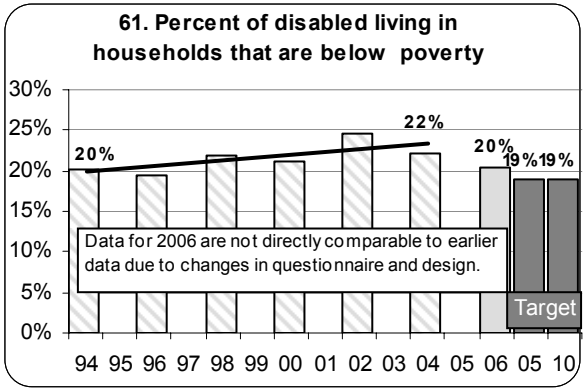


Oregon Benchmark #61 – Disabled Living in Poverty

Percent of Oregonians with lasting, significant disabilities living in households with incomes below the federal poverty level

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Human Services, Department of (DHS)	Page	Making Progress?**	Proposed change in 2007-09
PM #9: Average monthly earnings for persons with developmental disabilities who receive Seniors and People with Disabilities (SPD) services.	34	√	No change



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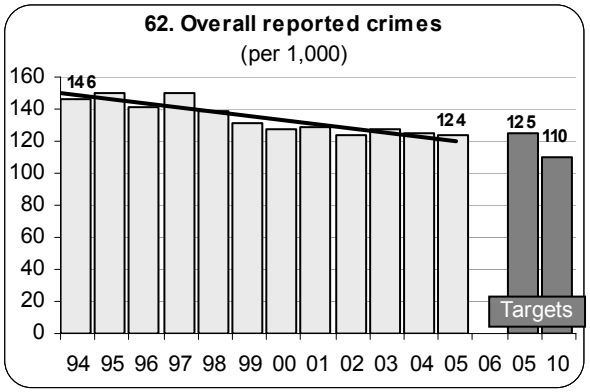
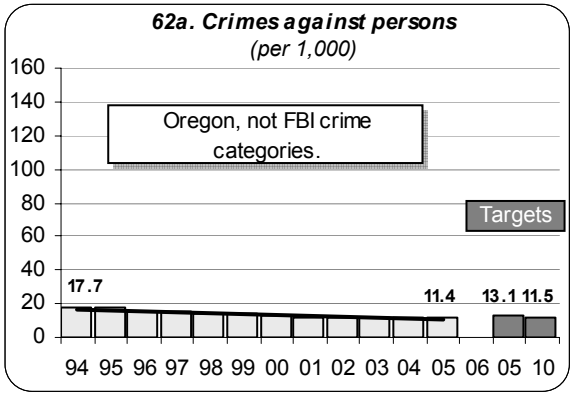
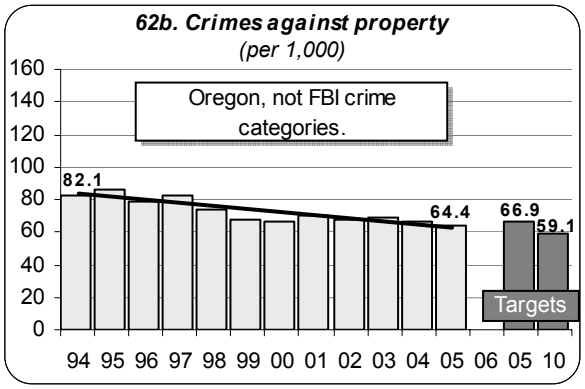
Oregon Benchmark #62 – Overall Crime
Overall reported crimes per 1,000 Oregonians: a. person crimes, b. property crimes, c. behavior crimes

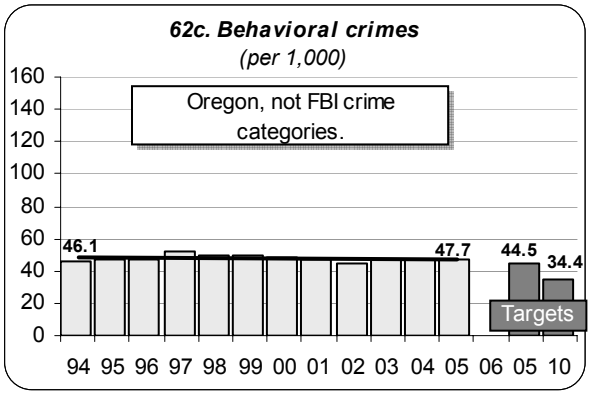
Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change
Justice, Department of			
Police, Department of State			









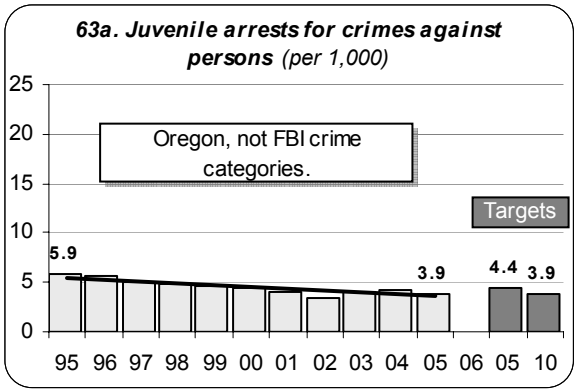
* Each agency self-links its key performance measures to Oregon Benchmarks.
** A "√" in the "Making Progress?" column means the agency indicated that actual data were at or trending toward target achievement in the most recent year shown in the 2006 Annual Performance Progress Report.

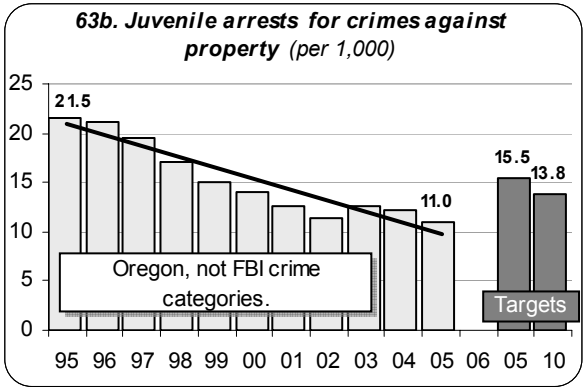
Oregon Benchmark #63 – Juvenile Arrests

Juvenile arrests per 1,000 juvenile Oregonians per year, a. person crimes, b. property crimes

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change
Youth Authority, Oregon (OYA)			
Police, Department of State			



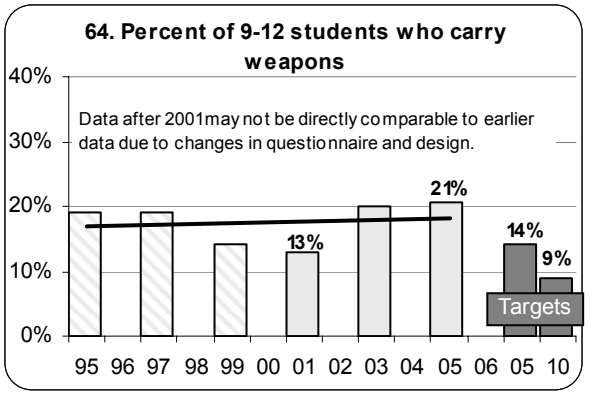


Oregon Benchmark #64 – Students Carrying Weapons

Percent of students in grades 9 – 12 who report carrying weapons in the last 30 days

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change
Education, Oregon Department of			



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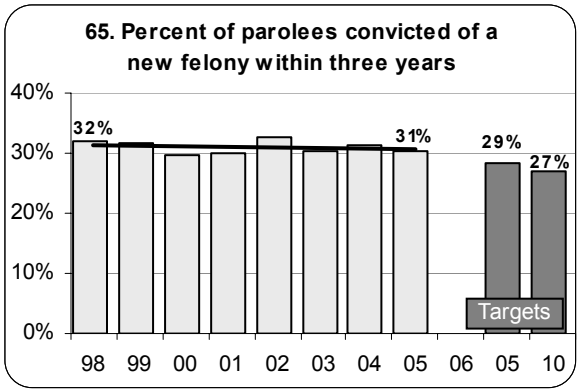
** A "√" in the "Making Progress?" column means the agency indicated that actual data were at or trending toward target achievement in the most recent year shown in the 2006 Annual Performance Progress Report.

Oregon Benchmark #65 – Adult Recidivism

Percent of paroled offenders convicted of a new felony within three years of initial release

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change
Psychiatric Security Review Board (PSRB)			
PM #1: Percent of revocations of conditional release based on commission of felony	82		No change
Corrections, Department of			
Parole and Post-Prison Supervision, Board of			

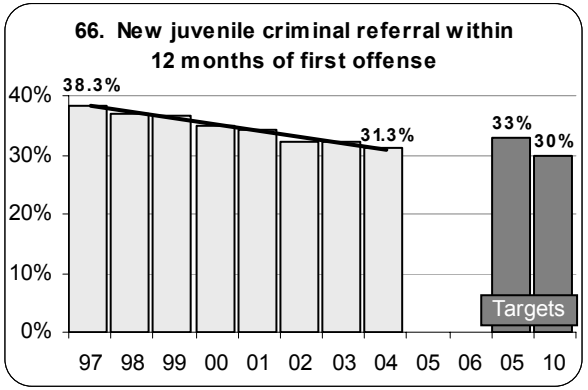


Oregon Benchmark #66 – Juvenile Recidivism

Percent of juveniles with a new criminal referral to a county juvenile department within 12 months of the initial criminal offense

Human Services Subcommittee agencies are in bold.
All other agencies linking to this benchmark are in italics.

Children and Families, State Commission on (OCCF)	Page	Making Progress?**	Proposed change in 2007-09
PM #4: Percent of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease	26		No change
Youth Authority, Oregon (OYA)			



* Each agency self-links its key performance measures to Oregon Benchmarks.
** A "√" in the "Making Progress?" column means the agency indicated that actual data were at or trending toward target achievement in the most recent year shown in the 2006 Annual Performance Progress Report.

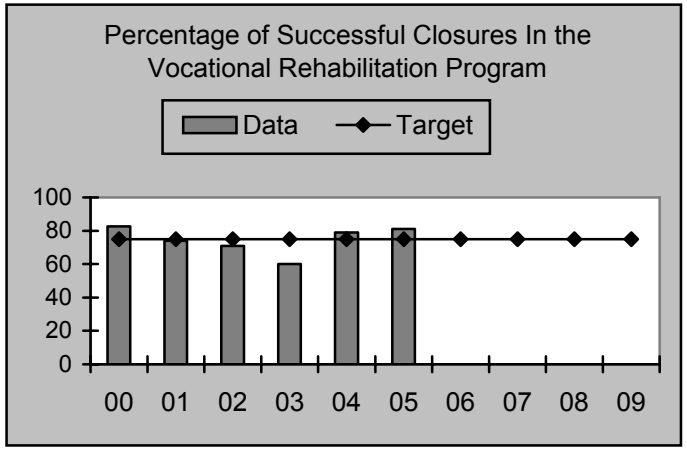
ANNUAL PERFORMANCE PROGRESS REPORT EXCERPTS

Benchmark-Linked Key Performance Measures
from
Human Services Subcommittee Agencies

The following pages have been excerpted and reformatted from
FY 2006 Annual Performance Progress Reports found at
http://www.oregon.gov/DAS/OPB/APPR06.shtml.

KPM #1	Employment - Percentage of individuals who enter into individualized plans for employment in the vocational rehabilitation program who are successful in reaching their outcome	Measure since: 1997
Goal	To assist blind Oregonians with employment in order to fully participate in society	
Oregon Context	#59, Number of adults with disabilities who are capable of working who are employed.	
Data source	Automated Case Management System	
Owner	Rehabilitation Services, Dacia Johnson, 971-673-1588	

1. **OUR STRATEGY** - the agency focuses on providing high quality, state of the art, individualized rehabilitation services to eligible blind Oregonians in order to assist them in reaching their employment goals. We believe that a holistic approach to rehabilitation leads to long term, successful outcomes. We believe that given the right tools and resources that blind Oregonians can fully participate in employment and achieve their full potential in the workforce.



2. **ABOUT THE TARGETS**
The target is higher than national standard of 68.9%. We believe in maintaining a high standard of excellence.

3. **HOW WE ARE DOING**
We continue to do well, which indicates that our service delivery approach continues to be effective in reaching the overall program objective.

4. **HOW WE COMPARE**
We continue to exceed the national average for blind agencies. The national standard is 68.9%.

5. **FACTORS AFFECTING RESULTS**
Since we are a voluntary program, individuals can select not to complete their program. In addition, another factor that can affect the employment outcome is the economy within the state and the specific area in which the person is residing.

6. **WHAT NEEDS TO BE DONE**
The agency will continue to work with our staff, commissioners, and constituents to find creative ways to improve our service delivery system in order to improve our outcomes. An example of this is that we have developed a healthy lifestyles program within our residential training center that focuses on dietary improvement and exercise. This program has demonstrated early on to significantly improve the health of the volunteers who have participated. We expect that if clients health improves, their employment outlook will also improve.

7. **ABOUT THE DATA**
This data is from Federal Fiscal Year 2005. It is captured from the automated case management system.

#1 **Employment Rate- Percentage of individuals who enter into individualized plans for employment in the vocational rehabilitation program who are successful in reaching their outcome.**

Goal(s): To ensure that as many blind Oregonians as possible seeking employment are successful in reaching their goal.
HLO(s): OBM # 59- Percentage of adults with lasting, significant disabilities who are capable of work who are employed.
Strategy: Provide comprehensive, state of the art vocational rehabilitation services to eligible blind Oregonians
Source: Automated Case Management Database
Owner: Dacia Johnson, Director of Rehabilitation Services, 971-673-1588

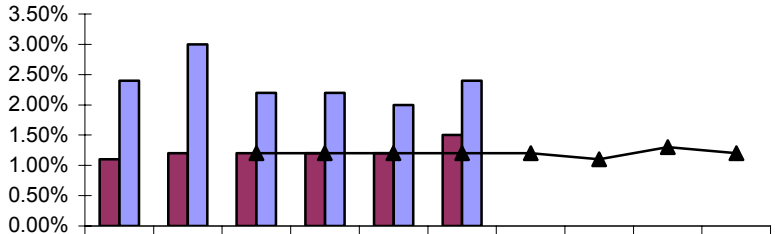
DATA:	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Cycle: FFY
Actual	82.6%	74%	71%	60%	79%	81%					
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	

KPM #42300-1	HEALTHY START PARTICIPANTS To have the incidence rate of child maltreatment lower for children, aged 0 – 2 years, participating in Healthy Start than for non-served families in the same counties.	**Measure since: 1999**
Goal	This KPM links to the OCCF's goal to "fund services that promote positive outcomes for children and their families consistent with the local plan."	
Oregon Context	Reduce Child Maltreatment [OBM 50], Improve Readiness to Learn [OBM 18]	
Data source	NPC data collection	
Owner	Pat Pitman, Pat.Pitman@state.or.us, 503.378.4658	

1. **OUR STRATEGY**
   The goal of the performance measure is to reduce the rate of child maltreatment in order to promote positive outcomes for children and their families in the state of Oregon. The strategy is to implement best practice programming with regard to the reduction of child maltreatment while addressing local needs and resources. Partners include the Partners for Children and Families, local providers, local and state agencies and community organizations.

2. **ABOUT THE TARGETS**
   The targets were set at rates which would be lower than that of the general population while still maintaining tangible goals for local providers and partners. The desired direction is down.

Incidence Rate of Child Maltreatment, Healthy Start Participants vs. Nonserved Families



	00	01	02	03	04	05	06	07	08	09
Actual	1.10%	1.20%	1.20%	1.20%	1.20%	1.50%				
Nonserved	2.40%	3.00%	2.20%	2.20%	2.00%	2.40%				
Target			1.20%	1.20%	1.20%	1.20%	1.20%	1.10%	1.30%	1.20%

3. **HOW WE ARE DOING**
   The agency has consistently been on target with the exception of the 2005 results. In 2005 the rate of maltreatment increased from 12/1000 to 15/1000. In addition to the Healthy Start Family increases there was also an increase in general population maltreatment rates.

4. **HOW WE COMPARE**
   The KPM is a comparison between the family participants of the Healthy Start programs versus the Non-Healthy Start families. In comparison to families not enrolled in the Healthy Start program, those who participate in the program have a rate of child maltreatment that is lower. During the comparison of partcipants versus non participants it is important to also note that Healthy Start families are already defined as high risk families for maltreatment. Consequently, the results demonstrate that higher risk families have a lower child maltreatment rate than the general population.

5. **FACTORS AFFECTING RESULTS**
   One of the major factors affecting the 2005 results has been the methamphetamines epidemic across the state of Oregon. This, along with other environmental factors, has increased the rate of child maltreatment for both the general population as well as families being served in Healthy Start. While the nonserved families' child maltreatment rate has increased from 20/1000 to 24/1000, the Healthy Start family child maltreatment rate has only increased from 12/1000 to 15/1000. Overall, the data indicates that children served by Healthy Start had a lower victimization rate than nonserved children similar to prior years despite the increase in substantiated abuse reports throughout the state.

