Oregon Health Authority
2013-15 Ways & Means Reference Documents
Index

Letter from the Director

A more sustainable health system and more efficient agency

Oregon is on a path to addressing the fastest growing portion of the state budget. With the creation of Coordinated Care Organizations in 2012, the Oregon Legislature created a foundation to redesign the state's Medicaid program for better health and more sustainable costs. The system is based on the three goals that have guided the work of the Oregon Healthy Authority since its creation in 2009:

- Improve the lifelong health of all Oregonians;
- Increase the quality, reliability and availability of care for all Oregonians; and,
- Lower or contain the cost of care so it is affordable to everyone.

Research shows that approximately 30 percent of health care spending is wasted. Money spent on repeated or unnecessary testing, red tape and administrative costs, inefficient care, fraud and illness that could have been prevented are draining state, federal and private sector coffers. And many of these costs are driven by people who need better care the most – those with serious or chronic illness.

The coordinated care model gives Oregon a new path. By focusing on chronic disease management and prevention, CCOs will be able to provide better quality care and reduce acute care and emergency room costs. They will be held to quality outcomes and a global budget that grows at a fixed sustainable rate. This creates a more stable system, gives incentive for innovation and efficiency, and gives the budget more predictability.

Under the Coordinated Care Organization model, the state has a new Medicaid partnership with the federal government and new accountabilities. In the 1115 waiver received in 2012, the federal government is giving our state the flexibility to move toward a system focused on prevention and management of chronic conditions, rather than just treatment.

After the close of the 2012 legislative session, local communities quickly came together to form the new model. By November 2012, 15 Coordinated Care Organizations were operating and serving nearly 90 percent of Medicaid clients.

Oregon Health Authority changing as well

As the private sector health care delivery system has improved to gain state contracts to serve Medicaid clients, so too is the Oregon Health Authority changing and improving. To support Coordinated Care Organizations, sections of the agency that have previously been separated in silos are coming together, duplicative processes are being streamlined and there is a drive for innovation.

For example, Addictions and Mental Health changed its payment model for non-Medicaid clients to align with the OHA health transformation goals of better health, better care and lower costs, giving local communities more flexibility for outcome based care. In addition, Public Health has reoriented its focus on key strategic initiatives to improve the health and wellness of everyone in Oregon and at the Oregon State Hospital, improvements to care focused on hope and recovery continue.

Structure of the Oregon Health Authority

The Oregon Health Authority includes the state's publically funded health programs: Medicaid for mental, dental and physical health services, the Office of Private Health Partnership, the Public Employees Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB). Public Health is also part of the Oregon Health Authority as are the campuses of the Oregon State Hospital and Blue Mountain Recovery Center.

Oregon Health Policy Board

The Oregon Health Policy Board is the nine-member citizen board appointed by the Governor that serves as the policy making body for the Oregon Health Authority. Over the next several years, the board will advance solutions for the key issues in health reform. The Board holds monthly meetings and is the central place for the public and stakeholders to get involved in the discussion.

Members: Eric Parsons, Chair; Lillian Shirley, Vice Chair; Michael Bonetto, PhD; Brian DeVore; Carlos Crespo, PhD; Felisa Hagins; Chuck Hofmann, M.D.; Carla McKelvey, M.D.; Joe Robertson, M.D.; Nita Warner.

Other Considerations: The impact of the economy on the Oregon Health Authority

The global recession is lingering in our state, increasing the demand for health care among low-income Oregonians through the Oregon Health Plan. Demand for the Oregon Health Plan began to grow aggressively in 2008. Currently, there are approximately 671,000 people receiving Medicaid benefits, a 56 percent increase over June 2008. While the rate of growth has decreased as the economy improves, based on current eligibility, by June 2015 the total caseload is predicted to be more than 706,000.

As the caseload has grown, the state has seen approximately $15.2 million in non-program budget general fund reductions to the Oregon Health Authority since the 2011-2013 Legislatively Adopted Budget passed last June. In addition, the number of people employed at the Oregon Health Authority has dropped by 286 since June of 2011.

Setting a course for the future

The last two years have brought challenges and opportunities for the Oregon Health Authority. Even as the effects of the recession continue, we have made great gains towards a future where the health care system is better

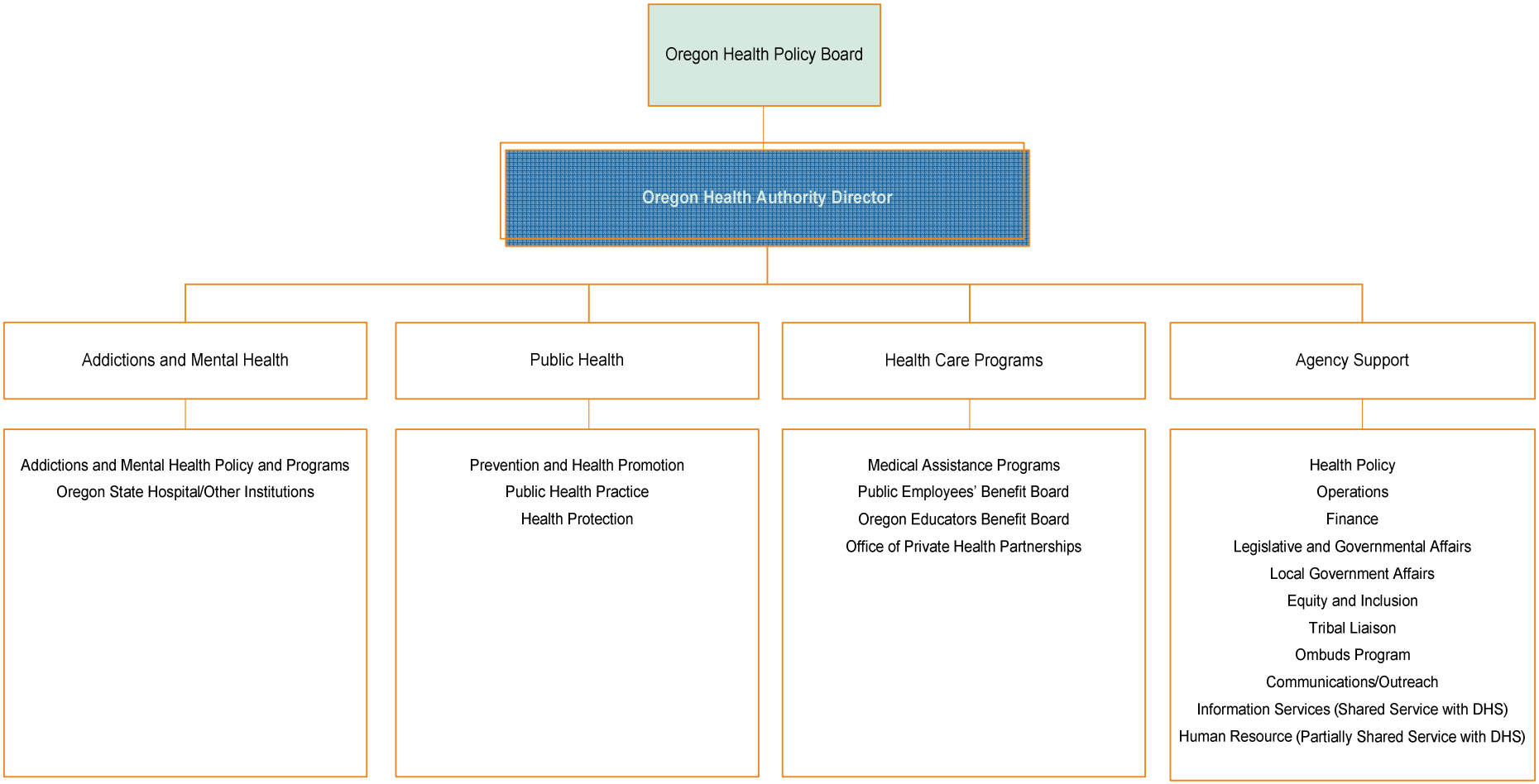
coordinated and patient-focused. We have continually worked to improve as an agency and to help transform the health system inside and out. And as a state, we are changing the way we do business.

Together, we are working to better address health disparities at the local level and promote a system of quality of services over quantity – where prevention and better management of chronic conditions are the ultimate solutions to better health and better care for Oregonians, at a lower cost to the health care system. The transformation of the health care system under way shows how much we can accomplish if we focus our attention, our efforts and our resources on solving the problems before us. And though we have a long path before us, we are on a path toward a truly healthier Oregon.

Sincerely,

Bruce Goldberg, M.D.
Director, Oregon Health Authority

2013-15 OHA Organization Structure



4,456 Positions / 4,137.31 FTE

Oregon Health Authority

Oregon Health Authority

OHA Mission Statement

The mission of the Oregon Heath Authority is helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality affordable health care.

The Health Authority will transform the health care system of Oregon by:

- Improving the lifelong health of Oregonians
- Increasing the quality, reliability, and availability of care for all Oregonians
- Lowering or containing the cost of care so it's affordable to everyone

Each program area of the Oregon Health Authority also has a specific area of focus to support the agency mission.

OHA Central and Shared Services

OHA Central Services supports the OHA mission by providing leadership in several dedicated key policy and business areas. This service area contains the following key areas:

OHA Office of the Director and Policy

The Office of the Director and Policy is responsible for overall leadership, policy development and administrative oversight for the Oregon Health Authority. This office coordinates with the Governor's Office, the Legislature, other state and federal agencies, partners and stakeholders, local governments, advocacy and client groups, and the private sector.

The OHA Director's Office provides leadership in achieving the mission of the agency to help people and communities achieve optimum physical, mental and social well-being through partnership, prevention and access to quality, affordable health care. The clear direction of OHA is to innovate, improve and rework the state health care system to meet three goals:

- Improve the lifelong health of all Oregonians;
- Increase the quality, reliability and availability of care for all Oregonians; and
- Lower or contain the cost of care so it is affordable to everyone.

OHA Office of Human Resources

The dedicated human resources department for the OHA business partners is charged with delivering services to internal customers with quality and timeliness. The dedicated areas will provide services focusing on people

strategy development; work force strategies to meet the agency's unique business needs; consolidation of work force strategic plans and HR policy development.

OHA Office of Budget, Planning and Analysis

The Office of Budget, Planning and Analysis (BPA) supports the mission of the Oregon Health Authority by providing leadership and collaboration for the strategic decisions of the programs by providing an in-depth knowledge of OHA financial processes, federal program and fiscal policy, business line funding streams, and state budget processes.

OHA Office of Communications

The OHA Office of Communications (OC) supports the mission of the Oregon Health Authority by providing information to employees, clients, legislators, stakeholders and interest groups, providers and partners, local governments, other state and federal agencies, policymakers, the news media, targeted audiences, and the general public. The office also provides support to the department's priority projects as defined by the agency's director and cabinet. The staff ensures that OHA complies with all statutory and legal requirements pertaining to public records requests, and other communication issues.

OHA Office of Equity and Inclusion

The Office of Equity and Inclusion (formerly the Office of Multicultural Health and Services - OMHS) strives to realize its vision of all people, communities and cultures co-creating and enjoying a healthy Oregon. The mission of the Office of Equity and Inclusion (OEI) is to engage and align diverse community voices and the Oregon Health Authority to assure the elimination of avoidable health gaps and promote optimal health in Oregon.

OHA Office for Oregon Health Policy and Research and the Office of Health Analytics (OHPR/Health Analytics)

The Office for Oregon Health Policy and Research (OHPR) was created in the early days of the Oregon Health Plan to be a resource to both the Executive and Legislative branches of state government on health policy and data analysis. Since moving into the newly formed Oregon Health Authority (OHA), the Office and the developing Office of Health Analytics continue to provide key functions for health system transformation and implementation of health reform. The Office for Oregon Health Policy and Research (OHPR) provides health policy analysis and development; coordinates strategic and implementation planning; conducts policy and health services research and evaluation to provide information needed for statewide and Oregon Health Authority (OHA) policy development, implementation and evaluation. It also provides technical assistance to OHA programs and other agencies on policy implementation, as well as monitoring national and state or local health innovations in order to provide information to OHA staff, the Governor's Office and the Legislature on emerging health care policy and delivery trends.

OHA Office of Health Information Technology (OHIT)

The Office of Health Information Technology (OHIT) is a central service office ensuring that, as part of all Oregon health reform efforts, any and all projects that should or could incorporate health information technology components are coordinated and funding sources maximized.

OHA SHARED SERVICES

OHA Shared Services supports both DHS and OHA by providing leadership in the delivery of efficient, consistent and coordinated administrative services to all programs within both departments. OHA Shared Services contains the following key programs:

OHA Office of Information Services (OIS)

The Office of Information Services (OIS) is a shared service provider for both the Department of Human Services and the Oregon Health Authority providing information technology (IT) systems and services that support 16,000 agency staff and partners located at 350 locations throughout Oregon.

Information Security Office (ISO)

The Information Security Office (ISO) is a shared service office providing information security services for DHS and OHA. ISO encompasses several programs focusing on protecting confidential information assets and educating staff, volunteers and partners of DHS and OHA on how to protect this information and report incidents when they occur. When compliance is compromised, ISPO takes appropriate enforcement action.

Medical Assistance Program

Vision
Improved access to effective, high-quality services for low-income and vulnerable citizens through innovation, collaboration, integration and shared responsibility.

Mission Statement
Provide a system of comprehensive health services to qualifying low-income Oregonians and their families to improve their health status and promote independence.

Goals

- Support effective and efficient systems that directly promote access to health care for low-income Oregonians;
- Support the entire health care provider system in Oregon by paying for needed services using federal matching funds to the extent appropriate;
- Maintain managed care / coordinated care enrollment at no less than 80 percent to promote access and to control health care costs;
- Improve the quality of health care for all Oregonians, especially for low-income Oregonians;
- Collaborate with legislators, advocacy groups, business partners, health care providers and the general public to improve health outcomes;
- Promote the use of prevention and chronic disease management services by all Oregonians, especially those with low incomes and special medical needs; and,
- Work with other insurers to improve health outcomes for all Oregonians.

Statutory Authority

Medical Assistance Program (MAP)

The Oregon Health Plan is not a federally mandated program, but supported by Medicaid and the Children's Health Insurance Program (CHIP). Title XIX and Title XXI of Social Security Act, respectively, provide the federal authorization. Oregon administers the program under the authority of the federally approved Medicaid State Plan, CHIP State Plan, and Oregon Health Plan Medicaid demonstration waiver.
The Oregon Health Plan is established and authorized in Oregon Revised Statute (ORS) 414.018 through 414.760.

Medical Assistance Program (Non-OHP)

CAWEM: The federal government authorizes the CAWEM program under section 1903(v) of the Social Security Act. The Oregon Legislature provides the authority for covering the program under Oregon Revised Statute (ORS) 414.025.

Breast and Cervical Cancer Medical: The federal government authorizes the Breast and Cervical Cancer Program under section 1902(z)(1)(aa) of the Social Security Act. The Legislature established the program at ORS 414.532 through 414.540.

Qualified Medicare Beneficiaries: The federal government authorizes the Qualified Medicare Beneficiaries program under section 1902(a)(10)(E) of the Social Security Act. Under state law, the Legislature authorizes the program at ORS 414.033 and 414.075.

Limited drug coverage program for transplant clients: There are no federal matching funds in this program. The Legislature created this program with a budget note to Senate Bill 5548 in during the 2003 legislative session.

Payments to the federal government for Medicare Part D: The federal government requires states to pay the federal government for Medicare Part D drug coverage provided to dual-eligible Medicaid clients under section 1935(c) of the Social Security Act.

Medical Assistance Program –Other Programs and Support

MAP program & support and Processing Center: The Oregon Health Plan is not a mandatory program, but it is supported federally by Medicaid and the Children's Health Insurance Program (CHIP). Title XIX and Title XXI of the Social Security Act, respectively, provide the federal authorization. Oregon administers the program under the authority of the federally approved Medicaid State Plan, CHIP State Plan, and Oregon Health Plan Medicaid demonstration wavier. The Oregon Health Plan is established and authorized in Oregon Revised Statute (ORS) 414.018 through 414.760.

Pharmacy Programs: OPDP was authorized in the 2003 legislation through Senate Bill (SB) 875. Ballot Measure 44 of 2006 opened the uninsured discount program to all residents. SB 362 of 2007 extended the discount program to underinsured and group business to the private sector. Also in 2007, SB 735 authorized Group Purchasing Organizations for all groups in OPDP.

CAREAssist is authorized by the federal Ryan White Act. This act provides funds to states to purchase drugs or health care insurance that provides a drug benefit for HIV positive individuals.

LEMLA: The Oregon Legislature authorizes the program under Oregon Revised Statute (ORS) 414.805 through 414.815.