The State Commission on Children & Families
Excerpt from FY 2006 Annual Performance Progress Report found at http://www.oregon.gov/DAS/OPB/APPR06.shtml

Note: Oregon Benchmarks were renumbered in 2006, so some benchmark references under "Oregon Context" may be off by one.

6. **WHAT NEEDS TO BE DONE**
   The most pressing issue to be addressed by program staff and data analysts is the increase in general maltreatment rates and the factors affecting those increases. A better assessment of how child maltreatment is changing and whether this is a long term trend or a short term reaction and an examination of current program operations to proactively address new issues affecting maltreatment will help the Healthy Start program to adjust for the future.

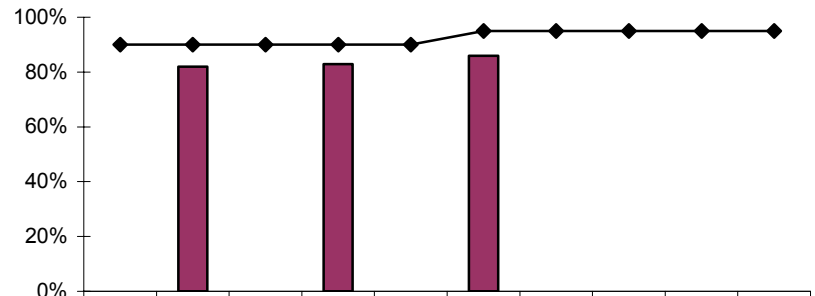
7. **ABOUT THE DATA**
   The reporting cycle for the performance measure is the Oregon fiscal year (recently changing from the calendar year). The data is collected by a research firm, then compiled and analyzed in collaboration with the agency. Each year a report is issued and distributed to interested parties. To receive more information or additional data please contact the primary contact on this report or visit the agency website.

KPM #42300-2	LOCAL PLAN OUTCOMES % of all commission-funded activity outcomes meeting targets as reported in the Fiscal, Monitoring & Outcomes Reporting System database.	**Measure since: 1999**
Goal	This KPM links to the OCCF's goal to "fund services that promote positive outcomes for children and their families consistent with the local plan."	
Oregon Context	Improve readiness to learn [OBM 18], Reduce high school dropout rate [OBM 22], Increase childcare availability [OBM 48], Reduce child maltreatment [OBM 50]	
Data source	FMORS Database, Fiscal, Monitoring & Outcomes Reporting System Database	
Owner	Matthew Tschabold, matthew.tschabold@state.or.us, 503.378.5175	

1. **OUR STRATEGY**
   The goal of the performance measure is to increase the percentage of programs which produce positive outcomes for children and their families in the state of Oregon. The strategy is to implement a range of programming with regard to positive results for children and their families while addressing local needs and resources. Partners include the Partners for Children and Families, local providers, local and state agencies and community organizations.

2. **ABOUT THE TARGETS**
   The targets were set at a rate which was determined to be tangible as well as effective. As improvements are continually made changes in the targets values are made. The targets are designed to allow for constant improvement for the local providers and partners. The desired direction is up.

Percent of Outcomes that Meet of Exceed Targets



	00	01	02	03	04	05	06	07	08	09
Actual		82%		83%		86%				
Target	90%	90%	90%	90%	90%	95%	95%	95%	95%	95%

3. **HOW WE ARE DOING**
   For the last three reporting periods the agency has been consistently under target, but there is steady improvement from year to year towards the target values.

1. **HOW WE COMPARE**
   The agency is not currently aware of any similar industry measurments.

2. **FACTORS AFFECTING RESULTS**

The State Commission on Children & Families
Excerpt from FY 2006 Annual Performance Progress Report found at http://www.oregon.gov/DAS/OPB/APPR06.shtml

Note: Oregon Benchmarks were renumbered in 2006, so some benchmark references under "Oregon Context" may be off by one.

There are a number of factors which affect the results of local outcomes reaching targets. These factors are generally environmental on local levels and change with program variety and time. Within the agency, significant factors include the successfulness in local assessment and comprehensive planning development, as well as training in strategy and goal setting.

3. **WHAT NEEDS TO BE DONE**
   As the comprehensive planning process begins in 2007, accurate local assessment of needs is a top priority. Correctly identifying the issues affecting communities, designing strong strategy and implementing effective solutions are essential to increase the success of the performance measure.

4. **ABOUT THE DATA**
   Data is reported on a biennial basis after the close of each Oregon Biennium. Some of the strengths of the data are its comprehensiveness, continuous revisions and usability. One of the main weaknesses of the data is the flexibility of the current database system. To verify reliability there is a review process every other quarter of the fiscal year to examine information accuracy and completeness. To receive more information or additional data please contact the primary contact on this report or visit the agency website.

KPM #42300-3	LEVERAGED FUNDS Amount of leveraged funds reported in the Fiscal, Monitoring & Outcomes Reporting System database.	**Measure since: 1999**
Goal	This KPM links to the OCCF's goal to "engage citizens and public and private partners in positive change for the community's children and families."	
Oregon Context	% of Oregonian who feel they are a part of their community [OBM 32],	
Data source	FMORS Database, Fiscal, Monitoring & Outcomes Reporting System Database	
Owner	Matthew Tschabold, matthew.tschabold@state.or.us, 503.378.5175	

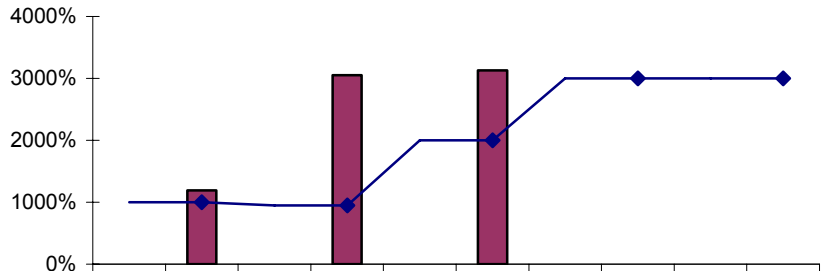
1. **OUR STRATEGY**
   The goal of the performance measure is to mobilize community support in order to develop and implement plans and programming that will promote positive outcomes for children and their families in the state of Oregon. The strategy is to use agency funding to initiate conversation, partnerships and governmental agency synergy while addressing local needs and resources. Partners include the Partners for Children and Families, local providers, local and state agencies and community organizations.

2. **ABOUT THE TARGETS**
   Targets were set based on available information and then adjusted as reported results changed. The desired direction is up.

3. **HOW WE ARE DOING**
   The agency has consistently exceeded the target values every reporting period with increasing targets and results.

4. **HOW WE COMPARE**
   The agency is not currently aware of any similar industry measurments.

Amount of Leveraged Funds Reported Biennially in FMORS



	00	01	02	03	04	05	06	07	08	09
Actual		$11.9		$30.5		$31.3				
Target	$10.0	$10.0	$9.5	$9.5	$20.0	$20.0	$30.0	$30.0	$30.0	$30.0

5. **FACTORS AFFECTING RESULTS**
   One of the major factors affecting the leveraging of resources is budget growth and constraints. As budget constraints have affected state agencies, the amount of resource development and leveraging has increased to compensate. But it is important to realize that the continually increasing leverage is not sustainable and market saturation will occur. This saturation will lead to a leveling out, and perhaps even a decline, in the amount of funds which can be leveraged. Secondary factors affecting the performance measure are primarily environmental factors that affect the ability of partners to contribute resources (economy, legal, etc)

6. **WHAT NEEDS TO BE DONE**
   Continual improvement of leveraging training & techniques and sustainability on local levels is a priority in order to continue the current success of the performance measure.

The State Commission on Children & Families
Excerpt from FY 2006 Annual Performance Progress Report found at http://www.oregon.gov/DAS/OPB/APPR06.shtml

Note: Oregon Benchmarks were renumbered in 2006, so some benchmark references under "Oregon Context" may be off by one.

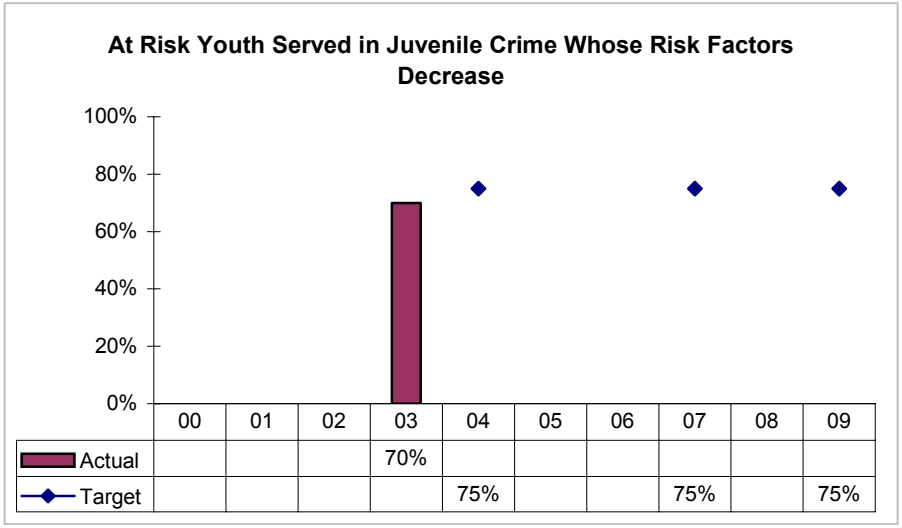
7. **ABOUT THE DATA**

Data is reported on a biennial basis after the close of each Oregon Biennium. Some of the strengths of the data are its comprehensiveness, continuous revisions and usability. One of the main weaknesses of the data is the flexibility of the current database system. To verify reliability there is a review process every other quarter of the fiscal year to examine information accuracy and completeness. To receive more information or additional data please contact the primary contact on this report or visit the agency website.

The State Commission on Children & Families

The agency links this performance measure to Oregon Benchmark(s): #22, High School Dropout Rate; #50, Teen Substance Abuse; #51, Child Abuse or Neglect; #62, Overall Crime; #63, Juvenile Arrests; #64, Students Carrying Weapons; #65, Adult Recidivism; and #66, Juvenile Recidivism

KPM #42300-4	JUVENILE CRIME PREVENTION % of at-risk youth served in juvenile crime prevention grant programs whose risk factors decrease.	Measure since: 2003
Goal	Develop effective juvenile crime prevention strategies.	
Oregon Context	Decrease eighth grade alcohol abuse [OBM 49a], Decrease eighth grade illicit drug abuse [OBM 49b], Decrease juvenile arrests [OBM 62], Decrease juvenile recidivism [OBM 65], Reduce high school dropout rate [OBM 22], Reduce child maltreatment [OBM 50], Reduce overall crime [OBM 61], Reduce students carrying weapons [OBM 63], reduce adult recidivism [OBM 64]	
Data source	NPC data collection; near completion of a new database	
Owner	Mickey Lansing, Mickey.Lansing@state.or.us, 503.378.5128	



1. **OUR STRATEGY**
   The goal of the performance measure is to prevent and reduce juvenile crime in order to promote positive outcomes for children and their families in the state of Oregon. The strategy is to implement best practice programming with regard to juvenile crime while addressing local needs and resources. Partners include the Partners for Children and Families, local providers, local and state agencies and community organizations.

2. **ABOUT THE TARGETS**
   The targets were set based on available information and will be adjusted as new data becomes available. The desired direction is up.

3. **HOW WE ARE DOING**
   Current information places the actual values below the target value, but additional data is needed to assess improvement over time.

4. **HOW WE COMPARE**
   Currently the information available does not allow for a comparison across industires or agencies.

5. **FACTORS AFFECTING RESULTS**
   Currently only preliminary data is available and for an investigation into the impact of results factors to occur, there will need to be multiple years of data.

6. **WHAT NEEDS TO BE DONE**
   The most pressing issue identified by program staff and data analysts being addressed is the inadequacy of the JCP database collection system discussed in bullet 7. As a result the development and implementation of a new database, the transition from paper records to data based entered information is the top priority.

7. **ABOUT THE DATA**
   The data is reported on a biennial basis through the agency web based database system. Since the transfer of Juvenile Crime Prevention the database was found to be inadequate. As a result an emergency working group was created to design and create a new information system. The new database was recently

The State Commission on Children & Families
Excerpt from FY 2006 Annual Performance Progress Report found at http://www.oregon.gov/DAS/OPB/APPR06.shtml

Note: Oregon Benchmarks were renumbered in 2006, so some benchmark references under “Oregon Context” may be off by one.

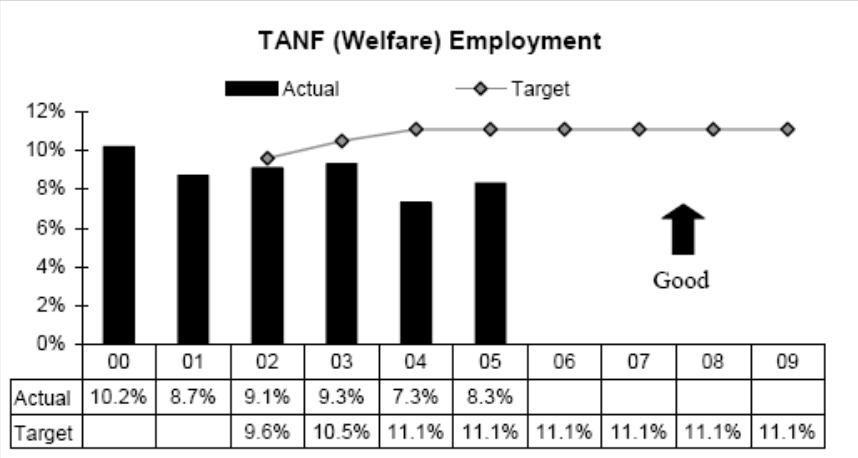
The agency links this performance measure to Oregon Benchmark(s): #22, High School Dropout Rate; #50, Teen Substance Abuse; #51, Child Abuse or Neglect; #62, Overall Crime; #63, Juvenile Arrests; #64, Students Carrying Weapons; #65, Adult Recidivism; and #66, Juvenile Recidivism

completed and trainings are currently underway. As a result, providers and partners have been keeping local records of their respective information and will be entering the information into the system over the coming months. To receive more information or additional data please contact the primary contact on this report or visit the agency website.

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.

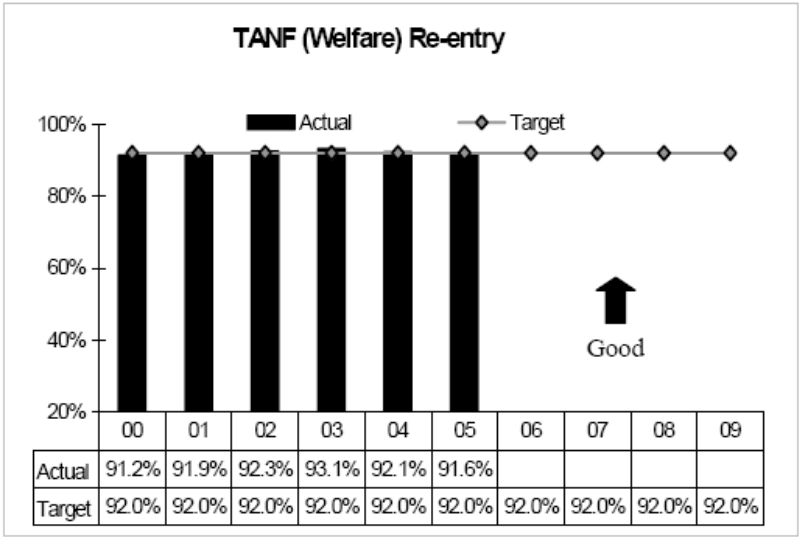
7. **ABOUT THE DATA**
Reporting cycle – calendar year. The data represented is run on a monthly basis, but reported annually. Monthly reports are issued on a monthly basis and studied for any potential anomalies, as well as to identify trends in performance. The data is sent to program managers and interested 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%	91.6%				
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**

92.1% 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. Since 2002 DHS has either met or exceeded the target for this measure.

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 level of high performance does not indicate any need for adjustments in this area; however, this may change after analysis of new TANF regulations from the Deficit Reduction Act of 2005 has been finalized.

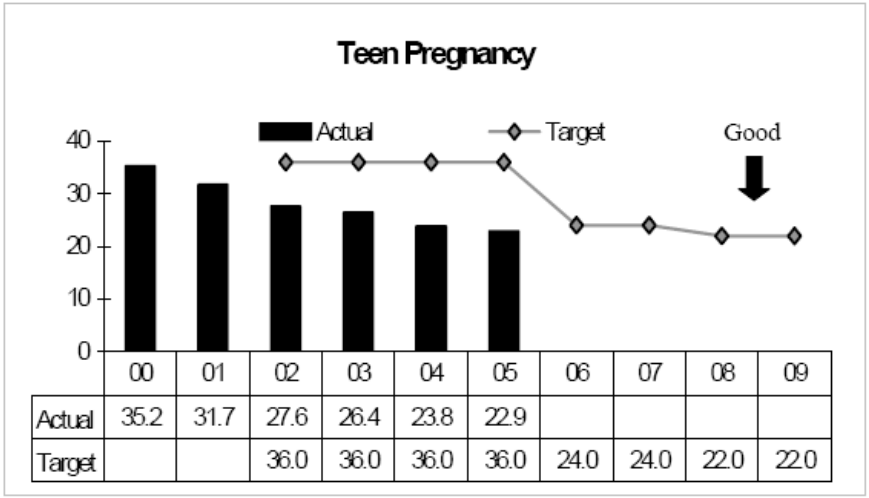
7. **ABOUT THE DATA**
   Reporting cycle – calendar year. The methodology and criteria used to obtain the data is adjusted as program changes occur, to ensure the validity of the data. Recidivism and Placement reports are issued separately, on a monthly basis and studied for any potential anomalies,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

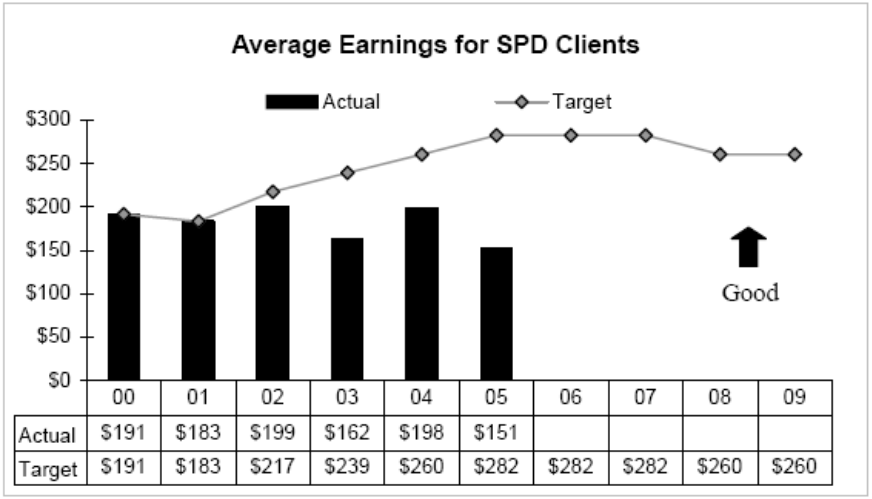
- Be long-term
- Be comprehensive
- Reach young people before they are sexually active and continue after they begin sexual activity
- Consider underlying risks and contributing factors, such as poverty and sexual abuse
- Utilize culturally sensitive approaches

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 #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

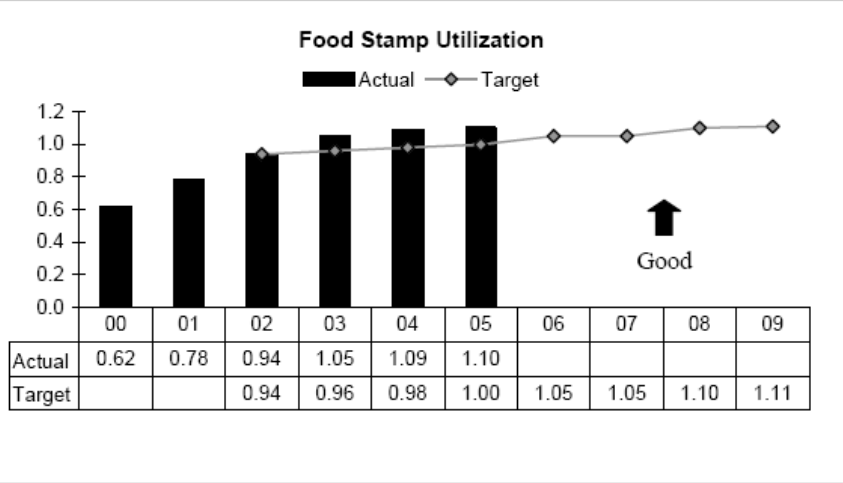
Full Employment Outcomes Report is available at http://www.oregon.gov/DHS/spd/data/.

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.

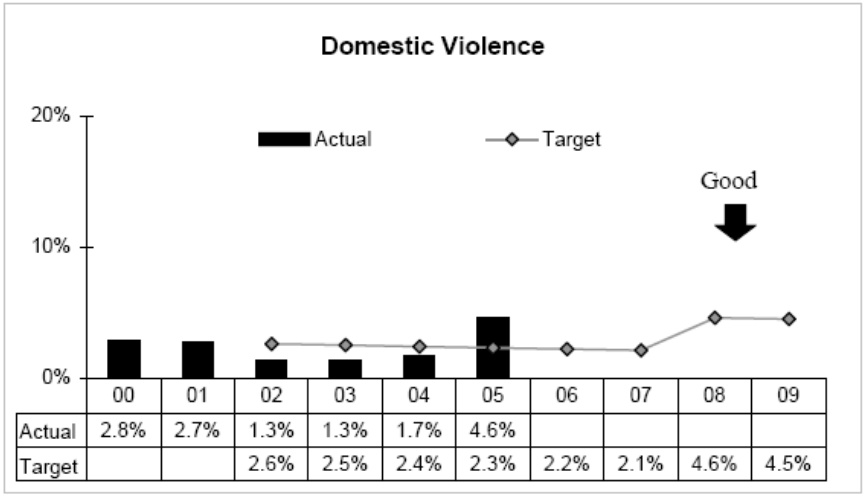
7. **ABOUT THE DATA**
   Reporting cycle - federal fiscal year. The Food Stamp Management Information system is compared to Census estimates of Oregonians living at or below the federal poverty level.

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.

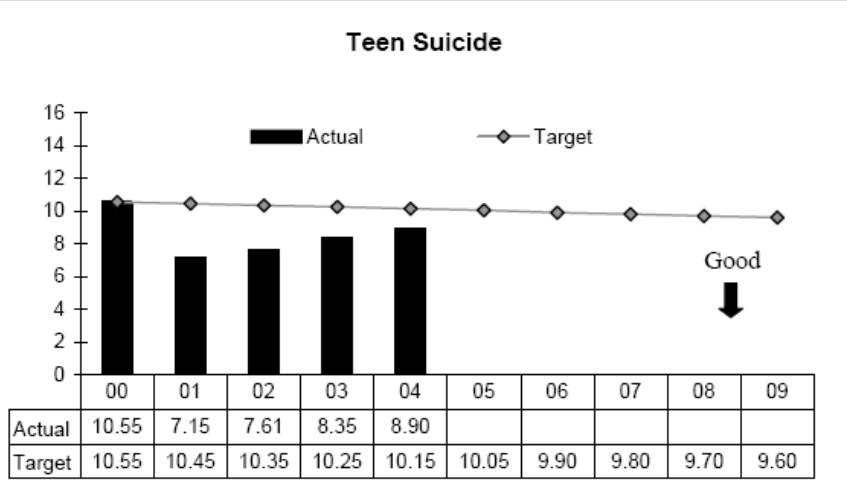
6. **WHAT NEEDS TO BE DONE**
   The state needs funds to implement prevention activities as a means to reducing the incidence of violence. Responding alone will not reduce violence. The state needs to implement evaluation of existing response programs. A public health data system is necessary to better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

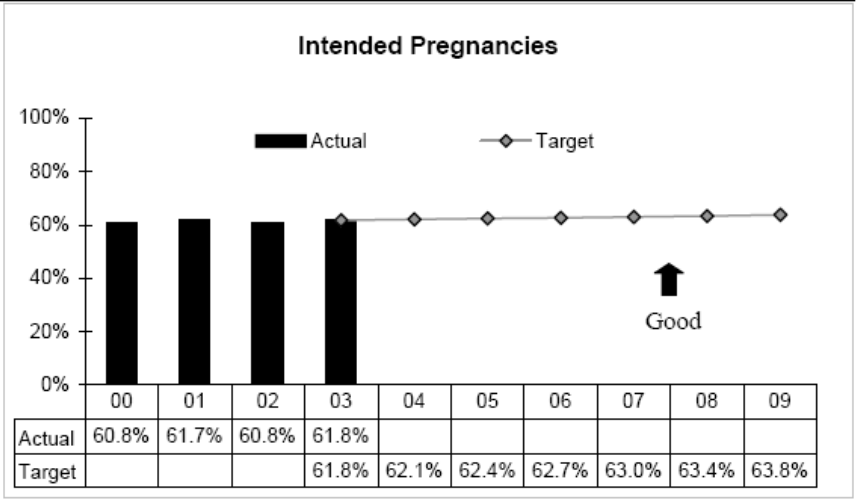
KPM #16	INTENDED PREGNANCIES The percentage of births where mothers report that the pregnancy was intended.*	Measure since: 2006
Goal	INTENDED PREGNANCY: Healthy – People are healthy.	
Oregon Context	Teen pregnancy	
Data source	Public Health Division, Office of Family Health, Pregnancy Risk Assessment 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

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.



	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%

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.

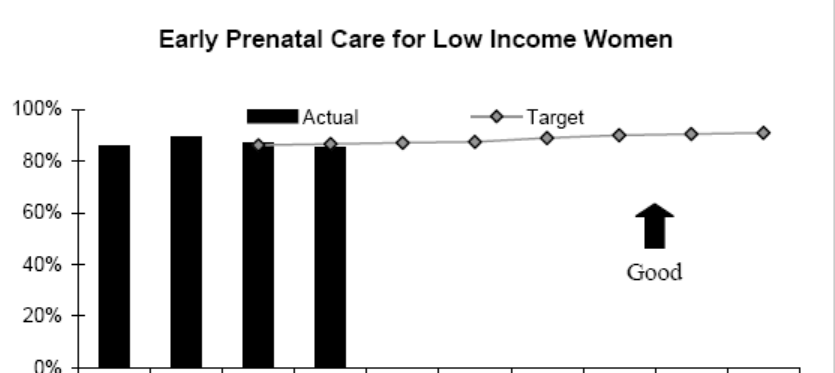
7. **ABOUT THE DATA**
   Reporting cycle - calendar year. The foremost strength of the data is that they directly reflect women's own reports of pregnancy intent; the population-based design and high response rate of the PRAMS survey are also strengths. The primary limitation of the data is that the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



	00	01	02	03	04	05	06	07	08	09
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.

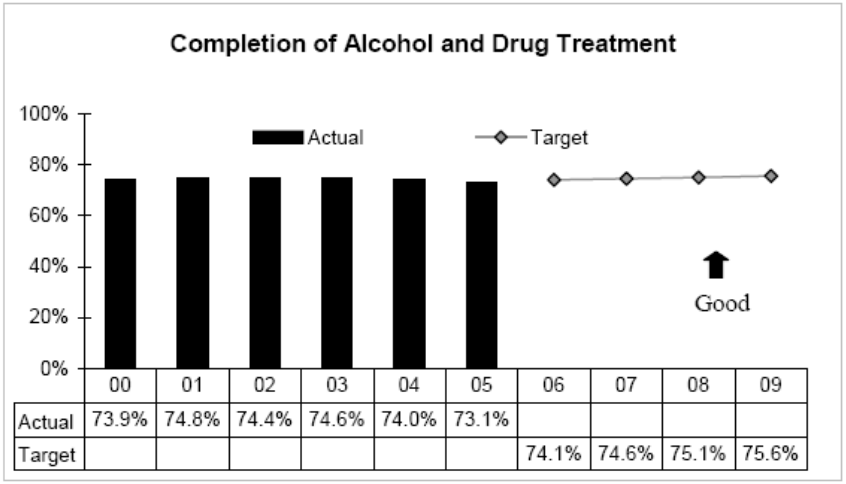
6. **WHAT NEEDS TO BE DONE**
Trends will continue to be tracked, comparing low-income Medicaid and non-Medicaid women for the entire state as well as by county and will likely use several measures including birth certificate data and perhaps birth record data linked to Medicaid-OMAP data.

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.



	00	01	02	03	04	05	06	07	08	09
Actual	73.9%	74.8%	74.4%	74.6%	74.0%	73.1%				
Target							74.1%	74.6%	75.1%	75.6%

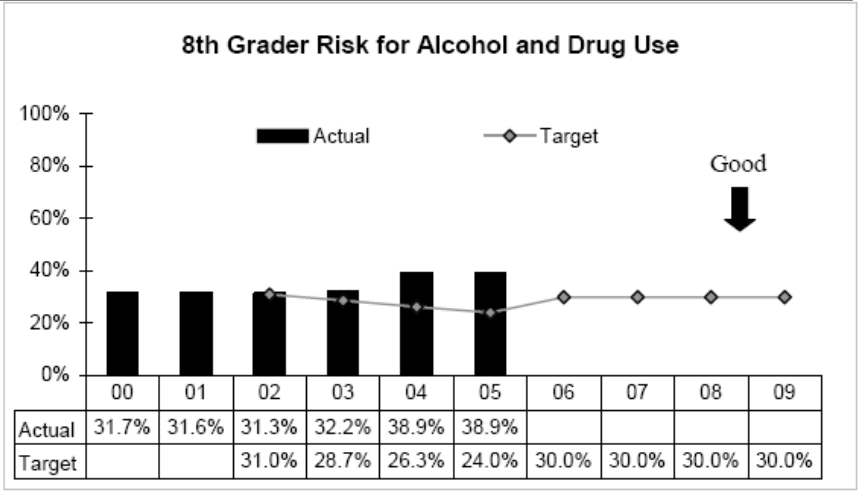
6. **WHAT NEEDS TO BE DONE**
   The Office will continue quality improvement efforts and the encouragement of the use of evidence-based practices.
7. **ABOUT THE DATA**
   Data is extracted from the Office's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment 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.

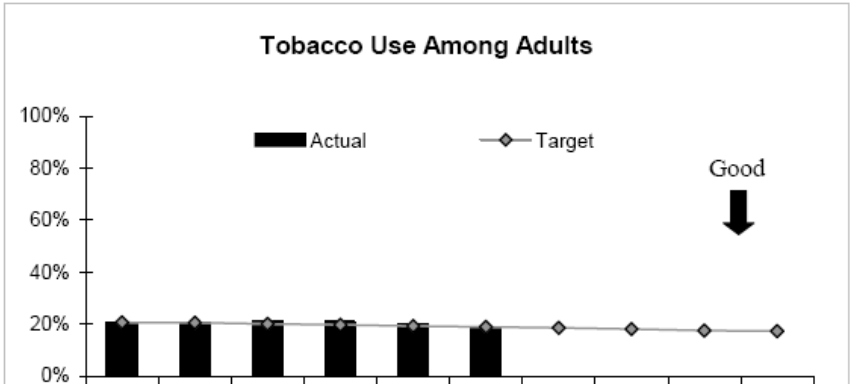
6. **WHAT NEEDS TO BE DONE**
Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol and other drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those 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**

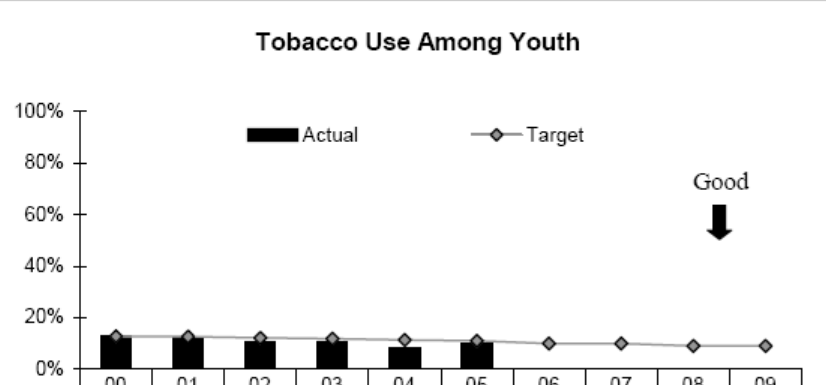
In 2005, the prevalence of smoking in Oregon was 18.6% for the general adult population, 9.8% among 8th grade adolescents, and 12.4% among pregnant women. For the general population of adults and for 8th graders, these measures were slightly better than targeted levels, while for pregnant women, this 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.

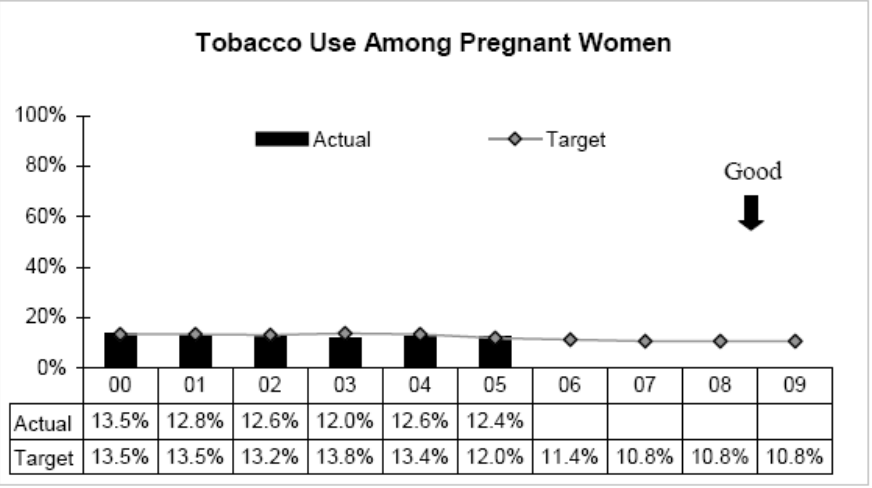
7. **ABOUT THE DATA**

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.