Public Employees' Benefit Board (PEBB)

Vision

PEBB seeks optimal health for its members through a system of care that is patient-centered, focused on wellness, coordinated, efficient, effective, accessible, and affordable. The system emphasizes the relationship between patients, providers, and their community; is focused on primary care; and takes an integrated approach to health by treating the whole person.

Key Component of the PEBB program are:

- Benefits that are affordable to the state and employees;
- Accessible and understandable information about costs, outcomes, and other health data that is available for informed decision-making;
- An innovative delivery system in communities statewide that uses evidence-based medicine to maximize health and utilize dollars wisely;
- A focus on improving quality and outcomes, not just providing healthcare;
- Promotion of health and wellness through consumer education, healthy behaviors, and informed choices; and,
- Appropriate provider, health plan, and consumer incentives that encourage the right care at the right time and place.

Statutory Authority

The Public Employees' Benefit Board authority lies in ORS 243.061 through ORS 243.302.

Oregon Educators Benefit Board (OEBB)

Vision

OEBB will work collaboratively with districts, members, carriers and providers to offer value-added benefit plans that support improvement in members' health status, hold carriers and providers accountable for outcomes, and provide affordable benefits and services.

Key components of the OEBB program are:

- Value-added plans that provide high-quality care and services at an affordable cost to members.
- Collaboration with districts, members, carriers and providers that ensures a synergistic approach to the design and delivery of benefit plans and services.
- Support improvement in members' health status through a variety of measurable programs and services.
- Measurable goals and programs that hold carriers and providers accountable for health outcomes.
- Encourage members to take responsibility for their own health outcomes.

Statutory Authority

OEBB was established under Senate Bill 426 in 2007. The OEBB Board, functions and responsibilities are authorized under ORS 243.860 to .886.

Office of Private Health Partnerships (OPHP)

Vision

The Office of Private Health Partnerships (OPHP) provides access to health insurance through programs for low-income, high-risk, and uninsured Oregonians. OPHP encourages and assists Oregon small businesses and consumers in making informed health insurance choices by providing outreach, education, and referral services.

OPHP administers the following programs:

- Family Health Insurance Assistance Program (FHIAP) – FHIAP helps uninsured, income-eligible Oregonians pay the monthly premium for private health insurance through subsidies on an income-based sliding scale. FHIAP will operate through December 2013, and close in January 2014 as enrollees transition to other state programs due to changes driven by the federal Affordable Care Act (ACA) implementation.
- Oregon Medical Insurance Pool (OMIP) and Federal Medical Insurance Pool (FMIP) – OMIP and FMIP provide insurance coverage for people who can't obtain medical insurance due to preexisting health conditions, or who exhaust health insurance benefits and have no other options. Both programs will operate through December 2013, and close in January 2014 as enrollees transition to other state programs and commercial coverage as the guaranteed issue component of the federal ACA law is implemented.
- Healthy KidsConnect (HKC) – The HKC program manages the private market insurance component of Healthy Kids, which provides coverage for uninsured children age 18 and under. Unlike the other programs in OPHP, the HKC program will continue operating following implementation of the ACA in 2014.
- Information, Education, and Outreach (IEO) – IEO educates employers, employees, industry professionals, civic groups, community partners, and the public on a variety of state programs, resources for Oregonians,

state and federal reforms, as well as changes in insurance law. IEO also connects business owners with health insurance producers in their community. The IEO program will operate through December 2013, and close in January 2014 due to changes driven by the federal ACA implementation.

Statutory Authority

OPHP programs are governed by a series of Oregon Revised Statutes: FHIAP – ORS 414.841 through 414.872; HKC – ORS 414.231, 414,826, and 414,828; OMIP and FMIP – ORS.735.600 through 735.650; and OPHP as a whole – ORS 735.700 through 735.714.

The FHIAP program is matched with federal Medicaid funds, and is therefore subject to the maintenance of effort established in the state's Section 1115 waiver. Both the FHIAP and HKC programs are matched by federal CHIP funds, and are therefore governed in part by the CHIP State Plan.

Addictions and Mental Health

Vision

Addictions and Mental Health (AMH), as part of the Oregon Health Authority, envisions a healthy Oregon where mental health disorders and addictions are prevented and treated through education, early intervention and access to appropriate health care.

Mission Statement

The mission of AMH is to assist Oregonians to achieve optimum behavioral, physical and social well-being. By providing access to mental health and addiction services and supports to meet the needs of adults and children,

AMH helps Oregonians to live, be educated, work and participate in their communities. The mission is accomplished by working in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities to accomplish the following goals:

Goals

- Improve the lifelong health of all Oregonians;
- Improve the quality of life for the people served;
- Increase the availability, utilization, and quality of community-based, integrated health care services;
- Reduce overall health care and societal costs through appropriate investments;
- Increase the effectiveness of the integrated health care delivery system;
- Increase the involvement of individuals and family members in all aspects of health care delivery and planning;
- Increase accountability of the integrated health care system; and
- Increase the efficiency and effectiveness of the state administrative infrastructure for health care.

Statutory Authority

Community Mental Health and Addiction Services

- ORS 430 provides OHA the statutory framework for the development, implementation and continuous operation of the community treatment programs to serve people with addiction disorders and mental health disorders subject to the availability of funds.
- Alcohol and Drug Programs operate under the authority of Oregon Revised Statute (ORS) 430.254 through 430.426 and ORS 430.450- 430.590 and Federal PL 102-321 (1992) Sections 202 and 1926.
- Problem gambling treatment and prevention services are mandated by Oregon Revise Statute (ORS) 413.520, which directs the Oregon Health Authority to develop and administer statewide gambling addiction programs and ensure delivery of program services.

Block Grant

Federal legislation 1992 PL 102-321 authorized community mental health services funded in small part by the Substance Abuse and Mental Health Services Block Grant.

Facilities

Statutory or legislative provision for the Oregon State Hospital and the state-delivered Secure Residential Treatment falls under ORS 179, which covers general powers, duties and responsibilities to supervise state institutions. ORS 443.465 provides oversight for secure residential treatment homes and facilities.

Commitment types

- Civil Commitments: Oregon Revised Statute (ORS) 426 provides OHA the statutory framework to deliver mandated treatment to persons, who because of a mental illness, are a danger to themselves or others.
- Guilty except for insanity:
    - Under ORS 161.390, AMH provides treatment services in OSH and in the community for individuals who have been found guilty of a crime except for insanity.
    - Under ORS 419C.532, AMH provides treatment services for youth who have been found responsible except for insanity. Treatment is provided in the Secure Adolescent Inpatient Program, OSH and in the community.

Mental Health Evaluations

Under ORS 161.370, AMH is delegated to provide the evaluation services to determine if an allegedly mentally ill individual who is accused of a crime is fit to proceed through the judicial processes.

Oregon State Hospital Replacement Project

The Oregon State Hospital Replacement Project (OSHRP) was initially authorized by the Legislative Emergency Board in September 2006. The project was fully authorized during the 2007 session by House Bill 5005 and House Bill 5006. It was reauthorized in 2009 by Senate Bill 5505 and Senate Bill 5506. The 2011 session reauthorized the project in House Bill 5005 and House Bill 5006. Additionally, all Capital Improvements beyond the OSHRP follow federal requirements under the Americans with Disabilities Act which requires people to be served in a safe, accessible environment.

Public Health (PH)

Vision: Lifelong health for all people in Oregon

Mission: Promoting health and preventing the leading causes of death, disease and injury in Oregon

Goals

1) **Making Oregon one of the healthiest states in the nation**
   PH aims to make Oregon one of the top 10 healthiest states in the U.S. by 2017. To achieve this goal, Oregon must address the three leading causes of death in the state: **tobacco use, obesity and overweight, and suicide**. Oregon must also reduce **heart disease and stroke**, which results from tobacco use and obesity, and increase the ability to survive those conditions. And, Oregon must reduce **family violence**. Increasing Oregon communities' **resilience to emergencies** of all kinds also will help to make Oregon one of the healthiest states.

2) **Making Oregon's public health system into a national model of excellence**
   To fully achieve its vision of lifelong health for all people, Oregon's public health system must transform itself into a national model of excellence. A system that is a model of excellence will **work with emerging health care partners, such as Coordinated Care Organizations (CCO)**, in new ways; ensure appropriate consideration of **health issues in all policy making**; partner with the private sector and other agencies to perform **health impact assessments**; and **maintain disease investigation and data collection capabilities**. **Public health accreditation**, which recognizes health departments that perform all of the core functions, is one mechanism Oregon will use to ensure the system conforms to national standards.

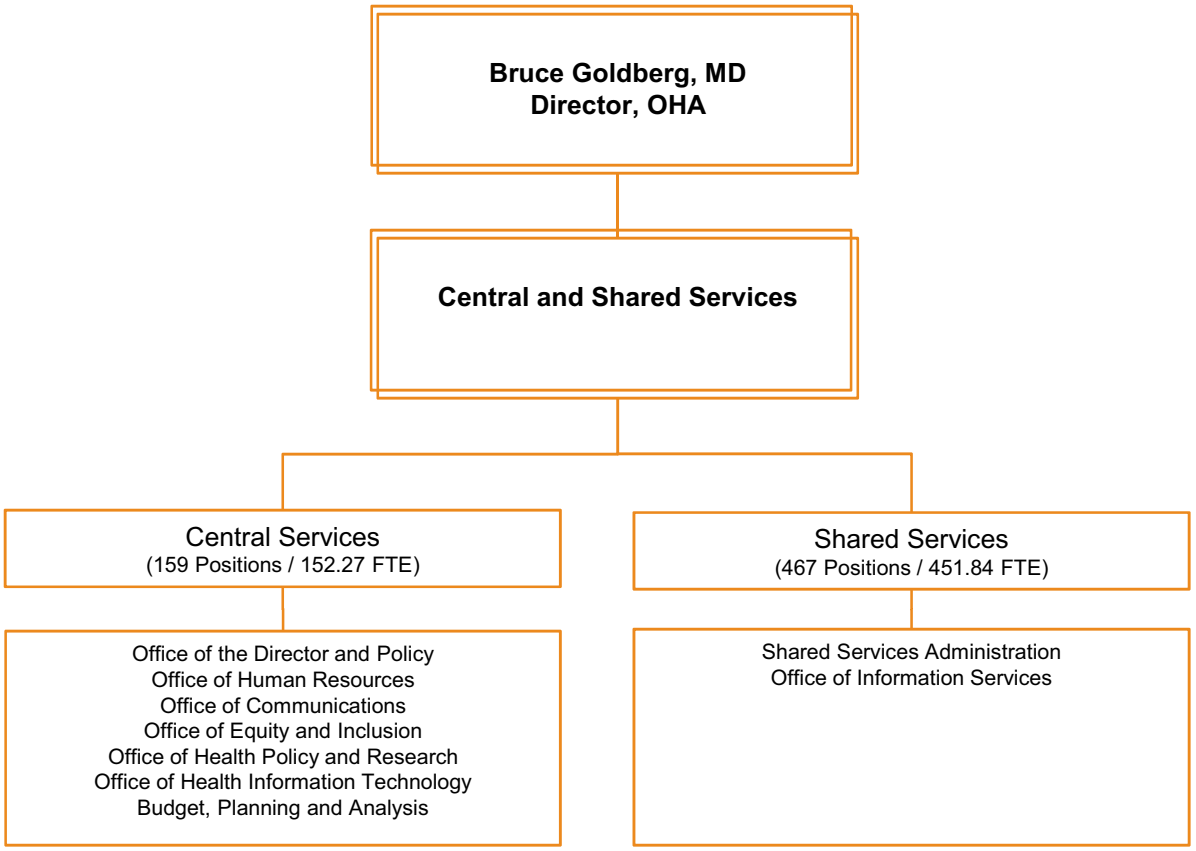
Statutory Authority

The Oregon Health Authority plays a central role in ensuring the health of all people in Oregon.

Chapters 431 and 433 of the Oregon Revised Statutes set forth hundreds of code sections enabling and mandating a wide range of public health activities carried out by Public Health and its county partners.

The power and duty to promote and protect the public's health is reserved to the states under amendment X of the U.S. Constitution. Title 42, among other titles, of the US Code authorizes federal funding for numerous public health programs carried out at the state level.

2013-15 Central and Shared Services Organization Structure



626 Positions / 604.11 FTE

Oregon Health Authority

OHA CENTRAL AND SHARED SERVICES

The Oregon Health Authority's Central Services supports the agency mission by providing leadership in the following dedicated key policy and business areas.

Office of the Director and Policy

The Office of the Director and Policy is responsible for overall leadership, policy development and administrative oversight for the Oregon Health Authority. This office coordinates with the Governor's Office, the Legislature, other state and federal agencies, partners and stakeholders, local governments, advocacy and client groups, and the private sector.

The Director's Office provides leadership in achieving the mission of the agency to help people and communities achieve optimum physical, mental and social well-being through partnership, prevention and access to quality, affordable health care. The clear direction of OHA is to innovate, improve and rework the state health care system to meet three goals:

- Improve the lifelong health of all Oregonians
- Increase the quality, reliability and availability of care for all Oregonians
- Lower or contain the cost of care so it is affordable to everyone

Office of Human Resources

The dedicated human resources department for the OHA business partners is charged with delivering services to internal customers with quality and timeliness. The dedicated areas will provide services focusing on people strategy development, work force strategies to meet the agency's unique business needs, and consolidation of work force strategic plans and human resource policy development. Human resource services are aligned with the OHA mission and core values. Service delivery is accomplished in person, by telephone and video conference, email and written communications, classroom training sessions, online training, and various formal and informal meetings.

Office of Budget, Planning and Analysis

The Office of Budget, Planning and Analysis (BPA) supports the mission of the Oregon Health Authority by providing leadership and collaboration for the strategic decisions of the programs by providing an in-depth knowledge of OHA financial processes, federal program and fiscal policy, business line funding streams, and state budget processes.

Office of Communications

The Office of Communications supports the mission of the Oregon Health Authority by providing information to employees, clients, legislators, stakeholders and interest groups, providers and partners, local governments, other state and federal agencies, policymakers, the news media, targeted audiences, and the general public. The office also provides support to the department's priority projects as defined by the agency's director and cabinet.

Communications staff also ensure that OHA complies with all statutory and legal requirements pertaining to public records requests and other related communication issues.

Office of Equity and Inclusion

The Office of Equity and Inclusion (formerly the Office of Multicultural Health and Services) strives to realize its vision of all people, communities and cultures co-creating and enjoying a healthy Oregon. The mission of the Office of Equity and Inclusion (OEI) is to engage and align diverse community voices and the Oregon Health Authority to assure the elimination of avoidable health gaps and promote optimal health in Oregon.

The office organizes its work in terms of four strategic imperatives:

- Assure and sustain an organizational structure that relentlessly pursues health equity and organizational diversity within OHA and in Oregon's health promoting systems
- Foster dynamic, strength-based, and authentic relationships among Oregon's diverse communities, OHA, and Oregon's health promoting systems
- Integrate and use diversity development best practices in recruitment, hiring, retention, performance management, contracting and procurement, and

leadership and employed development within OHA and Oregon's health promoting systems
- Leverage community wisdom, timely data, and research to develop and effectively communicate the rationale for investing in health equity and eliminating avoidable gaps in health outcomes

OEI collaborates with health systems leaders, clinicians, diversity and inclusion professionals, researchers, advocates and community members to promote good health and wellness for all Oregonians through policy development, training and consultation, and community and organizational capacity building. OEI provides consultation to programs within the Oregon Health Authority, local health departments, higher education programs, faith- and community- based organizations, universities, ethnic media outlets, Area Health Education Centers, emerging Coordinated Care Organizations, health and community advocacy organizations, and others working to improve the health of all Oregonians.

Office for Oregon Health Policy and Research and the Office of Health Analytics

The Office for Oregon Health Policy and Research (OHPR) provides health policy analysis and development, coordinates strategic and implementation planning, conducts policy and health services research and evaluation to provide information needed for statewide and Oregon Health Authority policy development, implementation and evaluation. OHPR provides technical assistance to OHA programs and other agencies on policy implementation and monitors national and state or local health innovations in order to provide information to OHA staff, the Governor's Office and the Legislature on emerging health care policy and delivery trends.

The Office of Health Analytics**,** is a sister office of OHPR, sharing administrative services and working in close collaboration. Health Analytics compiles and analyzes technical and statistical information about Oregon's health system that enables policy makers, practitioners, consumers and researchers to make data-driven decisions. Health Analytics conducts data collection and statistical analysis of utilization and financial data to evaluate OHA program performance and provide data to support health system and program planning and implementation. In addition, this office performs actuarial analysis to support rate development and

benefit design. Further, OHPR and Office of Health Analytics are responsible for developing financial, performance and administration information and metrics to support key management and cost decisions within OHA to optimally support its mission.

Office of Health Information Technology

The Office of Health Information Technology (OHIT) is a central service office ensuring that, as part of all Oregon health reform efforts, all projects that should or could incorporate health information technology components are coordinated and funding sources maximized.