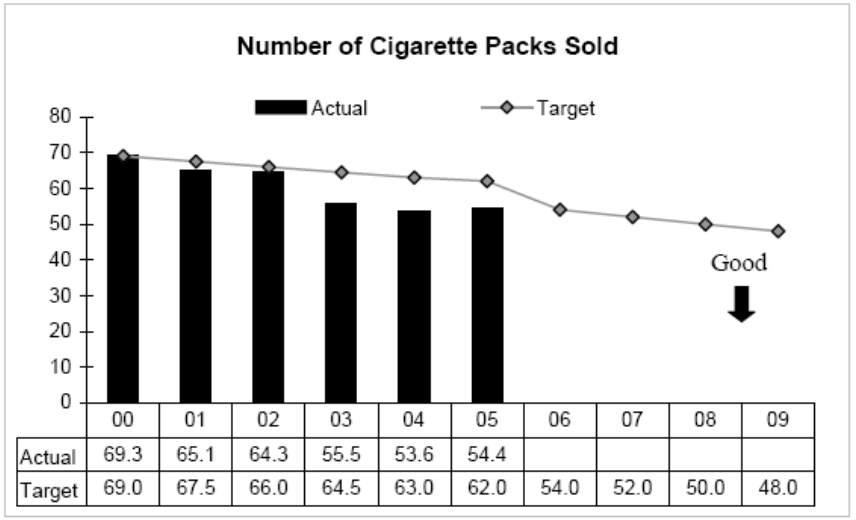


	00	01	02	03	04	05	06	07	08	09
Actual	13.5%	12.8%	12.6%	12.0%	12.6%	12.4%				
Target	13.5%	13.5%	13.2%	13.8%	13.4%	12.0%	11.4%	10.8%	10.8%	10.8%

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.

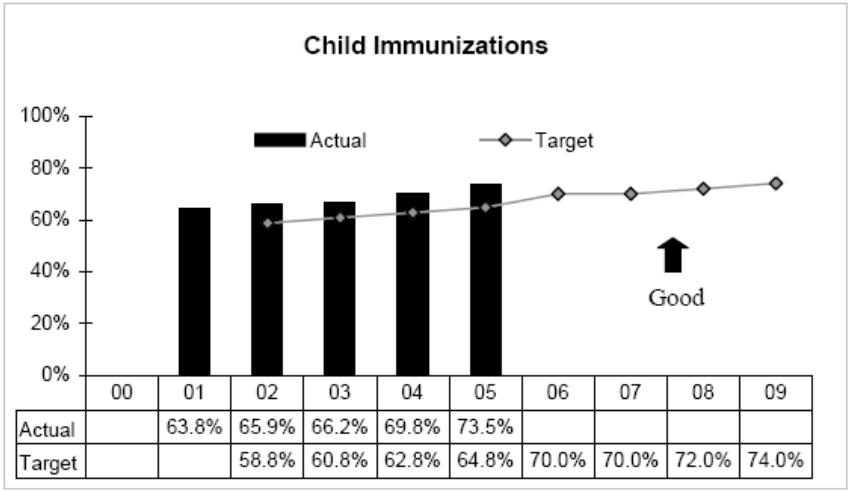
Advantages associated with these data are that they allow comparisons with national and other state estimates of consumption, which similarly rely on tax revenue data and population estimates. In addition, this estimator does not depend upon accurate self-reporting of smoking behavior. A disadvantage 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.

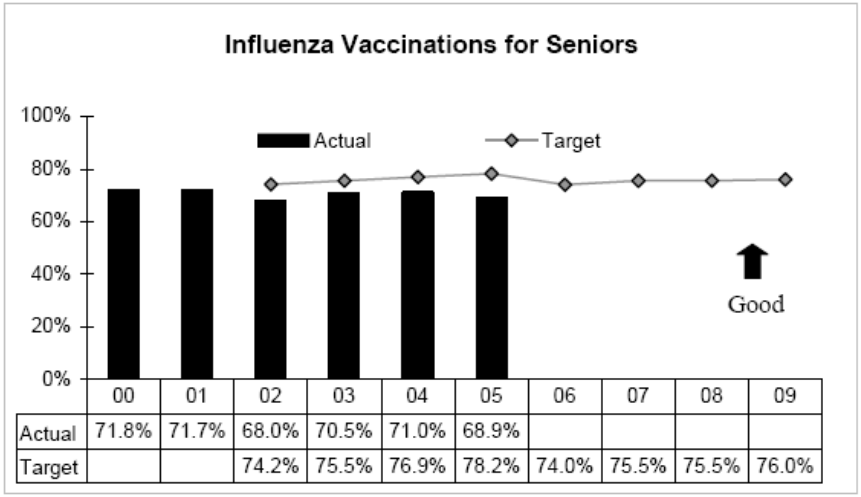
7. **ABOUT THE DATA**

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**

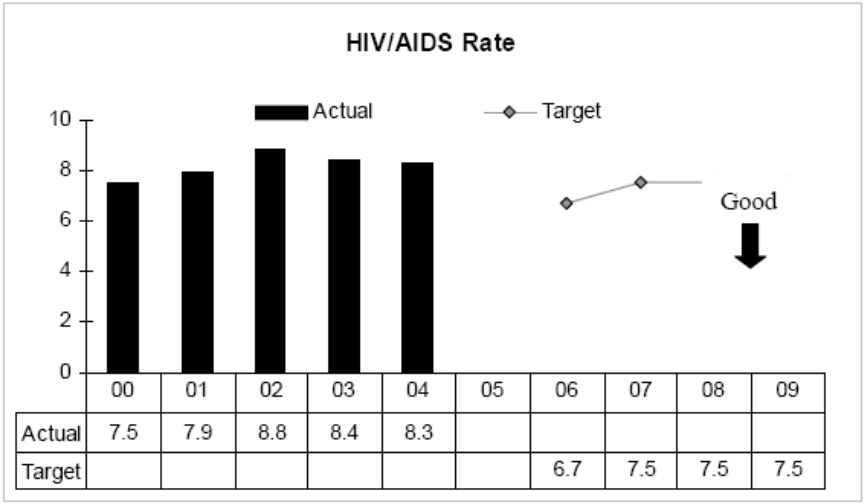
Reporting period - calendar year. This measures the percent of adults, 65 years and older, which reported receiving an influenza vaccination in the previous 12 months as reported on the Behavioral Risk Factor Surveillance survey (BRFSS). [Survey question: During the past 12 months, have you had a flu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

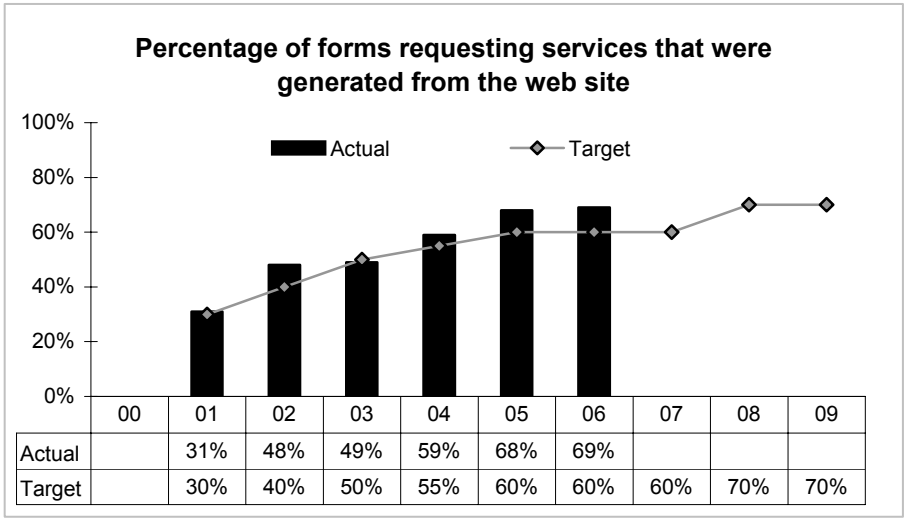
The agency links this performance measure to Oregon Benchmark(s):
#46, Self-perceived health status

KPM #2	**MAKE INFORMATION ACCESSIBLE** Percentage of forms requesting services that were generated from the web site.	**Measure since: 2002**
Goal	MAKE INFORMATION ACCESSIBLE - Provide information to the public about the Board's mission, services, and licensees.	
Oregon Context	OBM 46. PERCEIVED HEALTH STATUS	
Data source	Web site generated forms vary from hard copy forms. Agency staff examine the forms to determine the result.	
Owner	Licensing and Administrative Services, Carol Brandt (971) 673-2679	

1. **OUR STRATEGY**
   Public Information Specialists and a Complaint Resource Officer help direct the public and licensees to our web site for information and forms. Keep the web site informative and easy to use.

2. **ABOUT THE TARGETS**
   Targets are set based on past history and the expectation that the agency will continue to make its web site more useful. Higher percentages are desired.

3. **HOW WE ARE DOING**
   This measure reflects how well we are doing at protecting the well-being of citizens by providing them with easy to access public information and license forms. As the primary source of this information, this service is essential to the people of Oregon. With the exception of 2003, we have met or exceeded targets for this measure. We continue to add various forms to the web site and staff is working to inform the public about the availability of forms on the web.



	00	01	02	03	04	05	06	07	08	09
Actual		31%	48%	49%	59%	68%	69%			
Target		30%	40%	50%	55%	60%	60%	60%	70%	70%

4. **HOW WE COMPARE**
   There is no comparative data available.

5. **FACTORS AFFECTING RESULTS**
   Facilitating these results are good web site design with easy to find forms and embedded links.

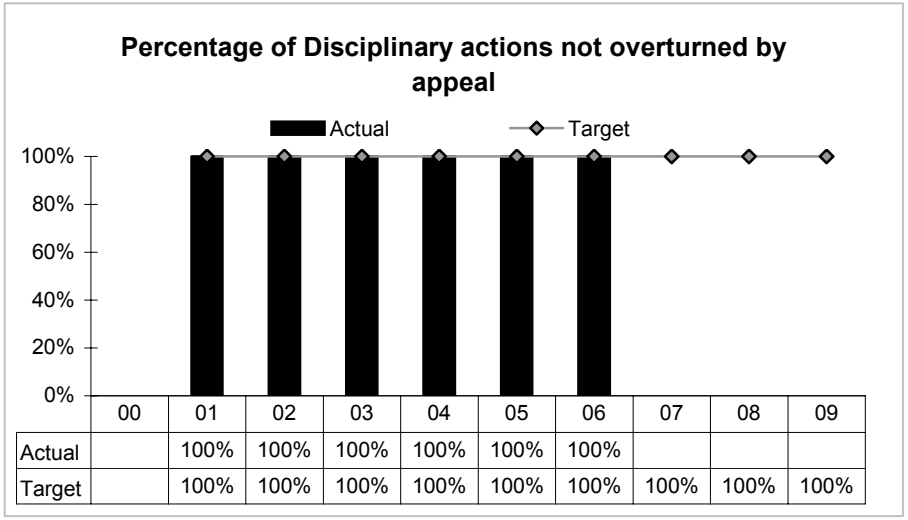
6. **WHAT NEEDS TO BE DONE**
   Continue with our current successful practices.

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

The agency links this performance measure to Oregon Benchmark(s):
#45, Preventable Death and #46, Perceived Health Status

KPM #3	**DISCIPLINE APPROPRIATELY** Percentage of disciplinary actions not overturned by appeal.	**Measure since: 2002**
Goal	DISCIPLINE APPROPRIATELY Investigate complaints against licensees, and ensure that the board members have sufficient information to take appropriate actions based on the facts of the case.	
Oregon Context	OBM 45: PREVENTABLE DEATH and OBM 46. PERCEIVED HEALTH STATUS	
Data source	Agency Investigative Database	
Owner	Investigations, Gary Stafford (971) 673-2700	

1. **OUR STRATEGY**
   Continue to provide thorough and complete administrative due process for licensees under investigation for possible violation of the Medical Practices Act.
2. **ABOUT THE TARGETS**
   Targets are set at 100% based on past history and the expectation that there will continue to be no successful appeals of our disciplinary decisions. The higher the percentage, the better we are doing at disciplining appropriately.
3. **HOW WE ARE DOING**
   The measure demonstrates that we are appropriately disciplining as there have been no successful challenges to the Board's disciplinary decisions since the measure was enacted in 2002.
4. **HOW WE COMPARE**
   There is no comparative data available.



	00	01	02	03	04	05	06	07	08	09
Actual		100%	100%	100%	100%	100%	100%			
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%

5. **FACTORS AFFECTING RESULTS**
   The Board provides extensive due process to all applicants, ensuring an appropriate outcome.
6. **WHAT NEEDS TO BE DONE**
   Continue with our current successful practices.
7. **ABOUT THE DATA**
   Reporting cycle is Oregon fiscal year.

The agency links this performance measure to Oregon Benchmark(s):
#45, Preventable Death and #46, Perceived Health Status

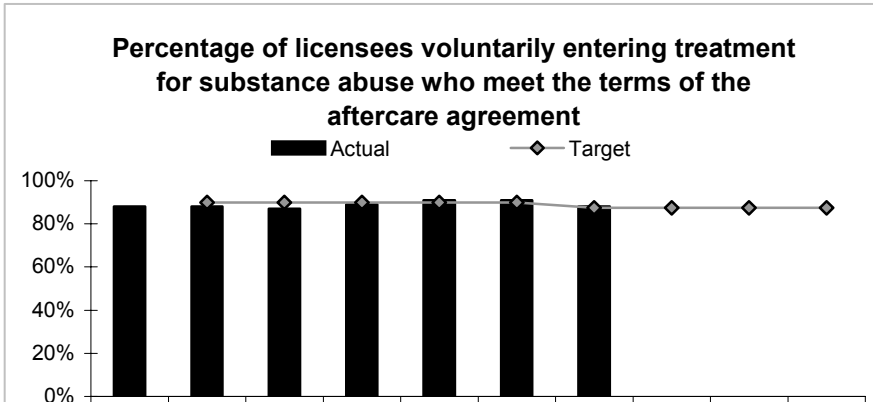
KPM #4	REHABILITATE LICENSEES WITH SUBSTANCE ABUSE Percentage of licensees voluntarily entering treatment for substance abuse who meet the terms of the aftercare agreement.	Measure since: 2000
Goal	REHABILITATE LICENSEES when possible while protecting public safety.	
Oregon Context	OBM 45: PREVENTABLE DEATH and OBM 46. PERCEIVED HEALTH STATUS	
Data source	Health Professionals Program records	
Owner	Health Professionals Program, Susan McCall, MD (503) 620-9117	

1. **OUR STRATEGY**
   Provide outreach in hospitals and the community to educate and encourage licensees to self-report problems and seek monitoring and treatment. Provide monitoring to prevent relapse

2. **ABOUT THE TARGETS**
   Targets have been established based on BME past history and the results of other states' physician health programs. The higher the percentage, the better we are doing at rehabilitating our licensees.

3. **HOW WE ARE DOING**
   The measure reflects how well we are doing ensuring that our licensees are safe to practice medicine. We have met our targets for fiscal years 2004, 2005, and 2006.

4. **HOW WE COMPARE**
   Direct comparisons are unavailable because these programs vary widely from state to state. Most states have an 85% or better success rate.



	00	01	02	03	04	05	06	07	08	09
Actual	88%	88%	87%	89%	91%	91%	88%			
Target		90%	90%	90%	90%	90%	88%	88%	88%	88%

5. **FACTORS AFFECTING RESULTS**
   Achieving this goal is disproportionately affected by the small population of licensees in Health Professionals Program. With a small data set, a single licensee can have a great effect on the percentage outcome. Overall, we are satisfied that the program is performing well but have concluded that the targets we had originally established may not be reasonable. Our 2005-07 Legislatively Approved Budget includes new targets for 2006 to 2007. We have modified the targets to cover a range of 85-90% rather than the current target of 90%. This will help us to maintain our high expectations of the program.

6. **WHAT NEEDS TO BE DONE**
   Continue with our current successful practices and implement the findings from the recent Performance Audit of the Health Professionals Program.