The immediate objective of OHIT is to accomplish the goals envisioned by the Oregon Legislature and to take full advantage of the opportunities afforded Oregon by recent federal funding in order to reach these objectives. OHIT will work in close collaboration with the OHA director, deputy director and other OHA governing bodies to convene staff planning and oversight.

OHIT is responsible for providing leadership and coordination across programs, departments and agencies in developing policies and procedures that:

- Accelerate state and federal health reform goals through organized support for adoption, implementation and integration of health information technologies
- Increase and convert health IT funding opportunities from federal agencies, philanthropic organizations and the private sector into results
- Increase collaboration and communication between state agencies and across programs for enhanced planning and shared decision making, leveraged IT purchases and coordination of service delivery

OHA Shared Services

OHA Shared Services supports both the Department of Human Services (DHS) and OHA by providing leadership in the delivery of efficient, consistent and coordinated administrative services to all programs within both departments. OHA Shared Services contains the following key programs:

Shared Services Administration

OHA Shared Services Administration provides oversight and leadership for the OHA Shared Services programs.

Office of Information Services

The Office of Information Services (OIS) is a shared service providing information technology (IT) systems and services that support 16,000 agency staff and partners located at 350 locations throughout Oregon.

The OIS structure consists of the Office of the Chief Information Officer and five major operational sections that play vital roles in meeting its mission and customer goals: Customer Services and Support, Enterprise Alignment and Design , Shared Services, and separate sections that support the specific IT needs of DHS and OHA.

DHS / OHA Information Services

DHS and OHA Information Services both work directly with agency program offices on custom application development, maintenance, and enhancement, Website support, business intelligence, and business collaboration services, ensuring that IT solutions provided by OIS meet the business needs.

DHS Information Services Support

The DHS Information Services Support section provides information technology support to DHS programs, including:

- Aging and People with Disabilities
- Child Welfare
- Self-Sufficiency
- Vocational Rehabilitation
- DHS Operations sections

OHA Information Services Support

The OHA Information Services Support section provides information technology support to OHA programs, including:

- Addictions and Mental Health
- Medical Assistance Programs
- Public Health
- Public Employees' Benefit Board
- Oregon Educators Benefit Board
- Oregon Health Policy and Research
- Office of Private Health Partnerships
- Oregon Medical Insurance Pool
- Oregon Prescription Drug Program

Information Security and Privacy Office

The Information Security and Privacy Office (ISPO) is a shared service office providing information security services for DHS and OHA. ISPO encompasses several programs focusing on protecting confidential information assets and educating staff, volunteers and partners of DHS and OHA on how to protect this information and report incidents when they occur. When compliance is compromised, ISPO takes appropriate enforcement action.

The ISPO drivers include federal and state security regulations and audit findings, contractual and grant obligations, DHS security policies and procedures, legislative mandates and the Oregon Consumer Identity Theft Protection Act.

ISPO strives to manage the confidentiality, integrity and availability of information through business risk management. This office helps DHS and OHA deal with the protection of information assets within the agencies and enterprise-wide. ISPO focuses on processes and procedures that make up sound business practices.

2013 -2015 Governor's Balanced Budget

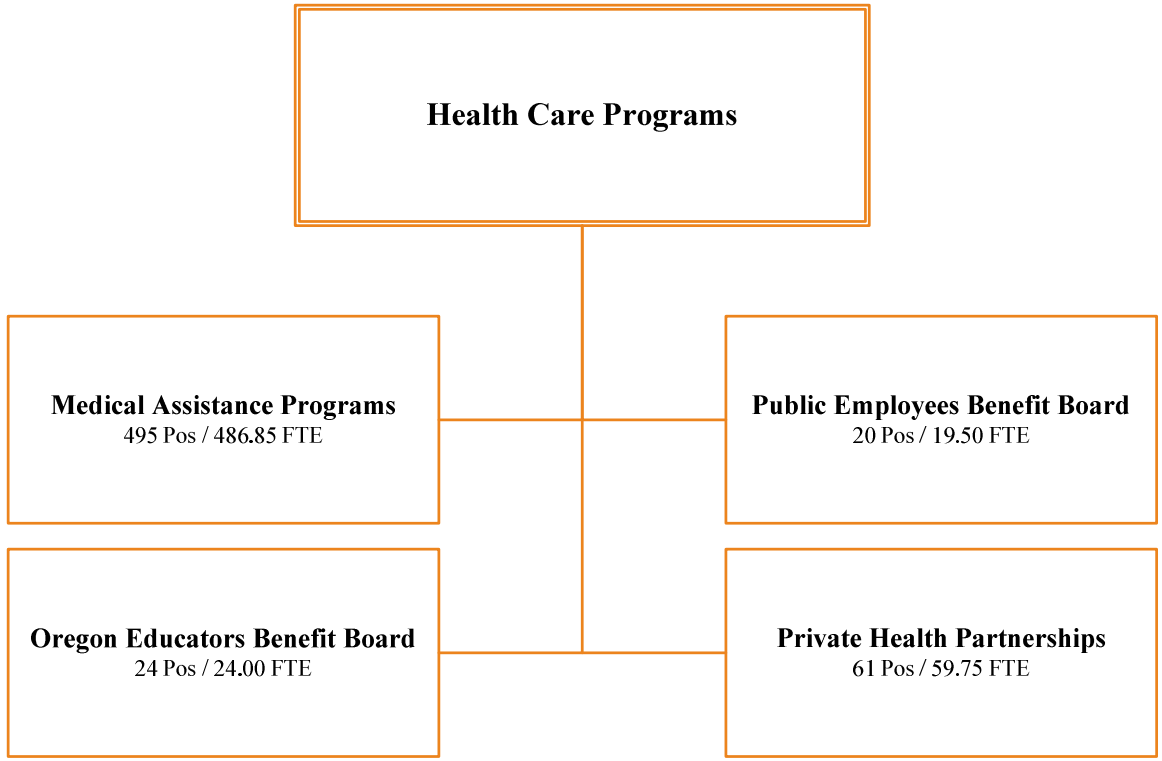
The 2013- 2015 GBB for OHA Central and Shared Services is $516,389,565 total funds. Of the $516 million, $159,220,168 is a general fund request. With all state assessments and debt service being budgeted with the Central Service Budget

structure, more than $215 million of the GBB ($133.6 million in general funds) is for the state assessments, DHS-OHA Shared Services, OHA Office of Information Services/Shared Services, and Debt Service of the Oregon State Hospital Replacement Project. Another $74.7 million is directly attributed to the Health Information Technology efforts, which leverages more than $73.0 million in federal funds.

The GBB total fund budget of the remaining Central Service units (Director's Office, Office of Health Policy and Research, Office of Equity and Inclusion, and all remaining dedicated functions) is $102,489,340.

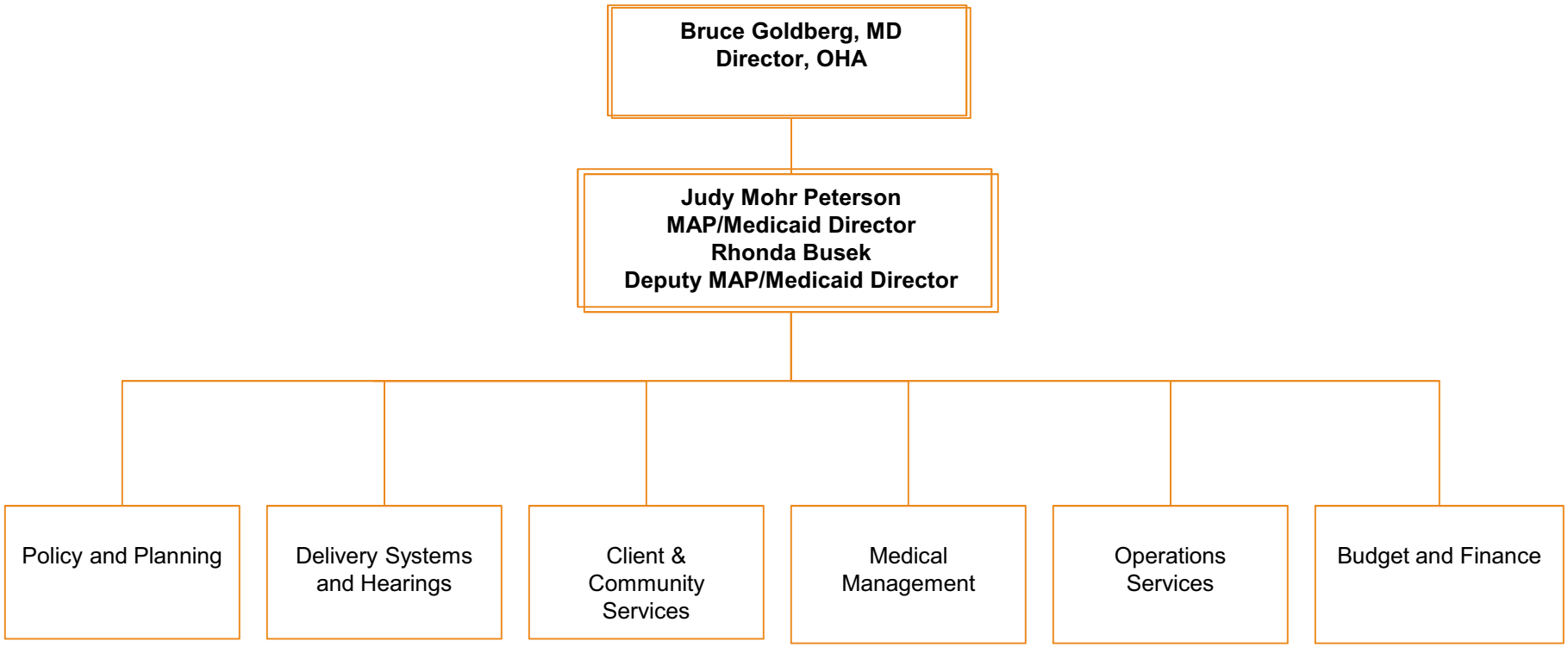
Strategic Investment Opportunities to further OHA's work on Health Systems Transformation, including the necessary work with Coordinated Care Organizations and the technology infrastructure needed for OHA delivery, total $10,230,176 of which $4,353,432 is general fund. These investment opportunities are described further in the OHA GBB Policy Option Package Narratives.

2013-15 HC Programs Organization Structure



600 Positions / 590.10 FTE

2013-15 MAP Organization Structure



495 Positions / 486.85 FTE

Oregon Health Authority

Medical Assistance Programs

The Medical Assistance Programs (MAP) is the state Medicaid agency, which delivers services to over 660,000 people, or one in six[1] Oregonians.

Mission

The Medical Assistance Programs support the agency's work to provide a system of comprehensive health services to eligible Oregonians and their families to improve their health status and promote independence.

Vision

The vision of the Medical Assistance Programs is to improve access to effective, high-quality health services for eligible Oregonians through innovation, collaboration, integration and shared responsibility.

Goals

The goals of the Medical Assistance Programs are to:

- Support effective and efficient systems that directly promote access to health care for low-income Oregonians.
- Support the entire health care provider system in Oregon by paying for needed services using federal matching funds to the extent appropriate.
- Maintain managed care enrollment at no less than 80 percent to promote access and to control health care costs.
- Decrease the number of people without health care coverage by expanding the percentage of people covered by the Oregon Health Plan (OHP).

[1] Source: PSU Population Research Center, 2011 Oregon Population Report & Tables, available at http://pdx.edu/prc/annual-oregon-population-report.

- Improve the quality of health care for all Oregonians, especially for low-income Oregonians.
- Collaborate with legislators, advocacy groups, business partners, health care providers and the general public to improve health outcomes.

- Promote the use of prevention and chronic disease management services by all Oregonians, especially those with low incomes and special medical needs.

- Work with other insurers to improve health outcomes for all Oregonians.

Programs

MAP's program budget includes three components: the Oregon Health Plan (OHP) –Oregon's Medicaid program, Children's Health Insurance Program (CHIP) also known as the no-cost option of the Healthy Kids program, and other Non-OHP medical programs.

The Oregon Health Plan

The Oregon Health Plan (Medicaid) budget covers services for Oregon's traditional and expanded Medicaid populations.

- The traditional Medicaid population meets federal Medicaid requirements, and receives OHP Plus benefit coverage[2].

- The expanded Medicaid population is comprised of uninsured adults (age 19 or older) with family incomes of no more than 100 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid or Medicare. This population receives OHP Standard benefit coverage[3].

[2] OHP Plus is a comprehensive benefit package with medical, dental, mental health and prescription drug benefits. Adults age 21 and older have limited optical coverage (for medically necessary conditions only). For a detailed benefit chart, see https://apps.state.or.us/Forms/Served/oe1418.pdf.

[3] OHP Standard provides most of the same benefits as OHP Plus, with a limited dental benefit. Services not covered by OHP Standard include routine dental care, hearing aids/exams, home health and private duty nursing, physical/occupational/speech therapy, and optical services.

The proposed extension of the hospital assessment allows MAP to support a monthly average of 60,000 adults through the OHP Standard program over the current biennium.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is a program for children from birth to age 6 with family incomes between 133 percent and 201 percent of the FPL, and for children from age 6 to age 19 with incomes between 100 percent and 201 percent of the FPL. The CHIP population also receives OHP Plus benefit coverage.

Non-OHP medical Programs

MAP's non-OHP budget covers the following populations:

- **Citizen/Alien Waived Emergency Medical:** Clients who are ineligible for OHP Plus or OHP Standard coverage because they do not meet the Medicaid citizenship or immigration status requirements, may qualify for CAWEM (emergency only coverage)[4].

- **Breast and Cervical Cancer Medical Program:** Uninsured women 40 years and over, whose incomes are no more than 250 percent FPL, are eligible for screening and diagnostic services through the Public Health's Breast and Cervical Cancer program. If a woman is diagnosed with breast or cervical cancer through this screening program, she is presumed eligible for OHP Plus benefit coverage under the Breast and Cervical Cancer Medical program, an optional Medicaid program. The woman remains eligible for the medical program until she reaches age 65, obtains other coverage or is no longer in need of treatment for her breast or cervical cancer.

- The **Qualified Medicare Beneficiary Program**: This program serves people who have family incomes of no more than 135 percent FPL. The program covers Medicare deductibles, co-insurance and co-payments.

- **Former Medically Needy:** Medically needy clients are clients who receive drug coverage that is limited to those necessary for direct support of their

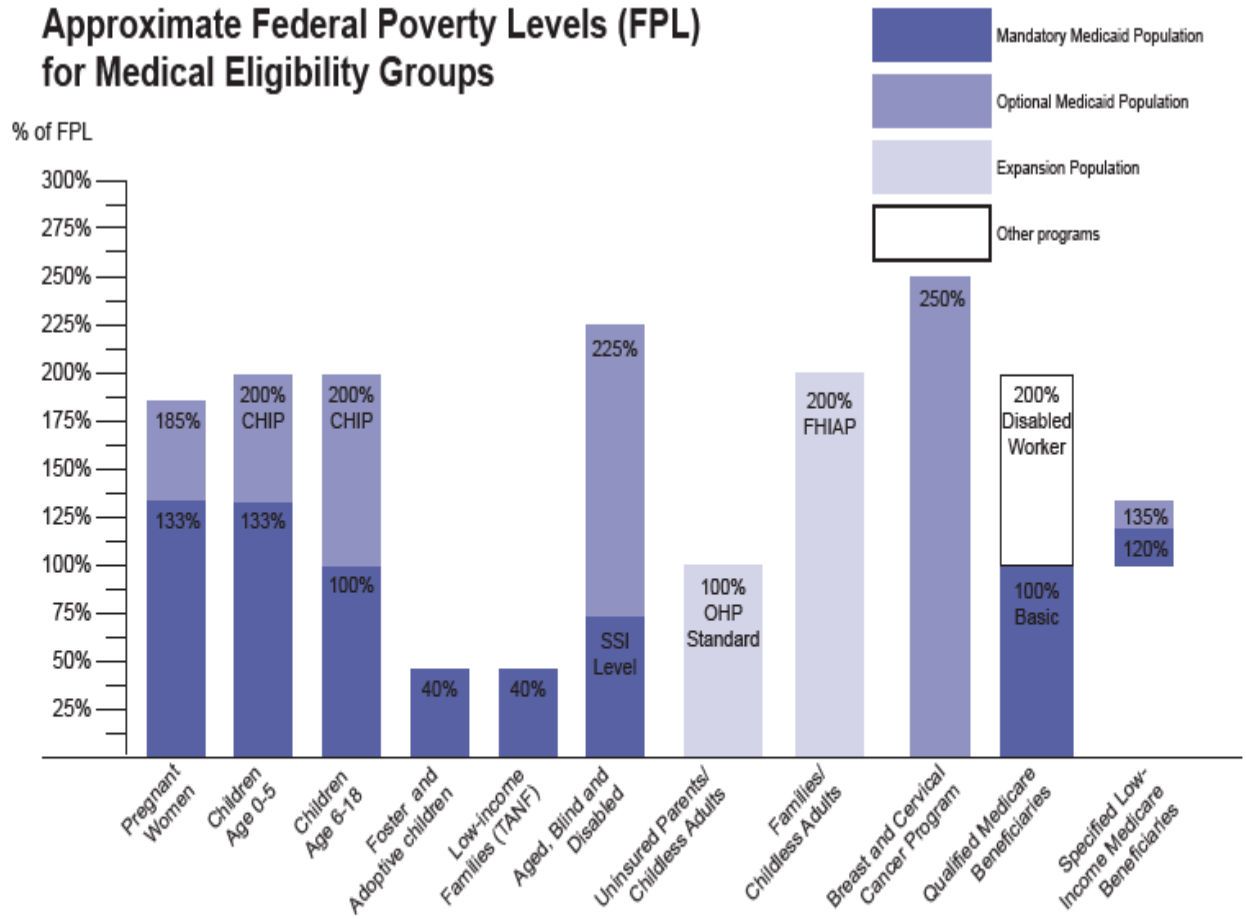
[4] CAWEM benefits are limited to emergency services, which include labor and delivery.

organ transplants. The Medically Needy program was eliminated on January 31, 2003, but continued drug coverage for this population was legislatively approved in 2004.Twenty clients[5] still receive this coverage.