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

OREGON BOARD OF MEDICAL EXAMINERS

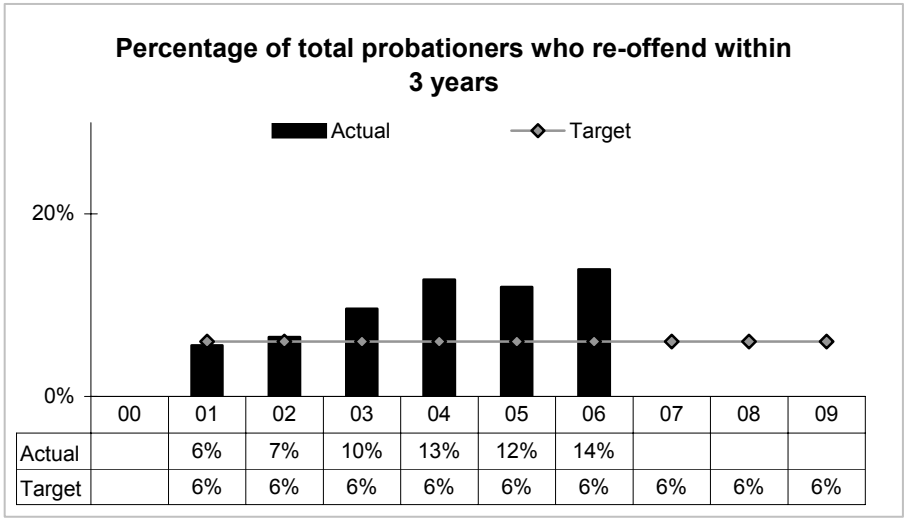
The agency links this performance measure to Oregon Benchmark(s):
#45, Preventable Death and #46, Perceived Health Status

KPM #5	REHABILITATE LICENSEES WHO ARE DISCIPLINED Percentage of total probationers who re-offend within 3 years.	Measure since: 2002
Goal	REHABILITATE LICENSEES when possible while protecting public safety.	
Oregon Context	OBM 45: PREVENTABLE DEATH and OBM 46. PERCEIVED HEALTH STATUS	
Data source	Agency Investigative Database	
Owner	Investigations, Gary Stafford (971) 673-2700	

1. **OUR STRATEGY**
   Monitor licensees under Board order to ensure they comply with the terms of a Board order. This monitoring is done through meetings and interviews by agency Compliance Officers.

2. **ABOUT THE TARGETS**
   A target of 6% was established at the time the measure was established based on the results available at that time. As we have been unable to achieve the target since the measure's establishment, we thought it may have been unrealistic. However, we believe that a 6% recidivism rate is more acceptable than a higher rate when considering the well-being of Oregonians and our goal is to meet this high expectation. The lower the percentage, the better we are doing to protect public safety.

3. **HOW WE ARE DOING**
   This measure reflects how well we are doing ensuring that our licensees are safe to practice medicine. We have been unable to meet our target since 2001. Please see "Factors Affecting Results" below.



	00	01	02	03	04	05	06	07	08	09
Actual		6%	7%	10%	13%	12%	14%			
Target		6%	6%	6%	6%	6%	6%	6%	6%	6%

4. **HOW WE COMPARE**
   There is no comparative data available.

5. **FACTORS AFFECTING RESULTS**
   This is a goal that has been difficult to achieve because of an increasing caseload and turnover in the original Compliance Officer position. We received authority for an additional .5 FTE Compliance Officer beginning with the 2005-07 biennium. We have had difficulty filling both of the Compliance Officer positions so results of the additional FTE have yet to be seen in outcomes for this measure. In addition, because of the small population of licensees who have Board orders, one or two cases can have a great effect on the percentage outcome. However, the overall recidivism rate is increasing.

6. **WHAT NEEDS TO BE DONE**
   We are working to fill both Compliance Officer Positions. We believe additional staffing for compliance monitoring will help to reduce the recidivism rate.

7. **ABOUT THE DATA**
   The reporting cycle is Oregon fiscal year.

OREGON BOARD OF MEDICAL EXAMINERS
Excerpt from FY 2006 Annual Performance Progress Report found at http://www.oregon.gov/DAS/OPB/APPR06.shtml

Note: Oregon Benchmarks were renumbered in 2006, so some benchmark references under "Oregon Context" may be off by one.

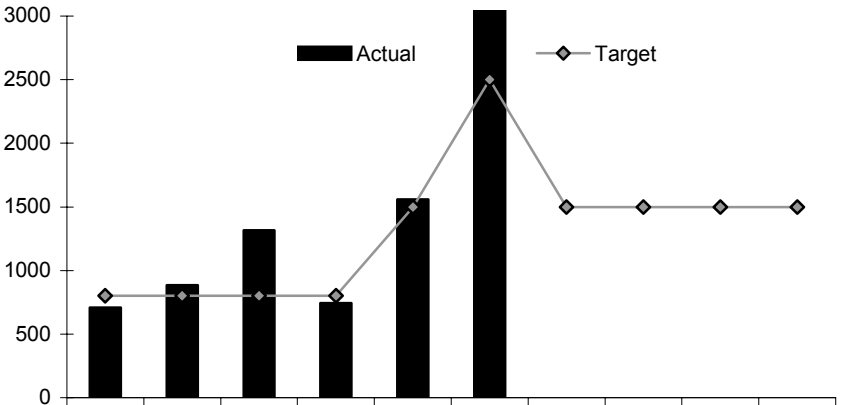
KPM #1	AGENT REFERRALS Number of referrals made to insurance agents involved in the Agent Referral Program.	Measure since: 1999 – Calendar Year
Goal	Provide access to health insurance, thereby reducing the percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	Referral Database	
Owner	Information, Education and Outreach Unit, Mark Jungvirt, Manager, 503-378-5461	

1. **OUR STRATEGY**
We train health insurance producers (formerly referred to as "agents") to help uninsured people and businesses navigate the health insurance system. One barrier to accessing health insurance is the complexity of the system. People and business owners are confused by how to choose a plan and how to fill out applications. The Producer Referral Program matches trained insurance producers with people from their communities who call OPHP for assistance. These producers help find plans that fit consumers' budget and medical needs. Additionally, producers:

   - Help clients complete applications, both for health insurance and for FHIAP.
   - Make referrals to Oregon Health Plan, including the Children's Health Insurance Program (CHIP).
   - Help people who are approved for individual market FHIAP subsidies select insurance from a list of approved plans.
   - Help small businesses find plans that meet their needs.

   Finally, the producers trained by OPHP become FHIAP liaisons who serve Oregonians throughout the state, greatly increasing the reach of our Salem-based agency.

Number of Agent Referrals that resulted in FHIAP enrollment



	00	01	02	03	04	05	06	07	08	09
Actual	708	883	1,315	743	1,560	4,606				
Target	800	800	800	800	1,500	2,500	1,500	1,500	1,500	1,500

2. **ABOUT THE TARGETS**
The spike in referrals in 2005 resulted from a significant expansion of FHIAP for budget reasons as well as the March 2005 launch of two, state-designed health plans for small, uninsured businesses. The FHIAP openings and the new plans resulted in more calls from individuals and business owners seeking help from referral producers. The number of referrals also reflects an aggressive training-marketing campaign that began in 2004, in response to the FHIAP openings. (See Performance Measures 2 and 3). The reduced number of referrals targeted for upcoming years reflects a more typical budget cycle for FHIAP.

3. **HOW WE ARE DOING**
We exceeded expectations in 2005 because the number of referrals is directly tied to the enrollment/budget cycle of FHIAP, and FHIAP's budget increased significantly. Growth in the individual subsidy market generates referrals because people who are approved for the subsidies often seek producer help in

selecting a health plan from the dozens of choices that FHIAP offers. However, OPHP also referred many small business owners to producers for help finding a plan that meets FHIAP's minimum standards or to learn more about the two new plans for small, uninsured businesses.

4. **HOW WE COMPARE**
   This is not applicable. FHIAP is a one-of-its-kind referral program in Oregon and referrals are driven by factors unique to the agency, including its program openings.

5. **FACTORS AFFECTING RESULTS**
   The number of referrals is directly tied to FHIAP's enrollment/budget cycle. When FHIAP has openings in the individual market, referrals are up; when FHIAP has a waiting list for individual subsidies, referrals drop.

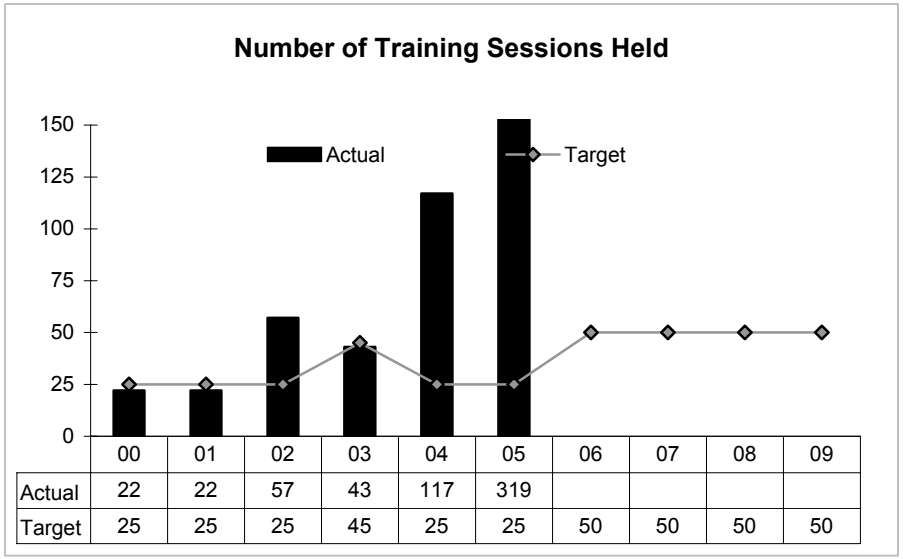
6. **WHAT NEEDS TO BE DONE**
   Because of turnover in the insurance industry and changes in state programs, the IEO unit will provide ongoing training to its referral producers as well as expand the number of referral producers. The staff will attempt to meet face-to-face with its more than 300 referral producers as staff travel statewide for other training and outreach. Finally, IEO will continue to promote the free referral program to FHIAP applicants because the number of people who complete the FHIAP application process and then enroll in insurance is greater when producers are involved.

7. **ABOUT THE DATA**
   The latest referrals occurred during calendar year 2005. FHIAP makes referrals by telephone and keeps an electronic record of each referral that involves FHIAP members/applicants. A database is maintained of referral producers (who complete training and meet other requirements). Referrals are distributed to the producers based on zip code or town of the person who is seeking producer help.

KPM #2	TRAINING SESSIONS HELD Number of training sessions or presentations made to insurance agents, community partners, and stakeholders.	Measure since: 1999 – Calendar Year
Goal	Provide access to health insurance, thereby reducing the percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	Monthly Reporting	
Owner	Information, Education and Outreach Unit, Mark Jungvirt, Manager, 503-378-5461	

1. **OUR STRATEGY**
   The IEO staff train insurance carriers, producers, employer associations, civic organizations and others in the public programs that help Oregonians obtain insurance or access health care. This allows people in the industry and consumers to make informed health insurance decisions. We are particularly concerned with linking lower-income Oregonians to programs such as FHIAP and OHP. FHIAP also provides training on OMIP, the state's high-risk pool for people who are turned down for insurance in the commercial market.

2. **ABOUT THE TARGETS**
   The agency sets training goals based on what is needed to keep insurance producers and carriers updated on changes in agency programs and changes in statutes that affect the health insurance industry. The goals include approximately 20 continuing education classes for newly licensed producers; these are scheduled a year in advance in various locations statewide. Since the agency is Salem-based without field offices, having people who sell health insurance trained in programs that can help Oregonians afford health insurance stretches our staff and helps to lower the uninsured rate.



	00	01	02	03	04	05	06	07	08	09
Actual	22	22	57	43	117	319				
Target	25	25	25	45	25	25	50	50	50	50

3. **HOW WE ARE DOING**
   OPHP exceeded the targeted number of presentations in 2005 because of openings for FHIAP subsidies and the need to educate key partners in those openings and how the program works. Additionally, trainings were conducted to educate producers about the new health plans for uninsured businesses. From January through March of 2006, staff conducted 26 trainings for more than 800 producers and carriers statewide. Additionally, in August 2005, FHIAP staff held 53 training sessions that reached more than 1,200 stakeholders. We visited stakeholders throughout Oregon, from Astoria to Brookings and from Ontario to Lakeview. The aggressive trainings of 2005 succeeded in boosting FHIAP enrollments and strengthening partnerships with groups statewide that share our concern with reducing the numbers of uninsured.

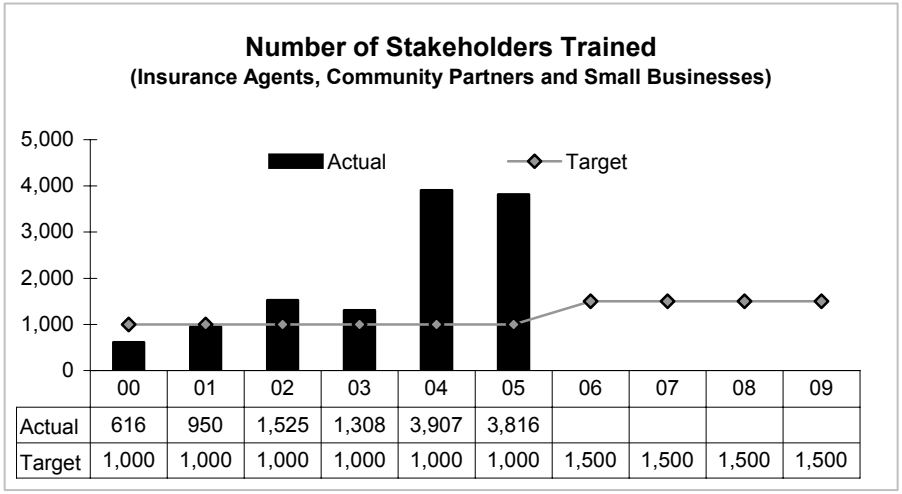
4. **HOW WE COMPARE**
   No other state agency offers training in health insurance statutes, insurance code changes and state programs that can help people obtain health insurance. IEO's aggressive outreach to all parts of Oregon is well received by insurance industry organizations and producers who often comment on the quality of the training and the opportunity to learn about state programs.

5. **FACTORS AFFECTING RESULTS**
   Although OPHP conducts ongoing training, the spike in presentations in 2005 was driven by the availability of subsidies for uninsured Oregonians and the need to educate producers on the small business health plans.

6. **WHAT NEEDS TO BE DONE**
   The agency will continue to promote continuing education classes for newly licensed health insurance producers so that they understand public programs available to help their clients. As technology and Insurance Division rules change, the agency will make on-line training available for a range of stakeholders, including producers, business owners and uninsured Oregonians.

7. **ABOUT THE DATA**
   FHIAP maintains electronic calendars and sign-in sheets at training sessions. Both are used to track the number of presentations and the number of people who attend. The most recent numbers here are for calendar 2005.

KPM #3	**STAKEHOLDERS TRAINED** **Number of insurance agents, community partners, and stakeholders trained.**	**Measure since: 1999 – Calendar Year**
Goal	Provide access to health insurance, thereby reducing the percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	Monthly Reporting	
Owner	Information, Education and Outreach Unit, Mark Jungvirt, Manager, 503-378-5461	



	00	01	02	03	04	05	06	07	08	09
Actual	616	950	1,525	1,308	3,907	3,816				
Target	1,000	1,000	1,000	1,000	1,000	1,000	1,500	1,500	1,500	1,500

1. **OUR STRATEGY**
   To succeed, IEO must educate the public about OPHP programs and the health insurance system. OPHP believes the best way to do this is through intensive and informative trainings for insurance carriers, producers and other community partners who work with our target audience. These partners, in turn, are better able to link the uninsured with programs that can help them, thus lowering the uninsured rate. In addition to carriers, producers, employers and advocacy groups, a key training target for IEO trainings is Department of Human Services (DHS) staff. FHIAP is an alternative for many Oregonians who qualify for Oregon Health Plan (administered by DHS) but either choose private insurance or can't get into OHP because of budget limits. FHIAP also serves people who are making the transition from public- to private-sector programs. There is a need for ongoing training about how the two programs work together. During stakeholder trainings, IEO also reaches out to county health departments, safety net clinics, medical providers, state employment offices, human resource personnel and advocacy groups that help people with applications.

2. **ABOUT THE TARGETS**
   Constant turnover in public and private organizations and changes in laws affecting state programs and the health insurance industry require OPHP to provide ongoing training to key partners. The extent and frequency of training, however, is dictated in part by program openings, budget and whether programs or statutes change significantly.

3. **HOW WE ARE DOING**
   OPHP historically has been close to reaching its target for training stakeholders. Fluctuations are based largely on whether there are FHIAP openings and the need for statewide producer training based on insurance law changes.

4. **HOW WE COMPARE**
   There are no relevant comparators.

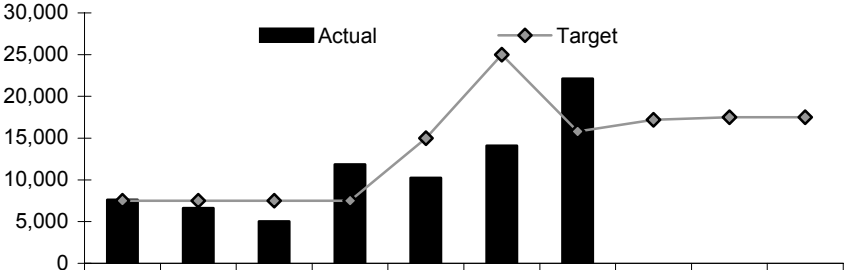
5. **FACTORS AFFECTING RESULTS**
   The number of stakeholders trained varies somewhat, based on agency budget and the need to explain changes in programs and statutes or new programs and insurance products.