Payments for services delivered to medical assistance clients represent 95 percent of MAP's budget:

- Because MAP coverage is limited to those in financial need, the program imposes financial eligibility requirements tied to the federal poverty level (FPL).
- The following chart shows the approximate FPL requirements for clients who are part of the OHP and non-OHP medical assistance populations.

[5] Source: DHS DSSURS, Apr. 15 2012, DMAP Data Informatics Unit



♦ Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (which is equivalent to approximately 225% of the FPL); otherwise, these populations are eligible up to the SSI level.

* The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low-income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of the FPL must enroll in FHIAP if they have employer-sponsored insurance. Parents and childless adults over 100% of the FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

Administration

The remaining five percent of MAP's overall budget is program support, eligibility and caseworker staffing for the OHP Central Processing Center.

Program support includes staffing and contracts that support functions such as:

- **Policy and planning**: Developing policies to implement medical assistance programs;
- **Quality improvement and medical management**: Quality assurance and improvement monitoring of the managed care, coordinated care and fee-for-service delivery systems;
- **Budget and finance**: Oversight and coordination of the budget, actuarial capitation rates and pricing, as well as oversight and coordination of federal reporting and federal matching funds;
- **Operations**: Managing all aspects of health care financing operations for medical assistance programs.

Four percent of MAP's budget supports the **OHP Central Processing Center**, which processes approximately 30 percent of all medical assistance applications[6].

- The purpose of the OHP Processing Center is to process medical applications, including enrollment into the appropriate programs, for eligible Oregonians.
- The center provides daily service to members, prospective members and community partners.

MAP's administrative budget also includes the **Office of Healthy Kids:**
Healthy Kids is Oregon's no-cost or low-cost health care coverage for children and teens 0-18 years of age. Since its inception in 2009, the children's uninsurance rate has dropped by nearly half, from 11.3 percent in 2009 to 5.6 percent in 2011.

[6] DHS Children, Adults and Families, Presentation to House Human Services Committee, Feb. 7, 2011. Available at http://www.oregon.gov/DHS/aboutdhs/budget/2011-2013/docs/caf-ss.pdf. The other 70 percent of applications are processed by DHS field staff.

The Office of Healthy Kids uses an innovative outreach and education strategy, working closely with community partners, to help families apply and stay enrolled in health care coverage.

- Healthy Kids works daily with local community partners with an emphasis on people who have access to populations who have been eligible for health coverage in the past but did not enroll for a variety of reasons.

- The Healthy Kids program contracts with 22 outreach grantees and 99 Application Assistor organizations that provide direct application assistance to families. In addition to direct application assistance, these organizations provide community based outreach, ongoing community education efforts and assistance to families for annual renewal of benefits. From the program's inception, application assistors and grantee organizations have provided direct application assistance to 12,120 families. The current forecast (Fall 2012) anticipates a growth in Poverty Level Medical Children and CHIP caseloads of approximately 6,500 clients between May of 2012 and the end of the 2013-2015 biennium (June 2015).

- The initial goal of the Healthy Kids program was to enroll 80,000 of Oregon's eligible children and teens. This goal was exceeded, and as of November 2012, 115,197 Oregon children and teens now have coverage through the Healthy Kids program. The uninsurance rate among Oregon children was cut in half, from 11.3 percent in 2009 to 5.6 percent in 2011. The goals of the program have evolved to focus on not only enrollment, but also annual renewal of coverage and continued community outreach and education.

- The Healthy Kids program is funded by the state's provider tax and matched with federal Medicaid/CHIP funds. The costs of the program remain stable and only change when responding to increases in publication costs, travel and workload. With another 230,000 newly eligible Oregonians anticipated for Medicaid/CHIP coverage in 2014, the Healthy Kids program will be poised to provide application training and program support with the many changes coming as a result of the Affordable Care Act.

Another portion of MAP's administrative budget is Pharmacy Programs:

- Pharmacy Programs provide all Oregonians access to reduced priced drugs through the Oregon Prescription Drug Program (OPDP). OPDP also provides consolidated purchasing power for the Oregon Education Benefit Board by jointly purchasing prescription drugs with state of Washington through the NW Drug Consortium. Pharmacy Programs also provides health insurance to persons who are HIV positive through CAREAssist, Oregon's version of the Ryan White AIDS Drug Assistance Program.

2011-2013 budget reductions

Due to the severe revenue shortfall, MAP was required to reduce its OHP budget by more than 11 percent. Because most of the OHP budget is dedicated to paying for health care services, the reductions affected payment rates for most health care providers and services. It also required reducing the capitation rates paid to contracted managed care organizations.

The only rates that remained the same were fee-for-service primary care rates, and most maternity case management and obstetric services rates.

July 2011 reductions

Reduction area	Description
Contracted transportation brokerages	Administrative budget allowance reduced 5 percent.

August 2011 reductions

Reduction area	Description
Ambulance service rates	Reduced 2.7 percent
Anesthesia service rates	Base rate reduced from $24.19 to $21.20.
Clinical laboratory service rates	Reduced 4 percent (from 74% to 70% of the 2010 Medicare Clinical Lab fee schedule).

Reduction area	Description
Contracted mental health service rates	Reduced rates and contracted provider capacity by 11.5%.
Dental service rates	All reimbursement reduced 5 percent
Durable medical equipment rates	Rates for complex rehabilitation/wheelchair codes reduced 4.6 percent (priced at 90.5% of 2010 Medicare Fee schedule). Non-Medicare covered codes reduced 7.6 percent Rates for all other Medicare-covered codes included on DMAP's fee schedule priced at 80% of 2010 Medicare Fee schedule.
Home health service rates	Reimbursement reduced one percent (from 75% to 74% of Medicare costs reported to DMAP). Medical supply (acquisition cost) daily maximum rate reduced from $75 to $50.
Maternity case management rates	G9011 –Case Management Visit Outside the Home reduced to $21.45 (50% of G9012 – CM Visit). Changes to billable codes: • Either G9002 or G9005 can be billed, but not both, and only if the client's case has been managed for at least three months. • G9009 – partial case management and G9010 – high risk case management no longer covered.
Medical supply rates and limitations	Utilization limitations added to incontinence supplies and gloves. Claims submitted for more than the amount listed below require prior authorization: • Incontinence supplies – limited to 200 per month. • Gloves – limited to 2 boxes (100 pairs) per month. Rates for all Medicare-covered codes included on DMAP's fee schedule priced at 80% of 2010 Medicare Fee schedule.

Reduction area	Description
Mental health and chemical dependency service rates	Fee-for-service (FFS) outpatient rates reduced to: • 110% of Medicare for codes reimbursed by Medicare; or • 66% of billed charges. FFS Provider Specific Rates reduced 11.5 percent.
Pharmaceutical service rates	Clozaril Management rate reduced from $18.72 to $10. Changed thresholds for dispensing fee tiers and reduced dispensing fees. Also • <30,000 claims = $14.01 • 30,000-50,000 claims = $10.14 • >50,000 claims = $9.68
Physician and other professional service rates	The Relative Value Units (RVU) conversion factor reduced from $27.82 to $26.00 (priced at 72% of Jan 2010 nationwide Medicare).
Prosthetics and orthotic rates	Rates for "L codes" reduced 2.3 percent (priced at 83% of 2010 Medicare Fee schedule). Rates for all other Medicare-covered codes included on DMAP's fee schedule priced at 80% of 2010 Medicare Fee schedule.

September 2011 reductions

Reduction area	Description
Managed care organization rates	Capitation rates reduced approximately 10 to 11 percent

January 2012 reductions

Reduction area	Description
Dental service coverage	Limited coverage of the following procedures: • Dentures, denture rebases and relines • Periodontal work (scaling and root planing, full mouth debridement) and follow-up treatment (periodontal maintenance)

Reduction area	Description
	• Root canals on molars
OHP Prioritized List coverage	Coverage ends at line 498, eliminating coverage for the following treatment/condition pairs: • Medical and surgical methods to treat keratoconjunctivits (inflamed or infected cornea)
OHP Prioritized List coverage, continued	• Talk therapy to treat mutism (inability to talk in certain situations) • Surgery to remove hemorrhoids; removal of a blood clot in a hemorrhoid • Surgery to place tubes in the ears, remove tonsils or repair certain injuries to the ear canal due to Chronic Otitis Media (chronic fluid or infection in inner ear) • Surgery to treat rectal prolapse (rectal tissue that falls through the anal opening) • Surgery to correct otosclerosis (a bone growth in the inner ear that can cause hearing loss) • Removal of foreign body in ear/nose • Surgery to treat anal fistula (tear in the anal wall or in the connection between the anus and the skin) • Surgery to treat fractures of the vertebral column (a broken bone in the back that has not injured the spinal cord) • Counseling for conduct disorders (*e.g.*, delinquency or disruptive behavior) • Drainage or removal to treat disorders of the breast (cysts, non-cancerous lumps) • Drainage of infected areas, destruction of lesions, and repairs of injuries not resulting from childbirth to treat disorders of the vagina • Drainage of infected areas or collections of fluid to treat cysts of Bartholin's gland

Health system transformation

Senate Bill 1580 from the (2012 Regular Session) launched Coordinated Care Organizations (CCOs), which form the center of Oregon's health system transformation efforts.

- CCOs are local health entities that deliver all health care for OHP clients.
- A local network of providers coordinates care at every point – from where services are delivered to how the bills are paid.

CCO implementation provides a direct connection to Oregon's 10-year goals for achieving better health, better care, and lower costs.

Better health

CCOs will focus on prevention, using primary care homes and community health workers to coordinate care, for improved health outcomes such as:

- Decreased chronic disease rates, including mental health
- Decreased tobacco use rates
- Improved self-reported health status

Better care

The previous system that delivered services to over 85 percent of OHP clients was complicated and fragmented:

- 16 managed care organizations delivered physical health care services
- 10 mental health organizations delivered mental health care services
- 8 dental care organizations delivered dental care services

The remaining 15 percent of OHP clients received services from providers who bill MAP directly for reimbursement on a fee-for-service (FFS) basis. Rate reductions and a lack of payment incentives make it difficult to always locate FFS providers available or willing to treat OHP clients.

Behavioral health issues and chronic conditions are major drivers for negative health outcomes and high health care costs. When these conditions go unrecognized or untreated, they could lead to more expensive care (*e.g.*, emergency department visits) for an unmanageable condition.

CCOs will reduce fragmentation and focus on the "whole patient" through a redesigned delivery system featuring:

- Integration and coordination of benefits and services
- Local accountability for health resource allocation
- Standards for safe and effective care
- A global budget indexed to sustainable growth

With increased resources to coordinate care, CCOs can address behavioral health issues that lead to poor physical health outcomes. Increased awareness of behavioral health issues and chronic health conditions in all health care settings can get clients the right care at the right time, avoiding the need for more expensive care.

CCOs will also care for more of the OHP population than the previous managed care delivery system, which means fewer people seeking care on a FFS basis. This includes Breast and Cervical Cancer Medical Program clients, HIV/AIDS patients, and other higher-risk populations who will benefit from the local, coordinated care structure and community supports that CCOs will be responsible to establish and maintain.

Lower costs

The current health system is unsustainable. Health care costs are increasingly unaffordable for individuals, businesses, the state and local governments.

Inefficient health care systems bring unnecessary costs to taxpayers.

- Research shows that 30 percent of health care spending is due to waste and inefficiency and that approximately 80 percent of health care costs are driven by 20 percent of the population.
- When budgets are cut, services are slashed, as demonstrated by the many reductions MAP implemented in the current biennium.

Reduced administrative overhead in CCO contracts, a single point of accountability for client health (the CCO), and a single global budget all support greater efficiency and accountability in health care spending.

Under an agreement with the federal government, Oregon will reduce the projected growth in health care spending by 2 percent in two years through improved health outcomes and reduced waste and inefficiency. The projected total state and federal savings are $11 billion over ten years.

A third-party analysis estimated that savings due to CCO implementation would be more than $1 billion in state and federal funds within three years, and more than $3.1 billion over the next five years.

2011-2013 accomplishments

More health care for more Oregonians

OHP Standard hospital benefits increased so that all Medicaid-eligible Oregonians have access to scheduled, medically appropriate, inpatient and outpatient hospital care and surgeries, in addition to emergency hospital services. This change makes OHP Standard hospital benefits the same as hospital benefits for OHP Plus clients.

The Citizen/Alien Waived Emergent Medical (CAWEM) prenatal program opened in seven more counties. Now in 15 counties, the program covers prenatal care for CAWEM-eligible pregnant women who would otherwise only receive health care coverage for emergency services and deliveries.

Operations

Processes were put in place to ensure Oregon Medicaid collects Medicaid drug rebates for managed care prescriptions and physician-administered drugs under the federal Deficit Reduction Act and the Patient Protection and Affordable Care Act.

System and business process changes were implemented to comply with OHA Administrative Simplification and HIPAA 5010 requirements for electronic health care transactions.

New policies, provider enrollment and system processes were established to support the Patient-Centered Primary Care Home program.

Access to care

OHA worked with managed care plans on a renewal reminder strategy to help ensure that clients already enrolled in managed care remember to reapply for OHP benefits before their eligibility ends.

- Timely reapplication not only ensures that clients keep their OHP benefits, but that they remain enrolled in their current medical and dental plans.

- Managed care enrollment provides access to high-quality and cost-effective care with an emphasis on prevention and the provision of primary care services, such as patient education and promotion of healthy lifestyles, to avoid more serious health complications and hospitalizations.

The list of services covered when provided by Limited Access Permit (LAP) Dental Hygienists were expanded within their scope of practice. LAP dental hygienists can provide dental hygiene services without the supervision of a dentist in certain settings for patients who may not be able to otherwise access dental care services.

Client access to diabetic supplies was increased by allowing pharmacies to bill MAP for these supplies using their point of sale systems. Before this system change, pharmacies could only bill MAP for these supplies as enrolled medical supply providers using the professional medical claim format.

Quality of care

Contracts were extended with APS Healthcare for Medical Case Management and Disease Case Management, which serves an average of 60,000 fee-for-service OHP clients through the Oregon Health Plan Care Coordination Program (OHPCC). This contract is now in its third year.

- In a recent survey, 97.6 percent of OHPCC clients rated that they were very satisfied with the overall quality of the program[7].
- OHA is investigating the feasibility of adding clients eligible for both Medicare and Medicaid, and additional risk populations previously excluded

[7] APS Healthcare Client Satisfaction Survey (initial results, not yet released)

from the OHPCC contract, in order to help transition these populations to the Coordinated Care Organization environment.

OHA participated in the High Value Health Leadership council's Statewide Commercial and Public Medical Home Demonstration Pilot. This two-year pilot project goes through February 2013. Administrative support with this project is provided by APS Healthcare as part of their contractual support for medical homes.

Tobacco cessation

In Oregon, direct Medicaid costs related to smoking are an estimated $287 million per year (approximately 10 percent of total annual Oregon Medicaid expenditures). MAP partners with contracted medical and dental plans and OHA Public Health to promote tobacco cessation strategies.

In 2011, MAP began systematically assessing how contracted Managed Care Organizations screen for tobacco use and providing the required tobacco dependence and cessation services benefit to Oregon Health Plan members.

Positive gains have been made with tobacco cessation efforts since 2004[8].