6. **WHAT NEEDS TO BE DONE**
   OPHP will continue to provide free or low-cost education to newly licensed producers as well as key community partners. The agency should explore other ways to deliver training, such as on-line classes.

7. **ABOUT THE DATA**
   OPHP provides signup sheets at all its training. These numbers are for calendar year 2005.

KPM #4	**FHIAP ENROLLEES** **Number of Oregonians enrolled in the Family Health Insurance Assistance Program (FHIAP) for health insurance subsidies.**	**Measure since:** **1999 – Fiscal Year**
Goal	Provide access to health insurance, thereby reducing the percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	Family Health Insurance Assistance Program (FHIAP) database	
Owner	FHIAP Manager, Craig Kuhn, 503-378-6032	

1. **OUR STRATEGY**
After reaching an uninsurance rate of 11 percent in the late 1990s, Oregon's rate rose to 14 percent in 2002 and was 17 percent in 2004. Oregon's recession and slow economic recovery, fewer people served by the Oregon Health Plan, and an overall increase in the cost of health care and premiums (causing employers to drop coverage) have contributed to this increase in uninsurance. The OPHP directly impacts this benchmark by paying for health insurance coverage through the FHIAP program. The education and outreach efforts of the agency provide information insurance agents and consumers need to make informed health insurance decisions. Our partners include private-sector employers and insurance plans, insurance producers, our members, and sister agencies from DHS (e.g., CAF, OHP, and OMAP).



	00	01	02	03	04	05	06	07	08	09
Actual	7,628	6,599	5,013	11,857	10,238	14,091	22,123			
Target	7,500	7,500	7,500	7,500	15,000	25,000	15,800	17,200	17,500	17,500

2. **ABOUT THE TARGETS**
FHIAP provides economic assistance towards the purchase of private-sector health insurance plans, and thus has a direct influence on decreasing the percent of uninsured Oregonians. Through our ability to subsidize commercial health insurance plans, we facilitate enrollment in these plans, which thereby result in FHIAP members having access to quality health care via the coverage afforded by the commercial health insurance plan.

3. **HOW WE ARE DOING**
The number of Oregonians that FHIAP can serve is directly related to the program's legislatively approved budget. In 2002, the FHIAP program was approved to receive federal matching dollars through the Centers for Medicare and Medicaid Services (CMS) as part of the Oregon Health Plan waivers. The drop in enrollees in 2004 from that of 2003 is predominantly due to the reduction in "churning". Enrollees in the program stayed in longer, and therefore the budget served fewer people during the year. In 2005, enrollment increased by 37 percent over 2004. The target for 2005 enrollees was inflated, as this target was developed in 2003 when the program was expected to grow at a more rapid rate, be funded at a higher level, and reach a biennial average of 25,000. Since that time, negotiations in the federal waiver agreement and changes in the program reduced forecasts for 2006 and 2007 that more accurately reflect current enrollment trends. The agency exceeded the 2006 target by 40 percent, serving a total of 22,123 lives during the fiscal year. Enrollment for 2007 is expected to decrease and then balance out near 15,000 per month by the end of the 2007-09 biennium.

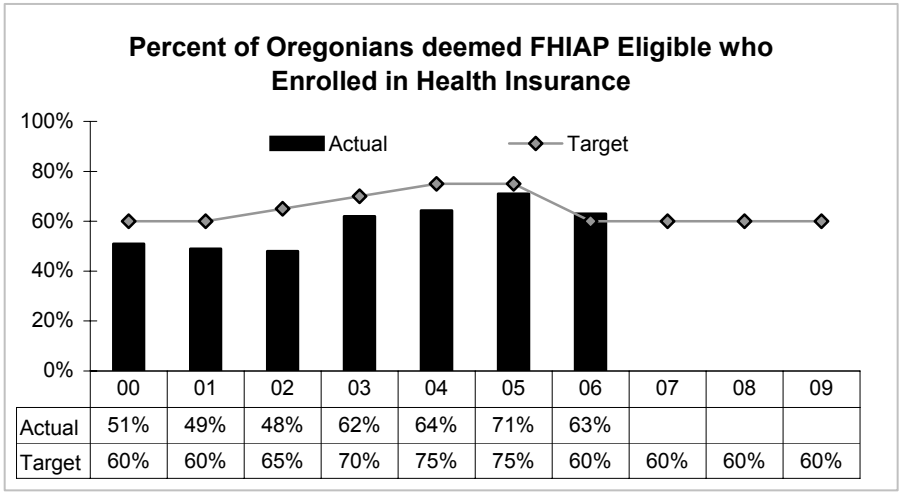
4. **HOW WE COMPARE**
While there are a handful of other premium assistance programs in the country, each program is operated under a unique federal waiver (including direct tie-ins to state Medicaid programs) and under different private market conditions, making direct relevant comparisons difficult. However, policy representatives from several states periodically contact staff to discuss how their state may design/implement a similar program to FHIAP because we continue to be successful in reaching our budgeted enrollment goals while also experiencing success in reducing our administrative costs.

5. **FACTORS AFFECTING RESULTS**
The primary factor affecting results is funding. While the ESI/Group market is the most cost effective, efforts to market this population are difficult and time consuming. There is a huge unmet need in the Individual market for those who do not have ESI available to them, however, premium costs continue to climb and state funds are limited. Focusing on the ESI/Group market, we expect to be able to fill the program to capacity within available General Fund appropriation.

6. **WHAT NEEDS TO BE DONE**
OPHP's Outreach unit is continually looking for new and innovative ways to reach the thousands of uninsured Oregonians who could qualify for assistance in the group market. The reservation list was reinstated for the individual market in the Fall 2005, while in 2006 FHIAP enrollments continued to grow beyond projections. The agency anticipates it will continue to allow new enrollments in the group market, as long as budgeted funds are available.

7. **ABOUT THE DATA**
The data reported represents the total number of persons served by the FHIAP program within the state's fiscal year (July 1, 2005 through June 30, 2006). This figure includes all those who were enrolled for any period of time during the reported year. The agency tracks the number of persons who enrolled in health insurance coverage, but is unable to measure health improvement outcomes as a result of enrollment.

KPM #5	FHIAP ELIGIBLE Percent of Oregonians deemed eligible for FHIAP who enrolled in health insurance.	Measure since: 1999 – Fiscal Year
Goal	Provide access to health insurance thereby reducing percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	FHIAP database system	
Owner	FHIAP Manager, Craig Kuhn, 503-378-6032	



	00	01	02	03	04	05	06	07	08	09
Actual	51%	49%	48%	62%	64%	71%	63%			
Target	60%	60%	65%	70%	75%	75%	60%	60%	60%	60%

1. **OUR STRATEGY**
   FHIAP opened enrollment into the program in November 2002 after receiving approval to use federal matching funds through the Medicaid and SCHIP programs. At the time of the waiver approval, FHIAP had a reservation list (for those waiting to apply) of over 25,000 lives. Many of those who applied had been on the reservation list for up to a year.

   Open enrollment for the individual market closed in October 2005, while those with employer sponsored insurance (ESI, or group) insurance were allowed to continue to enroll in FHIAP. This was done in concert with the Governor's office and the legislative direction the agency received in focusing on the ESI (group) market, because premiums are reduced by the employer's contribution, making it a more cost-efficient program to the state.

   FHIAP processes a large number of applications for eligibility that do not result in program enrollment. Once an applicant has met eligibility requirements and has been accepted into the FHIAP program, they must then enroll in private-sector insurance either through their employer or in the individual market. Many of our approved applicants end up not following through in the enrollment process, either for financial or other reasons. When the federal waiver was approved to allow federal matching funds for the FHIAP program, only about 50 percent of those who were approved for subsidy actually enrolled into a health insurance plan that was subsidized. This presented an administrative strain on the agency's resources, and the goal is to reduce the number who do not enroll after eligibility is approved.

2. **ABOUT THE TARGETS**
   When the federal waiver was approved to allow federal matching funds for the FHIAP program, only about 50 percent of those who were approved for subsidy actually enrolled into a health insurance plan that was subsidized. By increasing the number of approved applicants who enroll in the subsidy program, administrative costs are reduced.

3. **HOW WE ARE DOING**
   The percentage of those FHIAP eligible members who subsequently enroll in a health care plan is increasing. This is partly because new enrollment to the individual market were open, and people could get into the subsidy program when there was current interest. As people wait on the reservation list for openings in the program, frustration increases, interest wanes, and/or circumstances change.

4. **HOW WE COMPARE**
While there are a handful of other premium assistance programs in the country, each program is operated under a unique federal waiver (including direct tie-ins to state Medicaid programs) and under different private market conditions, making direct relevant comparisons difficult. However, policy representatives from several states periodically contact staff to discuss how their state may design/implement a similar program to FHIAP because we continue to be successful in reaching our budgeted enrollment goals while also experiencing success in reducing our administrative overhead costs.

5. **FACTORS AFFECTING RESULTS**
The primary factor affecting results is funding. While the ESI/Group market is the most cost effective, efforts to market this population are difficult and time consuming. There is a huge unmet need in the Individual market for those who do not have ESI available to them, however, premium costs continue to climb and state funds are limited. Historically, there is a higher percentage of those with ESI/Group that enroll in the FHIAP subsidy program once they are found eligible.

6. **WHAT NEEDS TO BE DONE**
The agency will continue to follow-up, as staffing allows, on those who are approved but do not subsequently enroll in the subsidy program. This measure has been submitted as a deletion in the 2007-09 Performance Measure process, but the agency will continue to monitor this as an internal measure for administrative accountability.

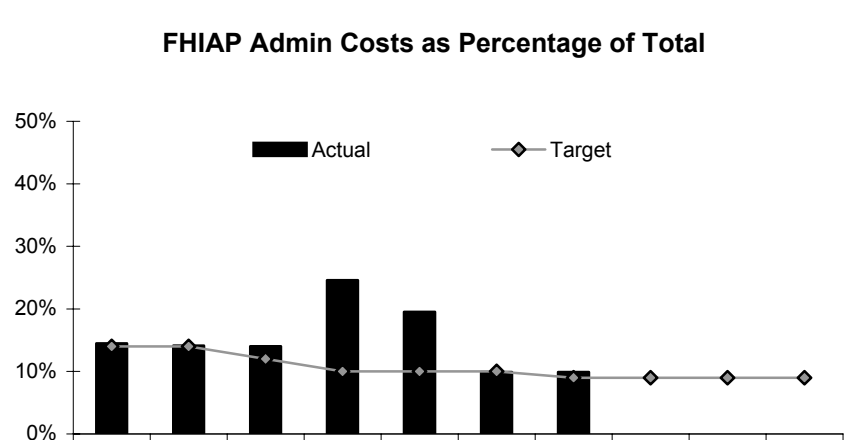
7. **ABOUT THE DATA**
The data is a calculation of the number of lives that enroll into the FHIAP subsidy program, divided by the number of lives approved for subsidy. For this measure, it includes all approved lives and all enrollments.

KPM #6	FHIAP ADMINISTRATION PERCENTAGE FHIAP Administrative expenses as a percent of total costs.	Measure since: 1999 – Fiscal Year
Goal	Provide access to health insurance, thereby reducing percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	SFMA Accounting Data	
Owner	Becky Frederick, Fiscal Manager, 503-378-4679	

1. **OUR STRATEGY**
   The agency has made progress in reducing the administrative costs of the FHIAP subsidy program by succeeding in getting enrollment in the program to a level that maximizes the efficiency of staff resources. In 2003 and 2004, during implementation of the agency's approval to gain federal funds through the federal Medicaid and SCHIP programs, administrative costs were high as a percentage of the budget because there were economies of scale that had not been realized.

   In 2005 and 2006, the agency met economies of scale, and was able to bring down administrative costs to reasonable levels.

2. **ABOUT THE TARGETS**
   In 2005, the legislature approved administrative costs of approximately 9.5% of the FHIAP budget. Because there was a subsequent reduction to the subsidy program of $1.1 million dollars General Fund, the actual administrative costs realized are a little higher than anticipated, although no additional dollars have been spent.



	00	01	02	03	04	05	06	07	08	09
Actual	14.5%	14.1%	14.0%	24.6%	19.5%	9.9%	9.9%			
Target	14.0%	14.0%	12.0%	10.0%	10.0%	10.0%	9.0%	9.0%	9.0%	9.0%

3. **HOW WE ARE DOING**
   The agency continues to streamline as many processes as possible to support the program within allowed budgets. We expect to remain on track to meet the projections.

4. **HOW WE COMPARE**
   While there are a handful of other premium assistance programs in the country, each program is operated under a unique federal waiver (including direct tie-ins to state Medicaid programs) and under different private market conditions, making direct relevant comparisons difficult. However, policy representatives from several states periodically contact staff to discuss how their state may design/implement a similar program to FHIAP because we continue to be successful in reaching our budgeted enrollment goals while also experiencing success in reducing our administrative overhead costs

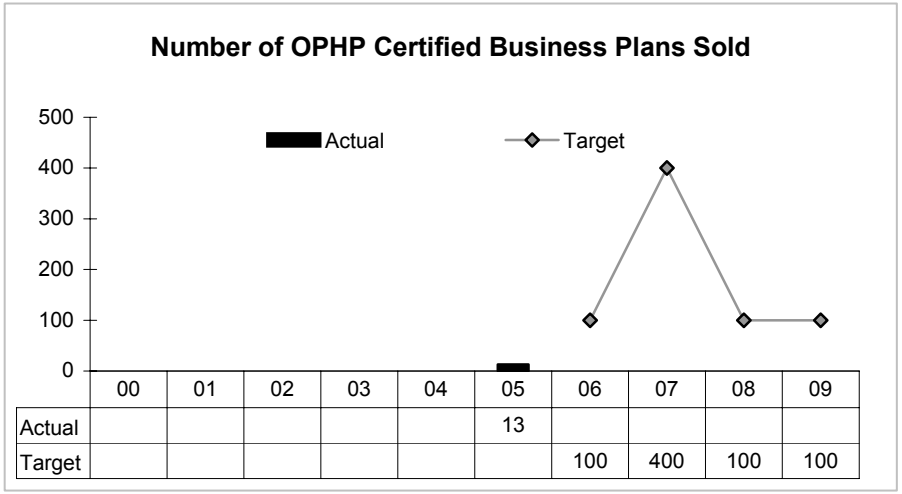
5. **FACTORS AFFECTING RESULTS**
   The biggest factor affecting results is economy of scale. There is an unwritten threshold of service required regardless of the number of lives served in the program, but which remains the same as the enrolled population increases. This measure has been submitted as a deletion in the 2007-09 Performance Measure process, but the agency will continue to monitor this as an internal measure for administrative accountability.

6. **WHAT NEEDS TO BE DONE**
   This measure has been submitted as a deletion in the 2007-09 Performance Measure process, but the agency will continue to monitor this as an internal measure for administrative accountability.

7. **ABOUT THE DATA**
   The percentage of administration is a calculation of total FHIAP administrative costs compared to the total FHIAP budget. It does not include administration of the Information, Education and Outreach program.

KPM #8	CERTIFIED BUSINESS PLANS The number of businesses who purchase and OPHP (formerly IPGB) Certified Plan.	Measure since: 2005 – Calendar Year
Goal	Provide access to health insurance, thereby reducing percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	Quarterly reporting by carriers	
Owner	Information, Education and Outreach Unit, Mark Jungvirt, Manager, 503-378-5461	

1. **OUR STRATEGY**
   OPHP initially trained and promoted the plans to over 1,000 producers in 22 cities throughout the state. Continued monthly trainings and one-on-one meetings have reached another 500 producers. We have centers and Service Corps of Retired Executives (SCORE) members. There have been nearly 3 months of radio and television advertising throughout the state. We have also promoted the plans through newsletters with the Construction Contractors Board, insurance carriers and have had several articles show up in newspapers throughout the state.



	00	01	02	03	04	05	06	07	08	09
Actual						13				
Target							100	400	100	100

2. **ABOUT THE TARGETS**
   Our targets are on the front line in meeting with and relaying important business information to small business owners throughout the state. There is no feasible strategy for direct agency contact with businesses not providing health insurance on or after July 1, 2003. We must rely on targets that can relay the information for us or position us to deliver the information to their members.

3. **HOW WE ARE DOING**
   Although the take up in these plans is far from target, we are seeing some ancillary benefit to promoting these plans.
   The ancillary benefit is a business owner purchasing a standard market plan as a result of their initial interest in the Certified plans. Each of the approximate 500 quote requests has created an opportunity for consultation between the small business owner and insurance producer. These consultations usually include showing and comparing standard market plans along with the Certified plans. We can confirm standard market plans placed with Regence and/or Health Net as a result of these presentations.

4. **HOW WE COMPARE**
   No state program, including the OPHP Certified Plans has had a meaningful impact on providing access for uninsured businesses.