- Among OHP medical and dental plan members, smoking prevalence declined from 41 percent in 2004, to 39 percent in 2007 and down to 31 percent in 2011.

- For people not enrolled in a medical or dental plan, smoking prevalence significantly declined from 41percent in 2004, to 29 percent in 2007, and 21 percent in 2011.

Partnerships

MAP strengthened partnerships with stakeholders, tribal organizations, the provider community and contracted managed care plans in extensive outreach to discuss options for budget reductions, legislative implementation, Health Systems Transformation, and HIPAA 5010 and NCPDP D.0 implementation. Strengthened partnerships allow better delivery of health care services, promotion of prevention strategies and increased access to services.

[8] Source: 2011 CAHPS Survey (initial results, not yet released)

Revenue sources

The state and the federal government share the costs of providing OHP services to eligible low-income people.

- For clients eligible for Medicaid, the state pays 37.09 percent and the federal government pays 62.91 percent[9].

- For clients eligible for the Children's Health Insurance Program (CHIP), the state pays 25.96 percent and the federal government pays 74.04 percent[10].

The following table summarizes MAP's revenue sources (in rounded millions).

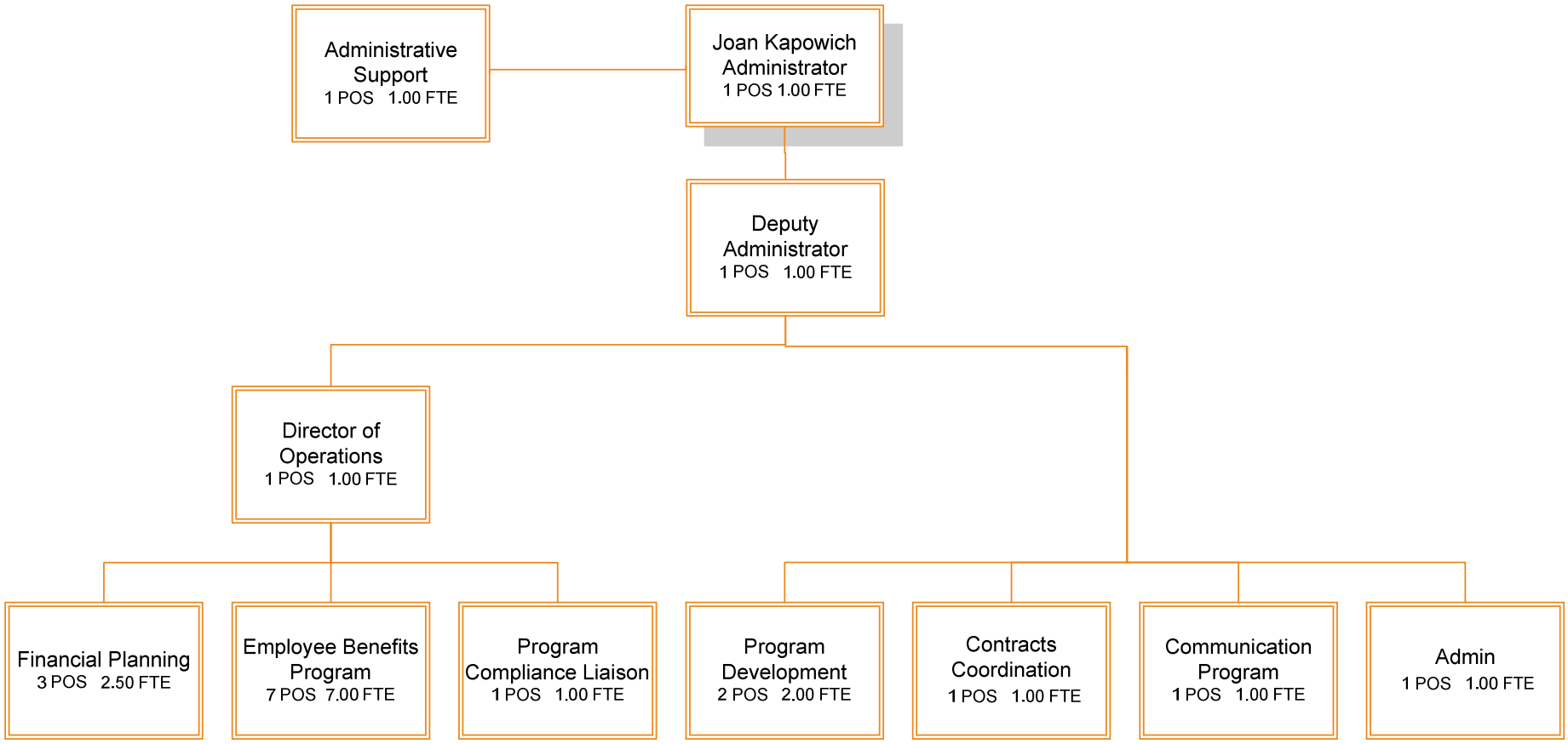
Numbers are based on the 2013-15 pre-audit Governor's Balanced Budget, which includes a Policy Option Package to transfer two programs from APD to MAP. This transfer, which is budget neutral at the state level, provides better alignment for delivering health care to Oregon Health Plan clients.

Source	Amount (in rounded millions)	Description
General Fund	$1,145	–
Other Fund	$1,887	Other Funds include 3 months of revenues from the existing Insurers Tax, GBB proposed extension of the Hospital Assessments, Medicaid drug rebates, supplemental drug rebates, Law Enforcement Medical Assistance Fund (LEMLA), Tobacco Settlement funds, Third Party Recovery, local match payments
Federal Fund	$7,215	Federal share of paying Medicaid/CHIP program costs
Total Fund	$10,248	–

[9] Rates provided are for Federal Fiscal Year 2012. The federal government sets this rate, and it fluctuates from year to year.

[10] Ibid

2013-15 PEBB Organization Chart



20 Positions / 19.50 FTE

Oregon Health Authority

PUBLIC EMPLOYEES' BENEFIT BOARD

Vision

PEBB seeks optimal health for its members through a system of care that is patient-centered, focused on wellness**,** coordinated, efficient, effective, accessible and affordable. The system emphasizes the relationship among patients and providers, primary care and the community. PEBB promotes integrated health plans that cover the whole person.

Key elements of the PEBB vision are:

- An innovative delivery system that uses evidence-based medicine to maximize health and use dollars wisely;
- A focus on improving quality and outcomes, not just providing healthcare;
- Promotion of health and wellness through consumer education, healthy behaviors and informed choices;
- Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place;
- Accessible and understandable information about costs, outcomes and other health data for informed decision making; and
- Affordable benefits for the state and the employees.

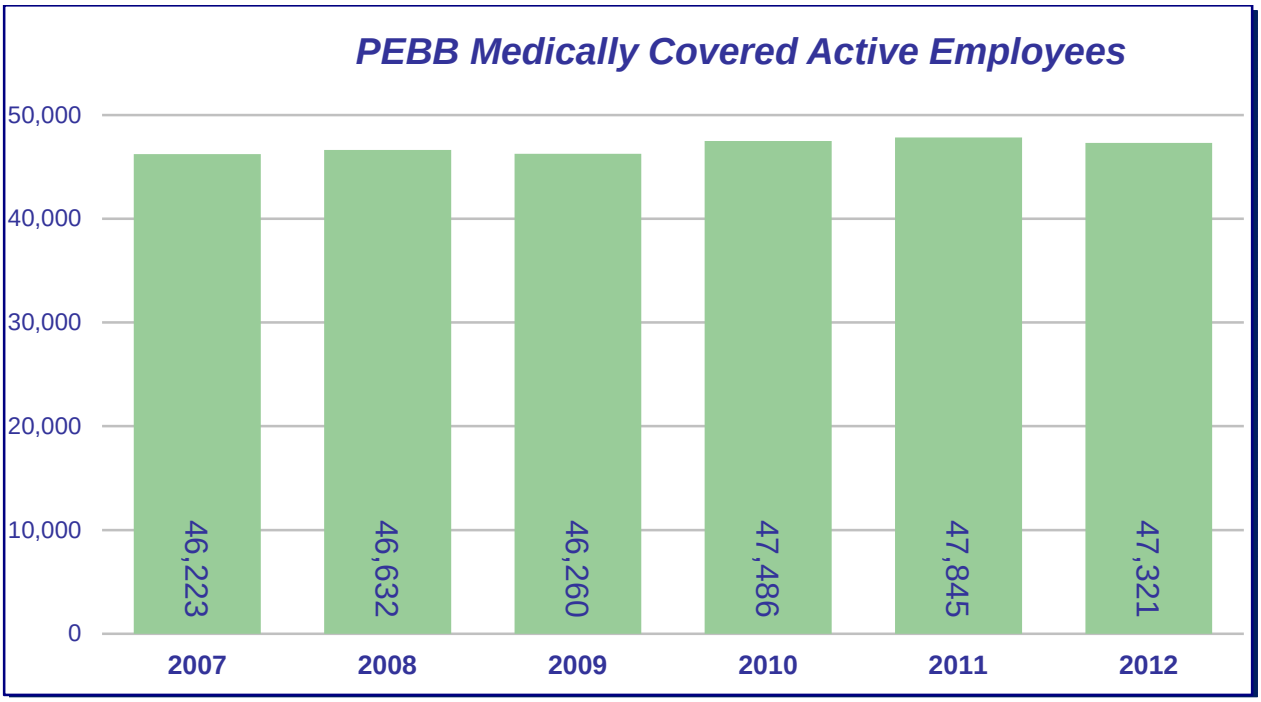
Goals

PEBB's goals are to design, contract and administer high-quality health plans, group insurance policies, and flexible spending accounts for state employees and their dependents that are affordable for the state and employees.

Who we serve

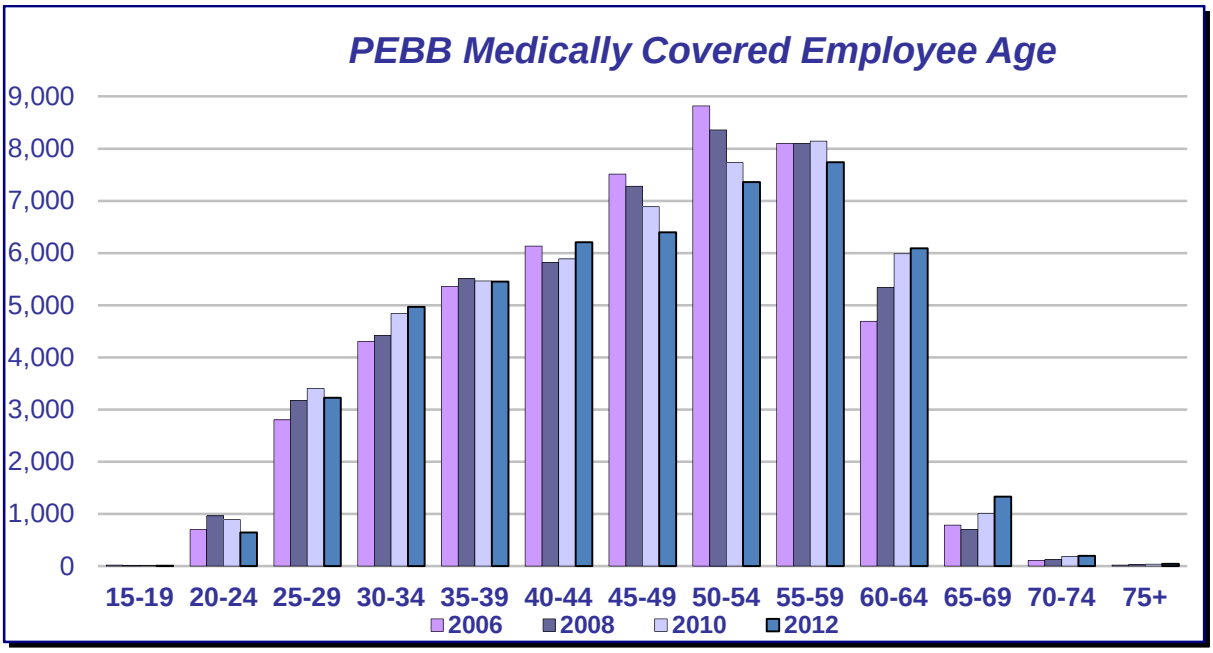
PEBB members include:

- Active agency and university employees and their dependents
- Active semi-independent agency employers and their employees
- Retirees and other self-pay participants and their dependents
- COBRA participants



Age trend

PEBB monitors the age trend of its membership to ensure its plans provide appropriate services and to anticipate future needs. The following graph shows member age bands for 2006, 2008, 2010 and 2011. Currently, 46 percent of PEBB's active employee population is age 50 or older.



Activities and programs

PEBB serves its members and customers through six central functions:

- Financial oversight of PEBB accounts, including the Revolving Fund and its subaccounts
- Program development through collaboration with agencies, universities, health plans and other benefit purchasers on programs to implement elements of the PEBB vision
- Regulatory compliance to ensure the benefit program meets all state and federal requirements
- Enrollment control through a benefit management system designed to ensure accuracy of data and data transfer between PEBB, state and university payroll systems, health plans and other vendors
- Accurate and timely contracting services
- Communications to engage PEBB members in the benefit program, their health and financial wellbeing, and the PEBB vision.

The program's most valuable benefit is health care coverage. The cost of this coverage continues to increase without evidence of a commensurate increase in measurable quality.

2013-19 six-year plans

- Provide high-quality benefits that are affordable to employees and employers.
- Implement additional value-based benefit design elements supported by scientific evidence.
- Continue to leverage self-insurance to create benefit designs that reflect and enhance the vision for a Healthy Oregon.
- Explore programs that engage members in their health and health care to reduce risks to their health and safety, improve their health and quality of life, and moderate premium costs into the future.
- Provide excellent service to members, agencies, universities and other customers.
- Enhance government services, and protect information and assets while controlling cost.
- Meet the information needs of members, agencies, universities and other customers.
- Provide effective policies with clear direction.

2013-15 two-year plans

PEBB supports OHA's vision, mission and goal to transform the health care system in Oregon by:

- Promoting the development of patient-centered primary care homes
- Supporting and promoting pilots that reimburse providers for health care services using global and pay-for-performance methodologies
- Implementing value-based plan designs that help members choose the right care at the right time in the right setting
- Promoting the development and success of Coordinated Care Organizations.

PEBB operations

- Offer plans that provide health care supported by the best available evidence.
- Promote a competitive marketplace by contracting with health systems that are accountable for their performance.
- Collaborate with partners to improve the market and delivery system.
- Meet or exceed standards for response time.
- Survey customers annually, and analyze and act on results.
- Maintain and improve the benefit management system.
- Develop and maintain comprehensive, user-friendly websites.
- Employ cost-effective, sustainable technologies to improve communication and reduce resource consumption.
- Continue to support agency and university efforts on employee health and wellness.
- Continue to seek agency and university input on benefit management and administration.
- Conduct audits to ensure that policies are applied equitably.
- Continue to solicit member and customer input on policies.
- Continue to support use of the benefit management system by state agencies and universities.
- Improve contracting and analytical capabilities.
- Refine reporting of benefits information.

2011-13 major accomplishments

Quality, affordable benefits

- Increased the percentage of PEBB members in a patient-centered primary care home.
- Implemented additional cost tiers to promote value-based benefits.
- Implemented benefit design elements aimed at reducing barriers to care for members with chronic diseases.
- Continued to support the state's public health and prevention initiatives.
- Achieved better cost and quality controls through direct contracting for the majority of the medical, vision and dental plans.
- Maintained a leadership role in health care purchasers' evaluation of commercial medical plans.
- Implemented a Health Engagement Model to promote member participation in reducing health risks and improving overall health status.
- Conducted a dependent eligibility verification audit to evaluate and ensure the integrity of member enrollment.
- Partnered with Public Health in surveying member health status to glean information that guides board decisions on design of benefit plans.
- Worked closely with Public Health to promote worksite wellness activities and policies.

Services for members and customers

- Met or exceeded response time expectations.
- Continued to solicit input on services and plan designs from employees, agencies, universities, plans and other customers.

Member and customer information needs

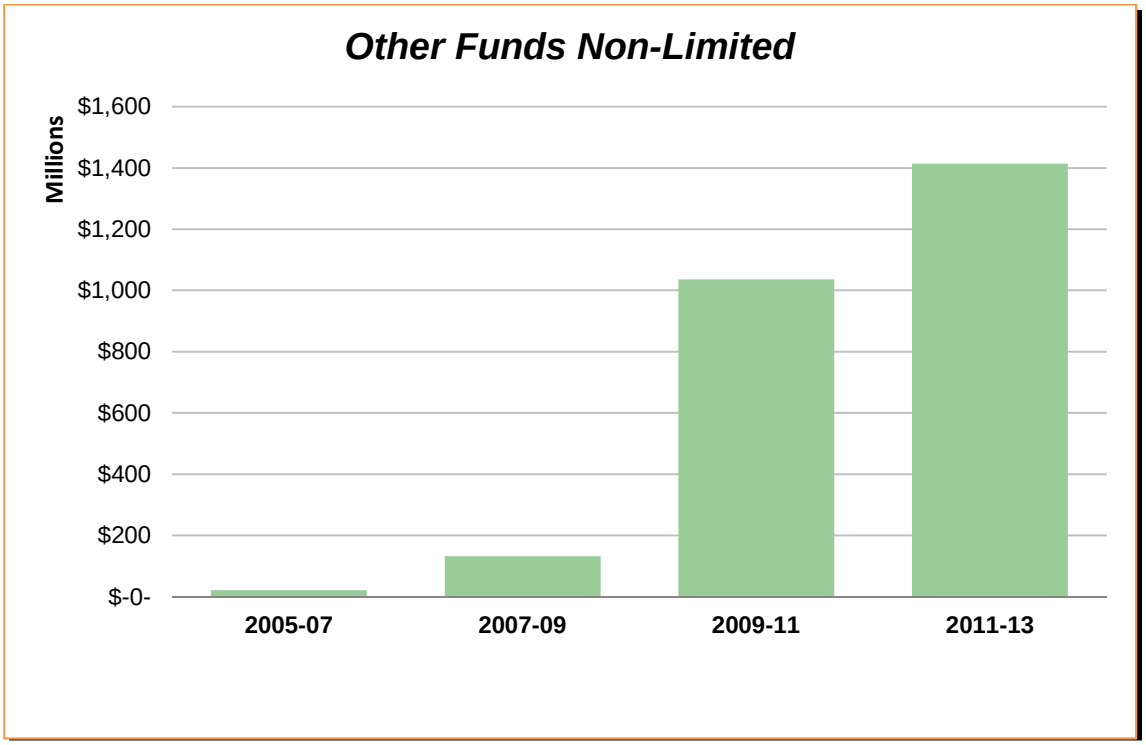
- Used online media such as web-based seminars and streaming video to communicate actively with more employees about their benefits.
- Continued to develop channels for employee and agency input.
- Incorporated employee and agency feedback on communication messages and media.

Policies and direction

- Continued to require all eligible employees to actively enroll in and declare eligibility for benefits for 2012 and 2013 to ensure further the integrity of enrollment data.
- Continued to audit compliance with eligibility and enrollment rules.
- Continued to clarify eligibility criteria and worked with agencies and universities to apply revised rules correctly, including regulations from the federal Affordable Care Act.

Self-insurance trend

PEBB began to self-insure plans in 2006, directly contracting for two regional medical plans administered by Samaritan Health System and Providence Health Plans. In 2007, PEBB began to self-insure the majority of its dental plans, which are administered by ODS Companies. In 2010, PEBB began to self-insure its largest medical and vision plans, administered by Providence Health Plans and Vision Service Plan, respectively. Other Funds Non-Limited expenditures increased in correlation with the rising percentage of members covered in self-insured plans.



Revenue sources

Revenue from Other Funds pays for PEBB administration through an administrative assessment added to medical and dental insurance premiums and premium equivalents. The assessment cannot exceed 2 percent of monthly contributions from employees and employers (ORS 243.185). For the years 2011, 2012 and 2013, PEBB has reduced the assessment from 0.6 percent to 0.4 percent.

PEBB also eliminated funding for annual open enrollment expenses. Printing and distribution costs were the main expenditure from this fund.

Revolving Fund

PEBB currently maintains two accounts within its Revolving Fund.

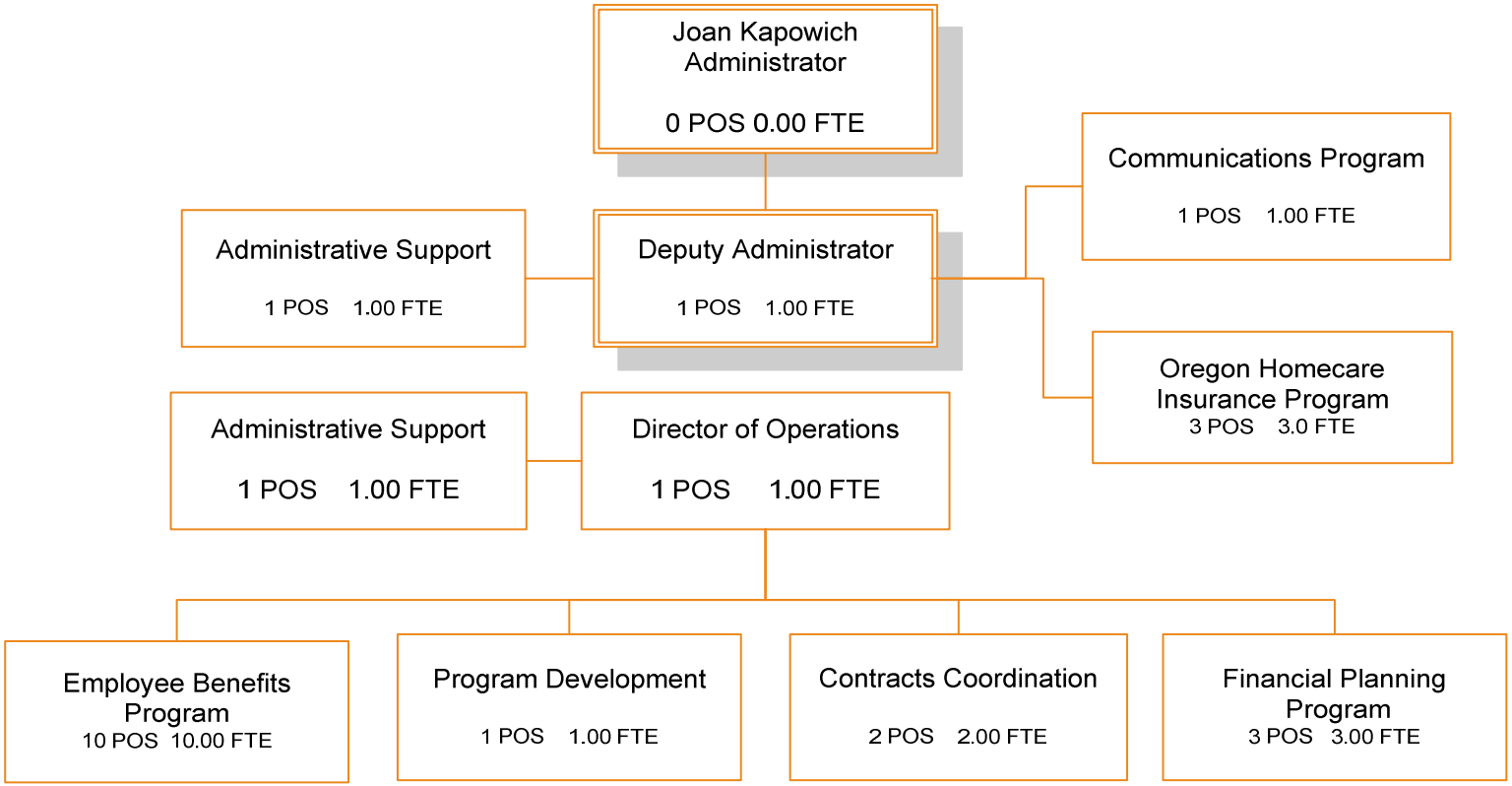
Stabilization account

PEBB has authority to use this account to control costs, subsidize premiums and self-insure. The Other Funds revenue source is primarily unused employer contributions for employee benefits. This account also holds proceeds generated when PEBB's life insurance carrier changed from a mutual organization to a public corporation.

Flexible spending account

PEBB operates two flexible-spending account programs for employees and maintains a non-limited fund to account for their administrative costs. The primary Other Funds revenue source for these programs is forfeitures from participants.

2013-15 OEBB Organization Structure



24 Positions / 24.00 FTE

Oregon Health Authority

OREGON EDUCATORS BENEFIT BOARD

Vision

The Oregon Educators Benefit Board (OEBB) is aligned with the vision of the Oregon Health Authority in creating a healthy Oregon. The OEBB vision is to provide high-quality benefits for eligible employees and early retirees at the lowest cost possible and work collaboratively with members, educational entities and insurance carriers to offer value-added benefit plans that support improvement in members' health while holding carriers accountable for outcomes.

Key components of the vision include:

- An innovative system that provides evidence-based medicine to maximize health and utilize dollars wisely;
- A focus on improving quality and outcomes, not just providing health care;
- System-wide transparency through explicit, available and understandable reports about costs, outcomes and other useful data; and
- Encouragement for members to take responsibility for their own health outcomes.

Goals

OEBB's goal is to provide high-quality medical, dental and other benefit plans for eligible employees at a reasonable cost.

The statutes governing OEBB (ORS 243.860 to 243.886) outline specific criteria that OEBB must follow in considering whether to enter into a contract for a benefit plan. In September 2007, the board further defined those criteria and adopted guiding principles**.**

Guiding principles

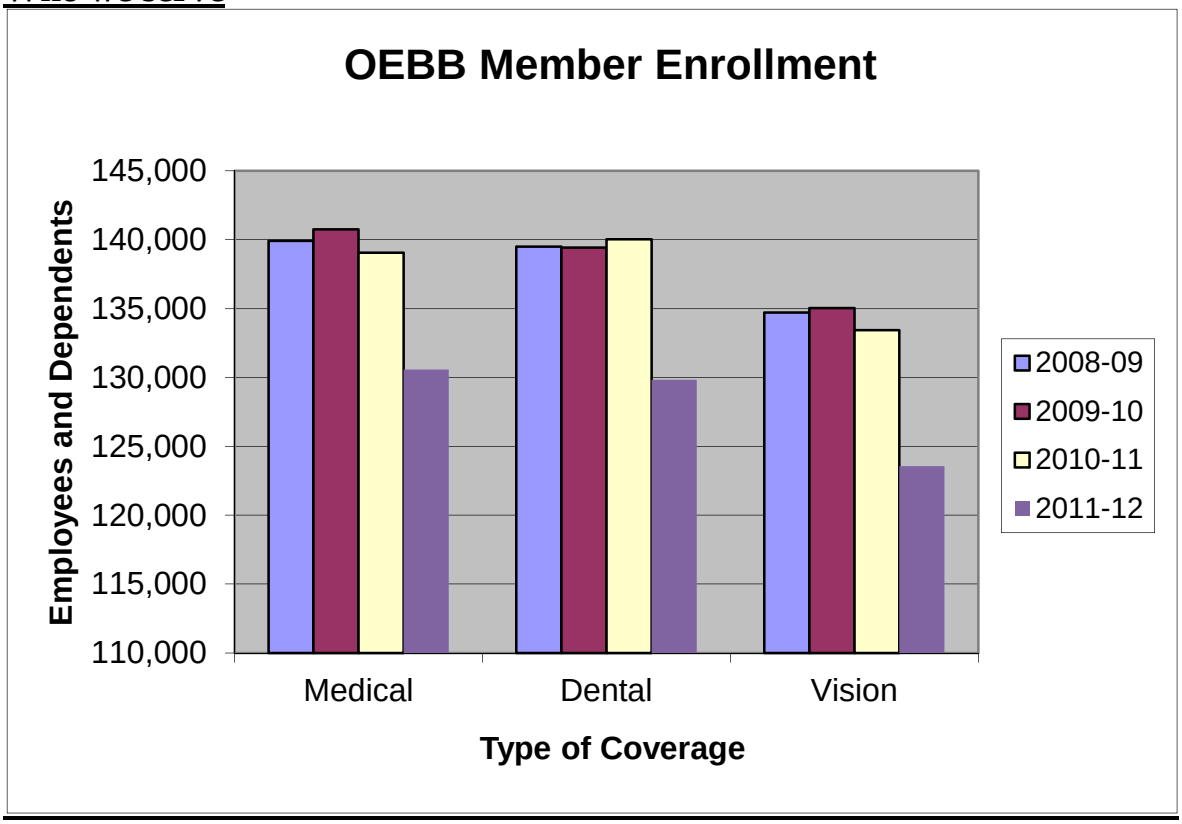
- OEBB will offer employees a range of benefit plans that provide high-quality care and services.
- OEBB will encourage competition in the marketplace in the areas of quality, outcomes, service and cost.

- In making its decisions, OEBB will consider plan performance in quality, administrative processes, costs and outcomes. It will promote system-wide transparency that provides comprehensive information on these issues.
- OEBB will offer a range of benefit plan designs that provide educational entities with the flexibility to choose options that meet their and their employees' financial and health needs.
- OEBB will encourage benefit plans and providers to offer members consistent access to care and services; integrated care systems that provide effective treatment; and personal and prompt service that meets customers' needs.
- OEBB will seek plans and providers that use creative and innovative methods and practices that are evidence-based or otherwise measurable.
- OEBB will recognize the impact of its decisions on employees' total compensation.
- OEBB will promote employee health and wellness through plan design components, disease and case management, and consumer education.
- OEBB will take into account the total costs of benefit plans, as well as employee cost-sharing for services, in offering a range of benefit plan designs.

Guiding principles of board operations

The board will operate as a cohesive unit that provides for open discussion on topics. The board also will operate in a transparent manner that fosters public trust, input and understanding of OEBB decisions and policies.

Who we serve



2013-19 six-year plan

- Keep medical rate increases at trend or below.
- Implement additional value-based benefit design changes supported by scientific evidence.
- Identify resources to support educational entities' health and wellness efforts.
- Continue to involve stakeholders in all aspects of policy development.
- Improve data systems to give educational entities reporting tools that support their business needs.
- Continue to operate in a transparent manner that fosters public trust, input and understanding of OEBB decisions and policies.
- Ensure the board operates as a cohesive unit that holds open discussion among its members.
- Continue to use workgroups to help the board make decisions based on analysis, discussion and development of options and recommendations. The board has established workgroups in three areas: business and operations, communications and engagement, and strategies on evidence and outcomes.

- Continue to enhance the board's long-term communication plan to include member engagement and wellness strategies.
-

2013-15 two-year plan

- Continue developing the "MyOEBB" benefit management system to increase efficiencies by providing OEBB members the ability to manage their benefits online, providing OEBB staff and educational entities the ability to access information related to benefit enrollments and communicating enrollment and eligibility information to benefit carriers electronically.
- Continue supporting educational entity administration through the use of electronic invoices and fund transfers and administrative reports that allow administrators to access and manage eligibility and enrollment information.
- Continue monitoring standards for customer response time and improving the Board's administrative and customer service models.
- Continue transitioning the business side of OEBB onto the internet.
- Emphasize technology as a way to increase efficiency and convenience.
- Regularly review existing security standards and practices in state government to ensure that OEBB meets enterprise wide security standards.
- Continue developing and maintaining a comprehensive and user-friendly website and online benefit enrollment system.
- Minimize the threat of unauthorized data access, both internally and externally.

OEBB supports the Oregon Health Authority's goal to improve the lifelong health of all Oregonians. OEBB is focused on improving the health status of its members and their access to quality care. The board is taking action to increase the quality, reliability and availability of care for all Oregonians, consistent with OHA's goal.

To facilitate the goals of OHA and OEBB, the board requires OEBB carriers to ensure that contracted physicians, providers and facilities render quality care at a sustainable cost. Facilities and providers may not be included in carrier panels if they do not meet these requirements.

- Quality care is consistent with evidence-based practice guidelines and within the context of individual clinical circumstances.

- Sustainable costs align with community reimbursement rates and, whenever possible, payment is made for outcomes rather than the provision of services.

2011-13 major accomplishments

- Designed and implemented additional benefit plans for Oregon's educational employees and their families. Health savings account (HSA) and flexible spending account (FSA) options were added to the life, disability, accidental death and dismemberment, long-term care, employee assistance program, medical, dental, pharmacy and vision benefits previously available through OEBB.
- Added eligible dependent coverage under the evidence-based weight management program to improve health outcomes by reducing the prevalence of obese and overweight members and weight-related illnesses. More than 12,000 OEBB members have participated in the weight management program through meetings held at worksite meeting locations and lost more than 127,000 lbs.
- Performed a Dependent Eligibility Verification (DEV) audit to evaluate and ensure the integrity of the member enrollment in the OEBB benefit plans.
- Maintained an average per employee medical coverage premium increase below trend every plan year since OEBB began renewals in 2009.
- Implemented value-based plan design changes to provide incentives for chronic disease management and disincentives for several surgeries and procedures that evidence shows are over-utilized, ineffective, have questionable outcomes, or can have harmful side effects.
- Established a health and wellness support program including implementing "Champs!," a diverse group of OEBB members that meet to share ideas for wellness activities, success stories and identify various resources available to assist in implementing or maintaining worksite wellness programs and activities.
- Effective January 2013, administration of the Oregon Homecare Insurance Program (OHIP) moved under the Oregon Health Authority (OHA). This new OHA program operates under the management and guidance of OEBB staff and is able to use OEBB's online benefit management system, MyOEBB. Under an agreement with DHS, OHA will administer the benefit plans for homecare workers. Three limited duration positions are included in OEBB's Governor's Budget along with an increase of $21.3 million in Other Funds Nonlimited authority to account for the pass-through of insurance premiums.