5. **FACTORS AFFECTING RESULTS**
   The low take-up rate appears to be directly tied to affordability. The pricing of the plans is not differentiated enough from standard market small business plans. Although we were hopeful that the carriers would be more aggressive in their renewal pricing, we also realize that an artificial reduction in pricing shouldered by only two carriers in not a viable long-term solution for Oregon's small businesses.

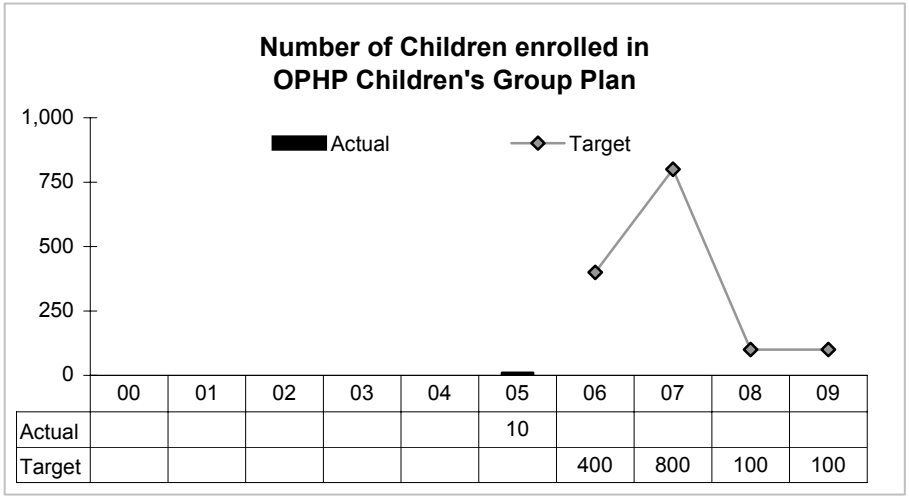
6. **WHAT NEEDS TO BE DONE**
   Create an affordably priced plan. We have heard from many stakeholders that further reductions in benefits to bring down the price is not an attractive alternative. Legislators who offered input leaned toward leaving the plans alone, suggesting that there was little expectation for meaningful enrollment and that OPHP made an excellent attempt. The IPGB board had similar input, feeling that reducing benefits strayed too far from the mission and purpose of the program. Without some form of subsidy, the only logical way to reduce cost is to reduce benefits. The legal basis for these plans is scheduled to sunset on January 2, 2008.

7. **ABOUT THE DATA**
   Data is compiled from reports sent quarterly from each participating carrier.

KPM #9	CHILDREN'S GROUP PLAN Number children enrolled in an OPHP (formerly IPGB) Children's Group Plan.	Measure since: 2005 – Calendar Year
Goal	Provide access to health insurance, thereby reducing percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	Quarterly reporting by carriers	
Owner	Information, Education and Outreach Unit, Mark Jungvirt, Manager, 503-378-5461	

1. **OUR STRATEGY**
   OPHP initially trained and promoted the plans to over 1,000 producers in 22 cities throughout the state. Continued monthly trainings and one-on-one meetings have reached another 500 producers. We have centers and Service Corps of Retired Executives (SCORE) members. There have been nearly 3 months of radio and television advertising throughout the state. We have also promoted the plans through newsletters with the Construction Contractors Board, insurance carriers and have had several articles show up in newspapers throughout the state.

   A separate health plan for children was developed to offer better benefits and comprehensive coverage to dependent children of employees who worked for employers purchasing the OPHP certified plans. There was general agreement among legislators, stakeholders and staff that placing children in the Alternative Plan (developed for adults) was not a desirable option.



	00	01	02	03	04	05	06	07	08	09
Actual						10				
Target							400	800	100	100

2. **ABOUT THE TARGETS**
   Our targets are on the front line in meeting with and relaying important business information to small business owners throughout the state. There is no feasible strategy for direct agency contact with businesses not providing health insurance on or after July 1, 2003. We must rely on targets that can relay the information for us or position us to deliver the information to their members.

3. **HOW WE ARE DOING**
   Although the take up in these plans is far from target, we are seeing some ancillary benefit to promoting these plans.
   The ancillary benefit is a business owner purchasing a standard market plan as a result of their initial interest in the Certified plans. Each of the approximate 500 quote requests has created an opportunity for consultation between the small business owner and insurance producer. These consultations usually include showing and comparing standard market plans along with the Certified plans. We can confirm standard market plans placed with Regence and/or Health Net as a result of these presentations.

4. **HOW WE COMPARE**
   No state program, including the OPHP Certified Plans has had a meaningful impact on providing access for uninsured businesses.

5. **FACTORS AFFECTING RESULTS**
   The low take-up rate appears to be directly tied to affordability. The pricing of the plans is not differentiated enough from standard market small business plans. Although we were hopeful that the carriers would be more aggressive in their renewal pricing, we also realize that an artificial reduction in pricing shouldered by only two carriers in not a viable long-term solution for Oregon's small businesses.

6. **WHAT NEEDS TO BE DONE**
   Create an affordably priced plan. We have heard from many stakeholders that further reductions in benefits to bring down the price is not an attractive alternative. Legislators who offered input leaned toward leaving the plans alone, suggesting that there was little expectation for meaningful enrollment and that OPHP made an excellent attempt. The IPGB board had similar input, feeling that reducing benefits strayed too far from the mission and purpose of the program. Without some form of subsidy, the only logical way to reduce cost is to reduce benefits. The legal basis for these plans is scheduled to sunset on January 2, 2008.

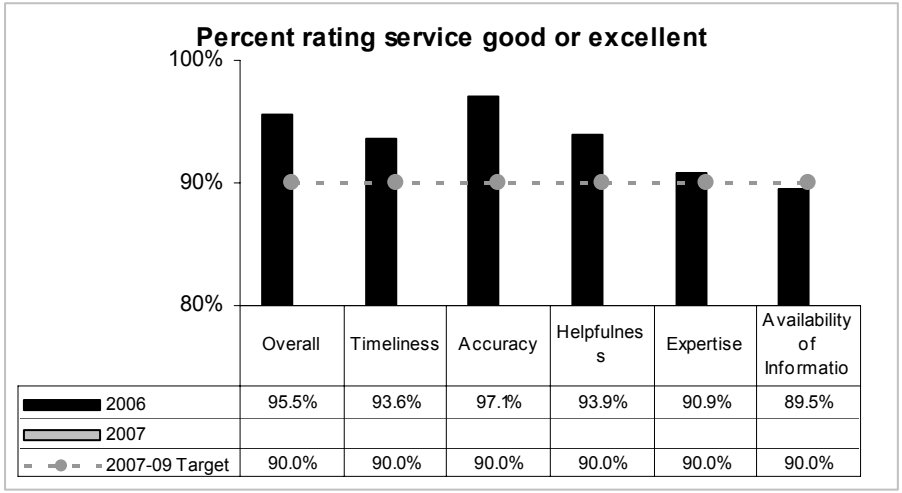
7. **ABOUT THE DATA**
   Data is compiled from reports sent quarterly from each participating carrier.

KPM #10	CUSTOMER SERVICE Percent of customers rating their overall satisfaction with the agency good or excellent for: Timeliness, Accuracy, Helpfulness, Expertise, and Information Availability.	Measure since: 2005 – Fiscal Year
Goal	Provide access to health insurance, thereby reducing percent of uninsured Oregonians.	
Oregon Context	54 HEALTH INSURANCE	
Data source	FHIAP Customer Survey Database	
Owner	Cindy Bowman, Project Coordinator, 503-378-4674	

1. **OUR STRATEGY**
   The agency surveys active FHIAP members using the statewide customer satisfaction survey created by the Oregon Progress Board and Customer Satisfaction Work Group. Active FHIAP members are surveyed monthly in conjunction with the reapplication process.

2. **ABOUT THE TARGETS**
   Targets are expressed as the percent of responses that are good or excellent. The agency has always focused on providing excellent customer service to our members, and we anticipate a high return of Good or Excellent responses.

3. **HOW WE ARE DOING**
   FHIAP began surveying in May 2006. Data represents responses received through August 31, 2006 on the prior fiscal year (FY 2006).



	Overall	Timeliness	Accuracy	Helpfulness	Expertise	Availability of Informatio
2006	95.5%	93.6%	97.1%	93.9%	90.9%	89.5%
2007						
2007-09 Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

4. **HOW WE COMPARE**
   This was a new Performance Measure required for all state agencies. OPHP began its first survey in May 2006, and it is too early to make comparisons to how we compare with other agencies.

5. **FACTORS AFFECTING RESULTS**
   While the agency makes every attempt to assist those who apply to the agency find health insurance options, there will be those who will not meet the qualifications of the program and will be turned down for subsidy.

6. **WHAT NEEDS TO BE DONE**
   Until initial data is received, we are unable to determine what, if anything, needs to be done better.

7. **ABOUT THE DATA**

Survey Name: FHIAP Customer Satisfaction Survey

Surveyor: Agency Staff

Date Conducted: Continuously, beginning 7/15/2006 and monthly thereafter.

Population: Consumers

Sampling Frame: About 50% of all active FHIAP members reapplying for subsidies, since the survey is mailed monthly versus bi-weekly when the redetermination applications are mailed.

Sampling Procedure: Systematic sample

Sample Characteristics: Population =; Sample = ; Responses = ; Response Rate =

Weighting: Single survey. No weighting required.

Survey Questions:

1. How do you rate the timeliness of the services provided by FHIAP employees?
2. How do you rate the ability of FHIAP employees to provide services correctly the first time?
3. How do you rate the helpfulness of FHIAP employees?
4. How do you rate the knowledge and expertise of FHIAP employees?
5. How do you rate the availability of information at FHIAP?
6. How do you rate the overall quality of service provided by FHIAP?

Placeholder for the Psychiatric Security Review Board's KPM pages from the Fiscal Year 2006 Annual Performance Progress Report.

The agency links its performance measures to Oregon Benchmark(s):

- 61, Disabled Living in Poverty

Note: Oregon Benchmarks were renumbered in 2006, so some benchmark references under "Oregon Context" may be off by one.

OREGON BENCHMARKS - ECONOMY

														Targets	
Business Vitality	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
1. Percent of Oregon jobs outside the I-5 corridor and Deschutes County	14.6%	14.5%	14.5%	14.2%	14.2%	14.3%	14.0%	13.8%	13.9%	14.1%	14.1%	14.0%		No targets	
2. Oregon's national rank in traded sector strength (1 = best)	40	36	33	32	31	30	33	28	30	33	33			20	20
3. Oregon's national rank for new Employer Identification Numbers per 1000 workers.	8	7	7	7	14	11	10		11	10	12	10		5-10	5-10
4. Net job growth (in thousands)	59.07	54.09	54.44	55.93	28.10	27.52	30.25	-10.97	-23.86	-9.43	32.03	45.13		24.00	23.00
a. urban counties	52.17	49.00	48.96	49.42	24.44	22.53	27.39	-6.65	-22.70	-10.50	26.90	40.28		20.16	18.86
b. rural counties	6.90	5.10	5.48	6.51	3.65	4.99	2.86	-4.32	-1.16	1.07	5.14	4.85		3.84	4.14
5. Oregon's concentration in professional services relative to the U.S. concentration in professional services. (U.S.=100%) (New Data Series)	83%	84%	84%	82%	79%	78%	77%	75%	75%	73%	72%	72%		80%	85%
6. Oregon's national rank in economic diversification (1st = most diversified)	26	32	29	32	28	27	35	37	34	33	31			25	20
Economic Capacity	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
7. Research and development expenditures as a percent of gross state product															
a. industry (public/private)		0.91%		1.10%	1.45%	1.40%	1.39%		2.01%	2.84%				1.2%	1.4%
b. academia	0.32%	0.32%	0.30%	0.29%	0.29%	0.29%	0.29%		0.34%	0.36%				0.4%	0.5%
8. Oregon's national rank in venture capital investments (measured in dollars per worker)	12	29	14	22	21	10	15		16	20	17	18		10	10
Business Costs	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
9. Oregon's national rank in the cost of doing business (1st = lowest)	27	27	26	24	24	26	26	26	28	31	34			14	14
a. labor costs	40	42	31	33	31	36	27	41	39	40	36				
b. energy costs	3	4	5	4	4	4	5	10	29	20	13			There will be no targets	
c. tax costs	34	27	27	38	32	31	42	37	35	41	43			for index components	
10. Percent of permits issued within the target time period or less															
a. air contaminant discharge	66%	62%	73%	50%	58%	61%	68%	90%	90%	88%	85%	84%		85%	95%
b. wastewater discharge	23%	15%	15%	11%	16%	28%	47%	48%	47%	51%	60%	42%		41%	49%
Income	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
11. Per capita personal income as a percent of the U.S. per capita income (U.S.=100%)	95%	97%	97%	97%	95%	95%	94%	93%	94%	93%	92%	93%		97%	100%
a. metropolitan as a percent of metropolitan U.S.	96%	97%	98%	97%	96%	96%	95%	95%	94%	94%	93%	93%		97%	100%
b. non-metropolitan as a percent of non-metropolitan U.S.	101%	104%	102%	102%	101%	101%	100%	100%	100%	102%	100%	100%		104%	105%
12. Average annual payroll per worker covered by unemployment insurance (in thousands, all industries, 2005 dollars):	30.77	31.41	32.16	33.24	34.27	35.21	36.43	36.20	36.21	36.34	36.63	36.59		36.92	37.87
a. urban	31.85	32.53	33.43	34.57	35.64	36.61	38.07	37.69	37.64	37.78	38.10	38.05		38.40	39.35
b. rural	25.30	25.49	25.67	26.09	26.85	27.33	27.44	27.67	28.29	28.41	28.58	28.33		28.90	29.54
13. Comparison of average incomes of top 5th families to lowest 5th families			Based on compilation of three years of data, middle year shown.												
a. ratio			9.4			11.3		10.0	10.4	9.3	9.6			11	9
b. national rank (1st = smallest gap)			27			40		25	28	19	18			No targets	
14. Percent of covered Oregon workers with earnings of 150% or more of the poverty level for a family of four	31%	31%	31%	32%	34%	35%	36%	36%	36%	36%	35%	35%		41%	47%
15. Oregon unemployment rate:															
a. annual rate	5.5%	4.9%	5.6%	5.6%	5.7%	5.5%	5.1%	6.4%	7.6%	8.1%	7.3%	6.1%			
b. as a percent of U.S. unemployment rate	90%	88%	104%	114%	127%	131%	130%	136%	131%	135%	133%	120%		115%	100%
International	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
16. Percent of total exports traded with non-primary partners. (Primary partners are Canada, Japan and South Korea.)	52.3%	56.1%	57.7%	56.7%	52.7%	53.9%	58.1%	58.6%	60.4%	59.4%	62.2%	60.7%		56%	60%
17. Percent of Oregonians who speak a language in addition to English	16%	The number for 2000 has been corrected from 15% to 17%. New calculation for 2004, not strictly comparable to previous years	14%		14%		17%				20%		22%	17%	20%

OREGON BENCHMARKS - EDUCATION

														Targets	
Kindergarten - 12th grade	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
18. Percent of children entering school ready to learn				58%			67%		76%		80%			85%	87%
19. Percent of third graders who achieve established skill levels				The numbers for 2002 and 2003 have been corrected from previous reports.											
a. reading		61%	70%	79%	78%	81%	82%	84%	80%	82%	82%	86%	87%	90%	97%
b. math		50%	53%	63%	67%	70%	75%	75%	74%	78%	81%	86%	86%	81%	90%
20. Percent of eighth graders who achieve established skill levels				The numbers for 2002 and 2003 have been corrected from previous reports.											
a. reading		48%	53%	56%	55%	56%	64%	62%	61%	61%	59%	63%	66%	71%	80%
b. math		49%	49%	49%	51%	52%	56%	55%	54%	59%	59%	64%	66%	69%	80%
21. Percent of high school graduates who earn regular diplomas (CIM and Non-CIM) who attain a Certificate of Initial Mastery								26%	31%	32.3%	33.4%	36.9%		Not enough data	Not enough data
22. Percent of students who drop out of grades 9 - 12 without receiving a high school diploma or GED.	6.6%	7.4%	7.2%	6.7%	6.9%	6.6%	6.3%	5.3%	4.9%	4.4%	4.6%	4.2%		5.4%	4.0%
Post Secondary	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
23. Percent of Oregon adults (25+) who have completed high school or equivalent	89%		91%		91%		92%		89.5%		93.0%		90.4%	93%	95%
24. Percent of Oregon adults (25+) who have completed some college	58%		60%		62%		58%		57.9%		62.9%		63.9%	70%	79%
25. Percent of Oregon adults (25+) who have an Associates degree or other occupation-related credential							25.7%		29.3%		32.2%		34.1%	Not enough data	Not enough data
26. Percent of Oregon adults (25+) who have completed:															
a. bachelor's degree	26%		29%		29%		29%		29.9%		32.6%		32.7%	38%	45%
b. advanced degree							11%		11.2%		12.8%		13.0%	10%	12%
Skill Development	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
27. Percent of adult Oregonians with intermediate and higher literacy skills	Inadequate funding to be part of 2002 National Assessment of Adult LIteracy														
a. prose														Not enough data	Not enough data
b. document															
c. quantitative															
28. Usage of computers:															
a. Percent of adults who use a computer ore related electronic device to create docs/graphics or analyze data	50%		58%		60%		61%		59%		57.8%		57.3%	65%	70%
b. Percent of households with computers who access the Internet	13%		24%		35%		63%		70%		89%		90%	75%	80%
29. Percent of Oregonians in the labor force who received at least 20 hours of skills training in the past year	35%		30%		37%		31%		38%		37.1%		32.7%	56%	75%