Customer service delivery

OEBB continues to enhance efficiencies, creating a reporting repository for use by educational entities human resources and payroll staff responsible for employee benefits and allowing easy data migration through a payroll interface. OEBB also automated mid-year changes for members and enhanced e-mail communications for new hire and open enrollment information. OEBB continues to conduct requested trainings on the benefit enrollment system and processes, and to make presentations educating members on rate, benefit and plan design changes.

- OEBB expanded its administrative activities to offer educational entities the option for OEBB to administer benefits for benefit-eligible early retirees. Early retirees no longer have to enroll for benefits through their former employer or through a third party administrator. This allows more consistent and efficient managing and processing of enrollments and payments. In some cases, this also allows an educational entity to reduce costs associated with benefits administration.

Performance measures

OEBB uses measures and checkpoints to evaluate progress and success in implementing its business plan with regards to customer service. The target sets the performance benchmark. Checkpoints are actions taken to evaluate progress or the success of efforts being developed as part of the business plan. The board is in the process of developing a set of measures designed to provide information to the board, educational entities, members and lawmakers.

Goal Excellent Customer Service	Measures or Checkpoint Percentage of customers who rate OEBB customer service as good or excellent*.	Target 90 percent
Overall Customer Service	2009 Member Survey Results	97 percent
Overall Customer Service	2010 Member Survey Results	89 percent
Overall Customer Service	2011 Member Survey Results	92 percent

**2010 & 2011 Member Survey used the terminology "satisfied or very satisfied" in place of "good or excellent"*

-

Results from the 2011 member survey results show:

- 92 percent of members who reported having contact with OEBB were satisfied or very satisfied with OEBB's customer service.
- 94 percent of members reported they were satisfied or very satisfied with the information OEBB sent to them.
- 91 percent of web users reported they were satisfied or very satisfied with the OEBB website.
-

Quality and efficiency improvements

OEBB is committed to ongoing process improvement and continually identifying and implementing administrative efficiencies. The strategic plan for improving quality and efficiency provides for:

- Gathering information, data and input from educational entities to develop or modify plan designs for medical, dental, vision and optional benefit plans.
- Reviewing and evaluating proposals and existing contracts and negotiating rates to provide high-quality plans at the lowest possible cost.

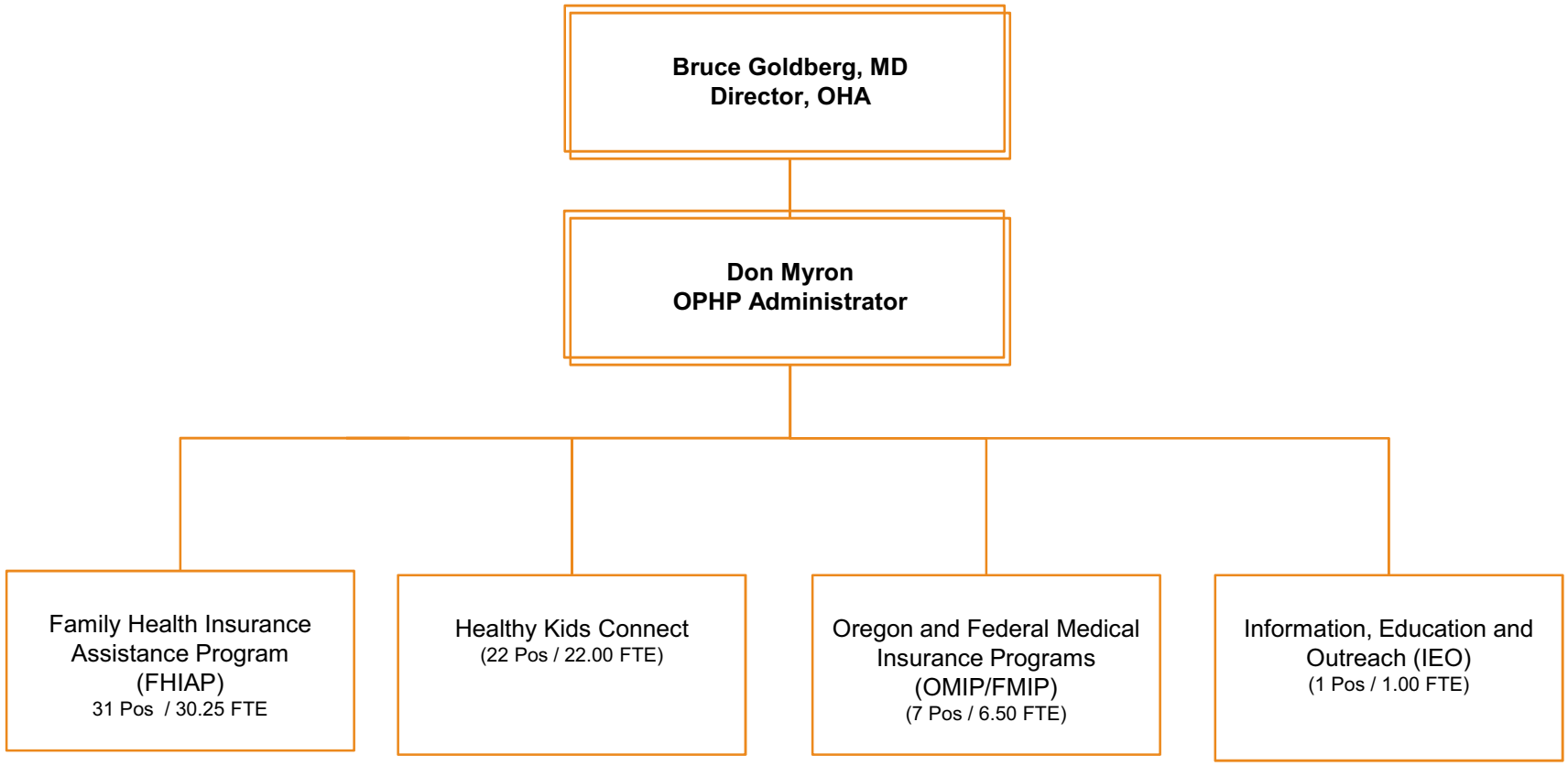
- Identifying potential policy and plan design changes to improve outcomes, quality of care and members' health status.
- Measuring provider performance based on improved quality of health services to members and outcomes, and minimizing avoidable costs.
- Monitoring carrier compliance with performance standards set in vendor contracts.
- Maintaining a viable and secure electronic benefit management system to process enrollment, eligibility, premium collection and disbursement.
- Participating in key initiatives to reform the health care system in Oregon.

Revenue sources

ORS 243.880 established the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated through an administrative assessment included in premiums for OEBB benefits. The administrative assessment is capped at 2 percent of total monthly premiums. ORS 243.882 prohibits the balance in the account from exceeding five percent of the monthly total of employer and employee contributions for more than 120 days.

ORS 243.884 established the Oregon Educators Revolving Fund to pay premiums, control expenditures, provide self-insurance and subsidize premiums. There is no dedicated revenue source for the OEBB Revolving Fund other than interest earned on the premium collection pass-through.

2013-15 OPHP Organization Structure



61 Positions / 59.75 FTE

Oregon Health Authority

OFFICE OF PRIVATE HEALTH PARTNERSHIPS

OPHP Mission, History, and Future in Summary

The Office of Private Health Partnerships (OPHP) was created as the Insurance Pool Governing Board in 1987 to help reduce the number of uninsured Oregonians. The agency was renamed in 2006. In July of 2009, OPHP began transitioning into the Oregon Health Authority (OHA) as detailed in House Bill 2009 passed during the 2009 Legislative Session.

OPHP directly supports OHA's vision for a healthy Oregon by reducing the number of uninsured Oregonians.

OPHP's programs offer consumer health insurance plan and provider choice, as well as providing members premium assistance. OPHP provides access to health care information and resources, enabling consumers to make informed decisions about their health care options. The quality, reliability and availability of care and the cost of care for both the insured and uninsured populations affects the lifelong health of Oregonians.

The agency's programs create a three-prong partnership between government, the private market and the insured. Since its inception, OPHP has designed, contracted, managed and administered programs that provide health care access to income-eligible individuals and families and to those who have been declined coverage due to pre-existing health conditions. Approximately 85 percent of OPHP's members do not qualify for other state health programs currently offered.

Combined, OPHP's programs provide access to health insurance coverage for approximately 26,000 Oregonians.

OPHP programs will continue providing access to these Oregonians largely unchanged for the first six months of the 2013-15 biennium. However, in January 2014, coverage for most of the 26,000 OPHP program enrollees will change due to passage of the federal Patient Protection and Affordable Care Act (ACA).

The associated Medicaid expansion, shift of federal premium subsidies to Cover Oregon, and implementation of guaranteed issue health insurance results in the

proposed closure of four of five OPHP programs in January 2014 in the 2013-15 Governor's Balanced Budget (GBB).

The following narrative describes the environment in which OPHP programs will operate for the first six months of the biennium, and the guiding principles, partnerships, program designs, enrollees, and other program characteristics that define the OPHP programs providing services to Oregonians.

Enrollees in the programs proposed for closure will transition to Medicaid, Cover Oregon, and the commercial market. Operation of these programs, and the new environment in which they will operate, is described in detail in their respective budget presentations. Discussion regarding the impacts of the ACA in this OPHP narrative will be primarily limited to the "Program Changes" sections toward the end of each program narrative, and will focus as necessary on enrollee transition and program closure planning.

OPHP Programs

Family Health Insurance Assistance Program (FHIAP)

The Oregon Legislature established the Family Health Insurance Assistance Program (FHIAP) in 1997. FHIAP provides health insurance premium assistance to Oregonians who would not be able to afford health insurance on their own. This reduces the number of uninsured, and encourages a healthy Oregon by helping members access quality medical providers.

This program supports the Oregon Health Authority's mission by:

- **Creating a path to health care independence**
  FHIAP offers monthly premium subsidies to adults on a sliding scale, ranging from 50 to 95 percent of the cost of insurance. All children under the age of 19 are subsidized at 100 percent regardless of income. The adult members' monthly subsidies decrease as their income increases. This sliding scale fosters self-reliance and continued movement toward health care independence. The sliding scale also aligns directly with the goal of more equitably sharing the cost of health care for the uninsured, reducing the number of uninsured at a minimum cost to the public.

- **Providing health care choice**
  FHIAP offers members numerous health insurance plan choices. Each plan includes a health care provider network that offers members the opportunity to select their care provider. Giving members the option to change providers if they are unhappy with their care helps ensure that Oregonians receive quality patient care.

  All FHIAP-subsidized plans offer comprehensive medical benefits including prescription drug coverage, affordable out-of-pocket costs, and a wide array of provider choice throughout the state. Weighing access and cost, members select the plan that best fits their family's medical and financial needs.

- **Partnering to share health care costs**
  FHIAP is unique in that it relies heavily on the combined contributions of employers, employees, and state and federal governments, to provide assistance to the uninsured. FHIAP addresses the gaps between the cost of health insurance and what people can afford to pay.

Program design

Commercial health insurance is the primary private sector partner of FHIAP. The program structure reflects a three-pronged partnership between government, the commercial health insurance market and consumers to provide health care to the uninsured. FHIAP pays a portion of a member's monthly health insurance premium purchased through:

- An employer, if a plan is available
- An individual private market carrier

If a member's employer offers health insurance coverage that meets minimum cost-sharing and benefit standards and contributes toward the premium costs, the member is required to enroll in employer coverage. This requirement leverages private sector dollars, reducing taxpayer costs and increasing program capacity so more families receive premium assistance.

When employer insurance is not available, the program subsidizes individual market insurance premiums. FHIAP works with five of the largest domestic

individual private market carriers in Oregon, including OMIP, FMIP, and other programs administered by OPHP.

Uninsurance requirement: FHIAP requires that members be without health insurance for at least two months in order to be eligible for the program. The period of uninsurance is intended to reduce the number of Oregonians without health insurance by targeting only uninsured individuals while discouraging people from dropping their existing coverage to join the subsidy program.

Who receives services and how services are delivered

FHIAP serves children and adults from zero through 200 percent of the federal poverty level in both individual and employer sponsored health insurance options.

Adults in FHIAP can only receive subsidies if all eligible children in the family are covered by health insurance in the commercial market or through the Oregon Health Plan, FHIAP or Healthy Kids programs. FHIAP pays 100 percent of monthly premiums for all children living in homes where the income is less than 201 percent of the federal poverty level.

FHIAP staff annually assess applicant eligibility, manages member accounts, including monthly premium billing in the individual market, payment to insurers and subsidy reimbursements in the employer market. FHIAP staff also process member appeals and administrative hearing requests.

The program mails applications in the order applicants put their name on the group or individual reservation list:

- Applications are sent out in date order when program openings become available
- Families with members who don't qualify for group insurance, but with at least one who does, are placed on the group reservation list

In June 2012 there were more than 43,000 people on the FHIAP reservation list.

This is the second time in the program's history that the reservation list reached more than 40,000 lives. Of the 43,000 on the list in June, approximately:

- 30,000 were adults

- 10,000 were children
- 9,000 said they have access to employer-sponsored (group) insurance

During the same period, FHIAP served approximately 6,800 members. Of those, approximately 2,800 were enrolled in employer-sponsored insurance, and approximately 4,000 were enrolled in individual coverage.

FHIAP provides subsidies to families with gross monthly incomes through 200 percent of the federal poverty level. A large number of members are at or below 100 percent of the poverty level. As of June 2012, the population was composed of the following enrollees by poverty level:

- Approximately 45 percent of members (group and individual) had incomes at or below 100 percent of the poverty level
- Approximately 20 percent of members had incomes between 100 and 125 percent of the poverty level
- Approximately 35 percent of the members had incomes between 125 and 200 percent of the poverty level

Quality and efficiency improvements

FHIAP works to promote improvements and efficiencies in the program. These activities range from improving the application process for members to sharing resources between programs to reduce administrative costs for the state. Combined, OPHP administrative costs are less than six percent.

During the last biennium, FHIAP:

- Simplified the program application
- Implemented rule changes to simplify application paperwork and program requirements
- Began a document imaging process
- Simplified the language in forms and letters to reduce member questions
- Worked to help build the database for the Healthy KidsConnect program
- Trained Healthy KidsConnect staff on eligibility and insurance

Program changes in 2013-15

The expansion of Medicaid up to 138 percent of the federal poverty level (FPL) and the shift of federal subsidies to the health insurance exchange, Cover Oregon, will make the Family Health Insurance Program (FHIAP) unnecessary, and the program is scheduled to close in January 2014 in the 2013-15 GBB budget.

OPHP is already working closely with internal partners in OHA leadership and Medical Assistance Programs (MAP), and external partners in Cover Oregon and in the insurance community to ensure the transition of FHIAP enrollees works as smoothly as possible. Enrollees who qualify will move to the Oregon Health Plan, following just under 1,000 enrollees who were moved as part of the reduction plan adopted by the legislature in the February 2012 session. Remaining enrollees will move to Cover Oregon and continue to receive subsidies from the federal government.

Revenue sources and expenditures

FHIAP is funded through state General Fund appropriation, Federal Funds, Miscellaneous Other Funds, and the Insurers' Tax.

As part of the Oregon Health Plan demonstration waiver, the subsidy program receives federal matching funds for Medicaid (Title XIX) and the State Children's Health Insurance Program (Title XXI). Additionally, FHIAP receives a portion of the Insurers' Tax to provide subsidies for enrollees.

The Insurers' Tax is collected through a one percent tax on private market health insurance premiums. The Insurers' Tax is scheduled to sunset as of September 30, 2013. The FHIAP CSL budget was adjusted to reflect the elimination of this fund source following the sunset, with the difference replaced by an increased General Fund appropriation.

The FHIAP GBB expenditure budget for special payments is abolished following program closure in January 2014. The FHIAP GBB expenditure budget includes 31 positions (30.25 FTE). While the program closes and the subsidy budget is abolished in January 2014, program positions remain budgeted for the entire 2013-15 biennium in the GBB budget. The same ACA provisions that caused the closure of the FHIAP program are also increasing the workload for staff elsewhere in OHA, in some cases serving the same enrollees that were served in FHIAP.

FHIAP staff has the skills, training, and experience necessary to meet this increased workload, and OHA leadership is working to identify programs most impacted by changes driven by the ACA implementation. FHIAP positions will be transferred to other OHA divisions later in the 2013-15 budget process as transition plans are formalized.