OREGON BENCHMARKS - CIVIC ENGAGEMENT

														Targets	
Participation	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
30. Percent of Oregonians 16 and older who volunteer time to civic, community or nonprofit activities in the last twelve months									31.7%	33.2%	33.7%	34.0%		Targets not set	
31. Turnout of the voting age population for presidential elections (1 = highest)															
a. Percent			59.9%				64.7%				70.5%				
b. National Rank			10				10				6			(2004) 5	(2008) 5
32. Percent of Oregonians who feel they are a part of their community	36%		41%		36%		37%		51%		49%		51%	45%	60%
Taxes	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
33. Percent of Oregonians who demonstrate knowledge of Oregon's main revenue source and main expenditure category.	1992-1999: Oregon State U. annual mailed survey. 2000 on: Oregon Population Survey 18%	19%	21%	19%	18%	18%	11%		17%		15%		15%	25%	50%
34. National ranking for state and local taxes and charges as a percent of personal income (1st = lowest burden) TOTAL	NOTE: previous reports showed 1st = highest burden 38	39	41	42	34	37	37		16		24			There will be no targets.	
a. Taxes	33	25	14	18	10	6	12		5		9				
b. Charges	40	42	47	46	46	40	45		41		42				
Public Sector Performance	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
35. Governing magazine's ranking of public management quality					B- 7		C+ 6				B 8			B 8	A- 10
36. State general obligation bond rating (Standard and Poor's)	AA- 4	AA- 4	AA 5	AA 5	AA 5	AA 5	AA 5	AA 5	AA 5	AA- 4	AA- 4	AA-		AA+ 6	AAA 7
Culture	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
37. Oregon adults participating in the arts at least once annually													86.3%		
37. Oregon's national ranking for arts participation. (Check wording)														Targets not set	
38. Percent of Oregonians served by a public library which meets minimum service criteria	84%	85%	88%	89%	80%	84%	84%	87%	87%	85%	83%	80%	79%	94%	99%

														Targets	
Health	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
39. Pregnancy rate per 1,000 females															
DROPPED ~~a. ages 10-14~~	~~1.7~~	~~1.8~~	~~1.5~~	~~1.7~~	~~1.7~~	~~1.3~~	~~1.1~~	~~1.0~~	~~0.8~~					~~0.9~~	~~0.0~~
b. ages 15-17	49.0	49.3	47.3	44.2	42.1	39.3	35.2	31.7	27.6	26.4	23.8	24.2		24.0	20.0
40. Percent of babies whose mothers received prenatal care beginning in the first trimester	78.9%	78.5%	79.7%	81.1%	80.2%	80.9%	81.3%	81.5%	82%	81%	80%	81%		85%	90%
41. Infant mortality rate per 1,000 live births	7.1	6.1	5.6	5.8	5.4	5.8	5.6	5.4	5.8	5.6	5.5			5.1	4.5
42. Percent of two-year-olds who are adequately immunized	67%	74%	72%	73%	76%	73%	79%	73%	74.5%	79.3%	81.1%	75.3%		82%	90%
43. New HIV infections in Oregonians aged 13 and over by year of initial diagnosis:	Entire data series updated since last report														
a. number	424	415	376	289	278	270	255	277	312	296	300	281		282	263
b. rate per 100,000	158.0	178.3	191.5	252.6	273.4	270.4	310.2	263.5	238.8	267.9	270.3	268.0			
44. Percent of Oregonians 18 and older who report that they do not currently smoke cigarettes.	78%	77%	77%	79%	78%	79%	79%	79%	78%	79%	79.9%	81.4%		85%	NA
45. Preventable Death: Years of life lost before age 70 (rate per 1,000)	61.9	61.4	59.6	56.4	56.7	52.7	53.5	51.8	54.1	54.7	54.1			54.3	49.3
46. Percent of adults whose self-perceived health status is very good or excellent	63%	62%	60%	59%	57%	57%	53%	55%	55%	55%	53.4%	53.6%		65%	72%
47. Percent of families with incomes below the state median income for whom child care is affordable	39%		36%		43%		35%		35%		43%			45%	Put off till OSIII
48. Number of child care slots available for every 100 children under age 13	16	16	19	20	21	21	20	18	18	17	17	17		25	25
49. Percent of Oregon teens who report positive youth development attributes:															
a. 8th graders													65%		
b. 11th graders													69%		
Protection	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
50. Percent of eighth grade students who report using in the previous month:															
a. alcohol	30.0%		30.0%	35.3%		26.6%		24.8%	24.4%	24.3%	28.5%	31.1%	31.9%	21%	17%
b. illicit drugs	19.0%		22.0%		18.6%		13.3%	18.1%	18.3%	18.5%	17.0%	15.9%	15.7%	15%	12%
c. cigarettes	19.0%		22.0%		20.2%		12.8%	12.3%	11.7%	10.5%	8.1%	9.8%	8.7%	16%	13%
51. Substantiated number of child abuse vicitims, per 1,000 under 18, total	10.1	10.1	10.4	12.1	12.3	13.5	12.1	9.6	9.8	10.8	12.0	13.0			
a. Substantiated neglected/abused (excluding threat of harm cateogry)	8.1	7.8	7.7	7.4	6.8	6.9	6.5	5.7	5.4	5.6	6.3	6.9		6.2	5.6
b. Substantiated threat of harm	2.0	2.3	2.7	4.7	5.5	6.6	5.6	3.9	4.4	5.2	5.7	6.1		5.9	5.3
52. Substantiated elder abuse rate per 1,000 Oregonians age 65 & older	3.5	Counterintuitive, but correct. Targets aim for increased reporting 3.6	5.9	6.1	5.9	6.8	7.8	8.4	8.0	6.7	5.1	4.5		15.0	27.0
53.Percent of pregnant women who report not using:															
a. alcohol	97%	97%	98%	98%	98%	98%	99%	99%	99%	98%	99%	99%		98%	98%
b. tobacco	82%	82%	82%	84%	85%	86%	87%	87%	87%	88%	88%	88%		91%	98%

														Targets	
Poverty	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
54. Percent of Oregonians with household incomes below 100% of the Federal poverty level	Except for 1999, these are three-year averages using the middle year as the reporting year (2001 = average of 2000, 2001 and 2002).													12%	10%
	12%	12%	12%	13%	13%	11.6%	11.6%	10.8%	11.7%	11.7%	12.5%				
a. 0-17						14.0%	16.0%	13.9%	16.3%	16.5%	17.7%				
b. 18-64	1999 data are from the 2000 Census.					11.0%	10.5%	10.6%	11.0%	11.1%	11.3%				
c. 65+						7.6%	7.1%	6.2%	6.4%	5.8%	5.5%				
55. Percent of Oregonians without health insurance	14%		11%		11%		12%		14%		17%		16%	8%	8%
56. Number of Oregonians that are homeless on any given night (per 10,000)	23	19	21	22	21	27	23	22	21	22	24	29	31	14	13
57. Percent of current child support due that is paid within the month that it is due.	60.0%	56.8%	58.3%	61.9%	62.9%	58.9%	59.6%	59.6%	60.4%	59.9%	59.3%	60.1%	60.4%	65.0%	70.0%
58. Oregon's national rank for percent of households that are:	Three-year averages, with middle year shown.														
a. food insecure (limited access to enough food for all household members to live a healthy, active life)				45				44	41	32	29			32	10
b. food insecure with hunger (at least one member must go hungry)				50				49	43	32	26			36	10
Independent Living	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
59. Percent of seniors (over 75) living outside of nursing facilities	1992-99 data were based on 65 and older.						96.4%	96.5%	97.1%	97.0%	97.2%	96.5%		97.2%	97.5%
60. Percent of adults with lasting, significant disabilities who are capable of working who are employed							85%		70%		72%		60%		
61. Percent of Oregonians with lasting, significant disabilities living in households with incomes below the federal poverty level	20.1%		19.5%		22.0%		21.2%		24.7%		22%		21%	19%	19%

														Targets	
Crime	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
62. Overall reported crimes per 1,000 Oregonians	145.9	150.5	141.8	150.1	138.5	131.7	127.8	128.4	124.2	127.7	125.4	123.6		124.5	110.0
a. person crimes	17.7	17.5	15.5	15.2	14.5	13.7	12.9	12.0	11.7	11.6	11.5	11.4		13.1	11.5
b. property crimes	82.1	85.6	79.0	83.0	74.4	68.2	66.9	69.7	67.5	69.5	66.5	64.4		66.9	59.1
c. behavior crimes	46.1	47.4	47.3	51.9	49.6	49.8	48.1	46.8	45.1	46.6	47.4	47.7		44.5	34.4
63. Juvenile arrests per 1,000 juvenile Oregonians per year															
a. person crimes	6.5	5.9	5.5	5.1	4.8	4.5	4.5	4.1	3.5	4	4.2	3.9		4.4	3.9
b. property crimes	23.5	21.5	21.0	19.6	17.0	15.1	14.1	12.7	11.4	12.6	12.2	11.0		15.5	13.8
64. Percent of grade 9-12 students who report carrying weapons in the last 30 days		19%		19%		14%		13%		20%		21%		14%	9%
65. Percent of paroled adult offenders convicted of a new felony within three years of initial release	33%	31%	31%	30%	32%	32%	30%	30%	33%	31%	31%	31%		29%	27%
66. Percent of juveniles with a new criminal referral to a county juvenile department within 12 months of the initial criminal offense	35.0%	38.0%	37.3%	38.3%	36.9%	36.6%	34.8%	34.1%	32.2%	32.1%	31.3%			33%	30%
Emergency Preparedness	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
67. Emergency preparedness															
a. percent of Oregon communities with geologic hazard data and prevention activities in place	10%	15%	20%	25%	30%	30%	40%	45%	46%	47%	50%	50%		50%	60%
b. percent of Oregon counties with emergency operations plans meeting minimum criteria.	83%	86%	96%	97%	94%	98%	50%	59%	81%	86%	88%	97%	89%	98%	100%

														Targets	
Growth Management	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
68. Hours of travel delay per capita per year in urbanized areas.															
a. Portland metro	14.4	18.4	18.5	19.3	19.7	20.8	22.9	19.1	19.4	20.0				25.5	28.0
b. Salem & Eugene	3.6	3.5	4.1	4.5	4.9	5.4	6.7	6.1	6.7	6.4				7.5	9.1
69. Percent of Oregonians served by public drinking water systems that mee health-based standards	49%	50%	55%	88%	90%	90%	93%	93%	92%	95%	95%	93%		95%	95%
Infrastructure	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
70. Percent of Oregonians who commute during peak hours by means other than driving alone	30%		33%		29%		24%				33%		28%	30%	31%
71. Vehicle miles traveled per capita in Oregon metropolitan areas for local, non-commercial trips	6430	6600	6780	6650	6780	6820	6750	6720	6660	6670	6950	6950		7,083	6,977
72. Percent of roads and bridges in fair or better condition															
a. State roads	80%	78%	78%	77%	77%	78%		81%		84%	85%	87%		78%	80%
b. Bridges															
i. State				97%	97%	97%	97%	94%	91%	88%	87%	87%			92%
ii. County & City (Local)				87%	85%	86%	87%	90%	89%	85%	84%	84%			89%
~~b. County~~ (county road condition was moved to developmental status 9/21/04)			~~75%~~		~~80%~~		~~84%~~		~~89%~~						
Housing	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
73. Percent of households that are owner occupied							64.3%		66.6%		65.2%			70.0%	72.0%
74. Percent of Oregon households below median income spending 30% or more of their income on housing (including utilities)															
a. renters			72%		69%		76%		76%		78%			70%	70%
b. owners			41%		39%		38%		36%		43%			38%	38%

OREGON BENCHMARKS - ENVIRONMENT

														Targets	
Air	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
75. AIR QUALITY - NATIONAL STANDARDS															
a. Number of days when air is unhealthy for sensitive groups			24	0	10	41	54	43	97	17	15	30			20
b. Number of days in cities when air is unhealthy for all groups			3	0	1	2	2	6	20	1	1	1			3
76. AIR QUALITY - NEW SCIENCE															
a. Percent of Oregonians at risk from toxic air pollutants that contribute to cancer (Oregon goals)			86%			98%									95%
b.Percent of Oregonians at risk from toxic air pollutants that contribute to respiratory problems (Oregon goals)			95%			99%									90%
77. Carbon dioxide emissions as a percentage of 1990 emissions (1990=100%)	Entire data series updated based on updated inventory since last repor														
	108%	109%	113%	113%	112%	119%	121%	121%	115%					106%	106%
Water	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
78. Net gain or loss of wetland acres in any given year															
a. freshwater	Data are provided on a fiscal year basis, ending year shown							129	91	35	75			0	0
b. estuarine								-2	1	-2	13			250	250
79. Percent of monitored stream sites with:															
a. significantly increasing trends in water quality		21%	32%	52%	70%	64%	70%	51%	37%	32%	24%	14%		75%	75%
b. significantly decreasing trends in water quality		8%	2%	0%	1%	1%	1%	5%	4%	6%	10%	14%		0%	0%
c. water quality in good to excellent condition		28%	35%	32%	37%	41%	42%	46%	46%	48%	49%	51%		40%	45%
80. Percent of key streams meeting minimum flow rights:															
a. 9 or more months a year	67%	88%	88%	88%	94%	94%	82%	82%	88%	65%	94%	82%		60%	65%
b. 12 months a year	28%	35%	76%	76%	76%	65%	59%	24%	35%	35%	47%	53%		35%	40%
Land	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
81.Percent of Oregon agricultural land in 1982 not converted to urban or rura development:				98.96%	Targets are based on a straight line projection from 1992 to 1997.									98.4%	98.1%
a. cropland				98.31%							ETA 2007			97.6%	97.1%
b. other ag land				99.21%										98.7%	98.4%
82. Percent of Oregon's wildland forest in 1974 still preserved for forest use	98.1%							97.8%							97.4%
83.Actual timber harvest as a % of planned & projected harvest levels under current policies															
a. public lands	22%	85%	89%	93%	68%	73%	67%	52%	59%	68%	83%	84%		90-110%	0%
b. private lands	95%	101%	89%	92%	83%	88%	93%	85%	97%	97%	106%	102%		90-110%	0%
84.Pounds of municipal solid waste landfilled or incinerated per capita	1,497	1990s and 2003 data updated since last report													
		1,987	1,541	1,596	1,609	1,644	1,617	1,531	1,568	1,588	1,639	1,677		1,575	1,495
85. Percent of hazardous substance sites cleaned up:			43.8%	44.2%	44.6%	46.4%	55.5%	62.5%	65.7%	69.4%	71.0%	72.7%			79.9%
a. non-tank sites			43.8%	44.2%	44.6%	46.4%	55.5%	62.5%	65.7%	69.4%	71.0%	72.7%			79.9%
b. regulated tanks			49.2%	51.2%	52.2%	56.5%	61.9%	68.0%	73.2%	76.5%	78.3%	80.0%			86.4%
c. heating oil tanks			40.4%	39.7%	39.8%	40.4%	54.1%	62.6%	65.1%	69.3%	70.9%	72.9%			80.7%
Plants & Wildlife	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
86. Percent of monitored freshwater species not at risk: (state, fed listing)															
a. -salmonids						50%	50%	50%	50%	50%	50%				
b. other fish						92%	92%	92%	92%	92%	92%				
c. other organisms (amphibs, molluscs)															
87. Percent of monitored marine species not at risk: (state, fed listing)															
a. fish						100%	100%	100%	100%	100%	100%	100%			
b. shellfish						100%	100%	100%	100%	100%	100%	100%			
c. other (mammals only - plant data N/A)	75%	Entire data series updated since last repor													
		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%			
88. Percent of monitored terrestrial species not at risk: (state, fed listing)															
a. vertebrates						98%	98%	98%	98%	98%					
b. invertebrates															
c. plants		98.3%			98.3%			98.3%		98.3%					
89. Percent of land in Oregon that is a natural habitat, TOTAL		Data expected in 2007													
a. forest															
b. shrubland															
c. grassland															
d. wetland/riparian															
90. Number of most threatening invasive species not successfully excluded or contained since 2000							0	0	1	0	0	0	0	5	
Outdoor Recreation	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**05**	**10**
91. Acres of state-owned parks per 1,000 Oregonians	30.0	29.0	29.0	29.0	28.0	29.0	28.0	27.5	27.5	28.0	27.6	27.8	27.7	35	35