Healthy KidsConnect

Healthy KidsConnect (HKC) was established with the passage of HB 2116 and signed into law on August 4, 2009. HKC helps families gain access to comprehensive insurance coverage for uninsured children by providing premium subsidies and partnering with private-market carriers to deliver services.

Healthy Kids Connect is the commercial insurance component of Healthy Kids, Oregon's program that offers health care coverage to eligible uninsured children age 18 and under. Healthy Kids was established with a goal of enrolling 95 percent of Oregon's uninsured children with family income at or below 300 percent of the federal poverty level. Healthy Kids Connect is designed for families that earn too much to qualify for the Oregon Health Plan, but can't afford to pay the full premium for their child's private health insurance. This program also provides qualified families with access to employer-sponsored insurance (ESI) or group subsidies to enroll uninsured children into their employer's plan. Employer's plan must meet federal benefits guidelines to qualify.

Healthy Kids Connect aligns with the Oregon Health Authority's mission by:

- **Expanding access to all Oregon's uninsured children**
  The program offers sliding scale subsidies for families whose income is between 200 and 300 percent of the federal poverty level (FPL). Expanding coverage to this previously under-served population provides opportunities for children to receive comprehensive health coverage. Families with income above 300 percent FPL pay full cost of insurance premiums.

- **Providing health care choice**
  Families enrolling children in Healthy Kids Connect have provider choice. Each plan includes a health care provider network that offers members the opportunity to select a provider to best serve their child's health care needs.

- **Partnering to share health care costs**
  Healthy Kids Connect provides cost sharing among consumers, government and the private market through income-based subsidy payments for families whose annual income is 300 percent FPL or lower.

Program design

The program structure creates a partnership between the commercial market, government, and consumers to provide health care for uninsured children.

Healthy Kids Connect manages the request for proposal process for the program's private-market health plan options. Currently, the program contracts with four insurance carriers to provide health insurance benefits comparable to Oregon Health Plan Plus. The plan offers comprehensive health care coverage that includes dental, vision, mental health, pharmacy, and physical health care benefits.

Staff manage member invoicing and payments and the employer plan benchmarking ensuring the plan meets federal standards. The program assists the Office of Client and Community Services (OHA) and the Department of Human Services with expediting annual program redetermination for members and manages member relations and ongoing carrier relations.

An important measure of health care affordability is the consumer's total out-of-pocket expenses. To align with federal standards and ensure Healthy Kids Connect insurance is affordable for the families that receive subsidies, OPHP set an out of pocket limit of five percent of the family's annual income for members who enroll in the private market plans. If a family reaches the five percent limit, OPHP or the carrier pays expenses above that amount. Healthy Kids Connect out of pocket expenses include monthly premium, co-pays, co-insurance, and all other expenses related to health care and incurred under the insurance plan.

Healthy Kids Connect expands coverage options to additional income levels, removing barriers to accessing health care coverage and building on existing programs already available to Oregon families.

Who receives services and how services are provided

OPHP helps families with incomes between 200 and 300 percent of the federal poverty level by paying 85 to 90 percent of their monthly health insurance

premium and encouraging enrollment and active financial participation in their child's health care needs. Subsidized members are responsible for approximately 10 to 15 percent of the premium cost, depending on their income level. OPHP pays 100 percent of the premium cost for children enrolled in a parent's employer plan through HK ESI and whose household income is zero through 200 percent FPL.

Oregon's Healthy Kids effort is an innovative, multi-agency collaboration of the Oregon Health Authority's (OHA) Office of Healthy Kids, Medicaid Assistance Programs, OPHP, the Department of Human Services (DHS), the Office for Oregon Health Policy and Research partnering with four private market insurance carriers, and community stakeholders. Each of these partners performs a vital role in marketing, application assistance, service delivery, and evaluation. This collaboration of public and private partnerships ensures "every kid is a Healthy Kid" and provides a seamless transition for children into health insurance coverage, regardless of income level.

There is one OHA application for medical assistance programs (except FHIAP), including Healthy Kids and Healthy KidsConnect. Applications are submitted to DHS for determination of family and child eligibility based on program rules and guidelines.

The applications of Oregonians who earn too much for the OHP component and meet Healthy Kids Connect and HK ESI eligibility are forwarded to the Office of Private Health Partnerships. OPHP provides qualified families with information on carrier and employer options for enrolling in private insurance.

OPHP administers HKC health insurance plans and member reimbursement for HK ESI benefits available through a member's employer plan.

One of OPHP's key performance measures is customer satisfaction relating to the family's experience with the private market carrier that provides the child's insurance coverage. OPHP's goal is to have more than 90 percent of its customer's rate their experience with their carrier as "Good" or "Excellent" on a satisfaction survey.

Program changes in 2013-15

The only OPHP operational program scheduled in the 2013-15 GBB budget to remain open after January 2014 is the Healthy Kids Connect (HKC) program. The

federal Maintenance of Effort (MOE) provisions in the ACA specifies that existing coverage for children under both Medicaid and the Children's Health Insurance Program (CHIP) remains in place through federal fiscal year 2019. HKC provides coverage for children in the 200% to 300% FPL range utilizing federal CHIP matching funds, and is classified as a discretionary group insurance product. Cover Oregon sells only individual and small employer group products. However, Cover Oregon does not sell discretionary group products, and as a result the HKC program is currently planned to continue operating in OHA for the 2013-15 biennium.

The impact of the ACA on HKC operations remains under review, and a diverse group of stakeholders including Cover Oregon, Insurance Division, OHA IT and Cover Oregon IT, Office of Client and Community Services, Medical Assistance Programs, Department of Justice, and Office of Private Health Partnerships have been working together since mid-2012 to clarify the future of the HKC program.

Revenue sources and expenditures

Healthy Kids Connect is funded with a combination of Federal Funds and Other Funds (Insurers' Tax), increasing the amount of federal dollars available to the state to help more families. Approximately 74 percent of program expenditures are Title XXI (CHIP) funds, with the balance matched by the member share plus Insurers' Tax funds.

The Insurers' Tax is collected through a one percent tax on private market health insurance premiums. The Insurers' Tax is scheduled to sunset as of September 30, 2013. The program's current service level budget was adjusted to reflect the elimination of this fund source following the sunset, with the difference replaced by an increased General Fund appropriation.

The HKC GBB expenditure budget includes 22 positions (22.00 FTE), and was adjusted in the current service level to reflect anticipated caseload increases in the 2013-15 biennium.

Oregon Medical Insurance Pool

The Oregon Legislature established the Oregon Medical Insurance Pool (OMIP) in 1987 as the state's high-risk health insurance pool.

OMIP provides medical insurance coverage for all Oregonians denied adequate medical insurance coverage because of current or prior health conditions. This program partners with private market health insurers to help reduce the state's uninsured rate by providing insurance options to people who otherwise would be without health coverage.

OMIP also provides a way to continue insurance coverage for those who exhaust COBRA benefits and have no other options.

OMIP supports the Oregon Health Authority's mission by:

- Providing access for Oregon's uninsurable
- OMIP serves the highest medical risk individuals in the state who otherwise would not have access to health insurance due to pre-existing health conditions
- Maintaining plan and provider choice
- OMIP offers four health benefit plans to accommodate the financial circumstances of individual enrollees. The plans differ in deductible amounts and other out-of-pocket costs which allows for varying premium amounts among the four plans
- Promoting health management
- OMIP provides the necessary resources, such as disease management, pharmacy, and case management programs, to allow chronically ill Oregonians to better manage their conditions

Sharing health care costs

OMIP is structured to distribute costs between the member and the private market. With commercial insurance plans, the total premiums generally cover the entire plan's costs for medical care and administration. However, OMIP member premiums cover about 50 percent of the program's total costs. The remainder is covered through assessments Oregon law authorizes OMIP to collect from Oregon health insurance companies.

OMIP provides access to health insurance for thousands of Oregonians, helping reduce the number of people seeking emergency room services as a last resort. OMIP allows members to utilize a network of primary care providers and specialists in a manner that benefits Oregon's overall health care system.

OMIP and FMIP private-public program design

OMIP and the Federal Medical Insurance Pool (FMIP) contract with a third-party administrator (TPA), Regence BlueCross Blue Shield of Oregon. Regence BCBSO handles the pools' day-to-day operations, including eligibility, enrollment, customer service, data reporting, claims processing, prior authorization, pharmacy benefit management, case management and disease management.

OMIP staff work closely with the third party administrator to coordinate operational and policy issues and promote improvements in service delivery.

The administrative cost for the third party administrator plus the state program management and staff during fiscal year 2011 was less than five percent of total expenditures.

- OMIP administration: expenses for state administrative staff and supplies comprise less than one percent of total expenditures
- Third party administrator: the cost of the third party administrator comprises four percent of total expenditures
- Insurance agent fees: OMIP pays a one-time $75 fee to Oregon licensed agents who assist an applicant in completing the OMIP application and obtaining coverage. These fees comprise approximately 0.2 percent of total expenditures

The third party administrator's administrative expense and agent fees increase as OMIP enrollment increases. OMIP pays the third party administrator a contracted dollar amount per enrollee per month for administration. Member premiums cover about 50 percent of the total program costs. The remaining 50 percent is covered by health insurer assessments. The insurers pass these assessments to the consumer through the individuals and companies insured under their private market insurance plans. Essentially, individuals and companies that pay for private insurance subsidize approximately 50 percent of OMIP's expenditures. This percentage has risen during the past several years from about 35 percent to its current level.

Who receives services and how services are delivered

The Oregon Medical Insurance Pool (OMIP) and the Federal Medical Insurance Pool (FMIP) are the high-risk health insurance pools for the State of Oregon. Oregonians served by OMIP and FMIP have been declined coverage by the individual health insurance market because of their medical conditions. Additionally, OMIP serves individuals who have exhausted employer-based COBRA benefits and have no other available options to continue coverage; have left employment and moved out of their employer's plan service area and are not able to continue that coverage; or are eligible for the Federal Health Coverage Tax Credit (HCTC).

OMIP and FMIP benefit plans mirror those in the commercial group preferred provider option (PPO) health market. The plans include case management services, disease management programs, prior authorization requirements, a drug formulary, and higher benefits when enrollees choose to use participating providers.

OMIP and FMIP receive guidance from a ten member board. The Oregon Health Authority director appoints nine of these members. The director, or a designee of the director, also serves on the board.

Eligibility

Enrollees must be residents of Oregon when they enroll and demonstrate that they have lived in Oregon for at least 180 days during each benefit year. OMIP does not have a citizenship requirement for coverage or a required period of uninsurance.

The federal pool has a six-month period of no insurance requirement and enrollees must be U.S. citizens or lawfully present in this country.

Quality and efficiency improvements

- Enrollees received more help managing their health care and benefits
- Expanded the range of diagnoses addressed by disease management programs
- Enhanced promotion of no-cost classes for smoking cessation and self-management of chronic diseases
- Promoted use of MyRegence website for enrollees to access a wide range of information about managing diseases and lifestyle, general knowledge about medical conditions and medication alternatives and history of claims

- Promoted healthy lifestyles by offering paid weight loss programs through Weight Watchers
- Took measures to control rising medical costs
- Increased the number of available generic prescriptions for covered medications, thereby controlling the rate of increase in drug expenditures for OMIP
- Increased the non-preferred drug co-payment to encourage generic drug use;
- Obtained a federal grant award to offset costs, support increased use of generic medications, and employ remote monitoring of individuals with complex multiple diagnoses in order to avoid emergency-room visits and inpatient admissions
- Improved access to information for enrollees, stakeholders, and the general public by expanding the Web site to include more information and providing easier navigation for a variety of audiences including enrollees, health care policymakers, and insurers affected by the OMIP assessment
- Improved access to resources by contracting with the Department of Health and Human Services to implement the Federal Medical Insurance Pool (FMIP) FMIP helps stabilize the OMIP assessment through a shift of OMIP eligible applicants to FMIP

FMIP history and differences

On April 30, 2010 Governor Ted Kulongoski sent a letter to the Secretary of HHS indicating Oregon's interest in administering the federally funded high-risk pool through the state's existing medical insurance pool (OMIP). HHS signed a contract with the state on July 12, 2010.

The biggest difference between FMIP and OMIP is funding streams. As described in more detail below, OMIP is funded by a combination of member premiums and an assessment on health insurance companies. The new federal high risk pool is funded by a combination of member premiums and funds from the federal government.

The federal pool is structured to be nearly identical to OMIP, but offers two insurance plans rather than four. A seamless and transparent structure simplifies the application process, aids in communicating the benefit plan details, and makes better use of program funds.

The existence of the new federally funded pool will have the effect of shifting future costs (new medically eligible enrollment) from OMIP to the federally funded pool. This may result in leveling out the cost of running the existing state pool.

OMIP and FMIP program changes in 2013-15

The FMIP and OMIP programs are available until 2014. In 2014, federal law will prohibit insurance companies from refusing to sell coverage or renew policies because of a person's pre-existing condition. Also starting in 2014, individuals whose employers don't offer them insurance will be able to buy insurance directly in Cover Oregon.

As a result, the FMIP program will close in January 2014, and the federal government is expected to release plans for transitioning federally funded high-risk pool program enrollees to exchanges and the commercial market in 2014 shortly.

The OMIP program is scheduled to close in June 2014 in the GBB, later than the FMIP program due to discussions regarding the future of OMIP that were ongoing at the time the GBB was published. This closure date may be adjusted based on the result of these ongoing discussions.

OPHP is already working closely with internal partners in OHA leadership and Medical Assistance Programs (MAP), and external partners in Cover Oregon, the federal CMS/CCIIO program, and in the insurance community to ensure the transition of OMIP and FMIP enrollees works as smoothly as possible. Enrollees who qualify will move to the Oregon Health Plan, and remaining enrollees will either move to Cover Oregon and continue to receive subsidies from the federal government, or move to the commercial market, depending on their federal poverty level and other eligibility requirements.

Revenue sources and expenditures

OMIP is funded with member premiums and assessments on health insurance carriers licensed to do business in Oregon. By statute, OMIP premium rates for pool coverage cannot be more than 125 percent of rates established as applicable for individual risks in the commercial market. In 2009, the premiums were 15 percent above the market average for comparable PPO plans; in 2010, they were

17 percent above the market; in 2011, they were 10 percent above the market; and in 2012, they were 6 percent above the market.

FMIP is funded with member premiums and an allotment from the Department of Health and Human Services as a result of the Patient Protection and Affordable Care Act. Funds from the federal allotment for the program period starting July 2010 and extending through December 2013 are forecast to serve 4,000 members with peak enrollment reaching 2,000.

The OMIP and FMIP program special payments budgets for claims and associated expenditures are abolished in 2014 following program closures, retaining necessary limitation and reserves to pay for claims runout costs.

OMIP/FMIP staff includes 7 positions (6.50 FTE). While the programs close and the subsidy budget is abolished in 2014, program positions remain budgeted for the entire 2013-15 biennium in the GBB budget. The same ACA provisions that caused the closure of the OMIP and FMIP programs are also increasing the workload for staff elsewhere in OHA, in some cases serving the same enrollees that were served in OMIP and FMIP. OMIP and FMIP staff have the skills, training, and experience necessary to meet this increased workload, and OHA leadership is working to identify programs most impacted by changes driven by the ACA implementation. Positions will be transferred to other OHA divisions later in the 2013-15 budget process as plans are formalized.

Information, Education and Outreach

The Information, Education, and Outreach (IEO) unit supports OPHP's goal of helping all Oregonians receive health benefit coverage.

IEO works to establish relationships with private-sector partners, train insurance producers (agents), and educate stakeholders and the community on the benefits and processes associated with enrollment in Oregon's insurance programs.

IEO's current outreach and training efforts will place an increasingly heavy emphasis on changes driven by implementation of ACA provisions as the transition date in January 2014 grows closer, and are as follows:

- *Insurance Producer Education.* IEO trains insurance producers in general health insurance information and the state programs that help insure Oregonians, as well as the changes in state insurance law.

- *Employer/Employee Education.* IEO conducts employer presentations targeting at educating employees on general health insurance information and public programs that can assist them in accessing health coverage for themselves and their families.

- *Community Outreach/Awareness.* IEO conducts presentations for non-profits, business associations, service groups, and other community and civic organizations, general health insurance information, and the state programs that help insure Oregonians, as well as the changes in state insurance law. IEO also conducts targeted community outreach/enrollment events that are aligned with private partner trainings in targeted regions.

- *Producer Referral Program.* IEO connects business owners and individuals with insurance producers (agents) who have been specially trained through IEOs insurance producer education on state administered health insurance programs. Insurance producers help businesses navigate the insurance system and find the appropriate plans that meet the needs of families and employees.

IEO is working to coordinate all informational, educational, and outreach efforts with partners in OHA, Cover Oregon, the federal government, producers, and carriers to ensure a smooth transition for all enrollees in 2014.

Program changes in 2013-15

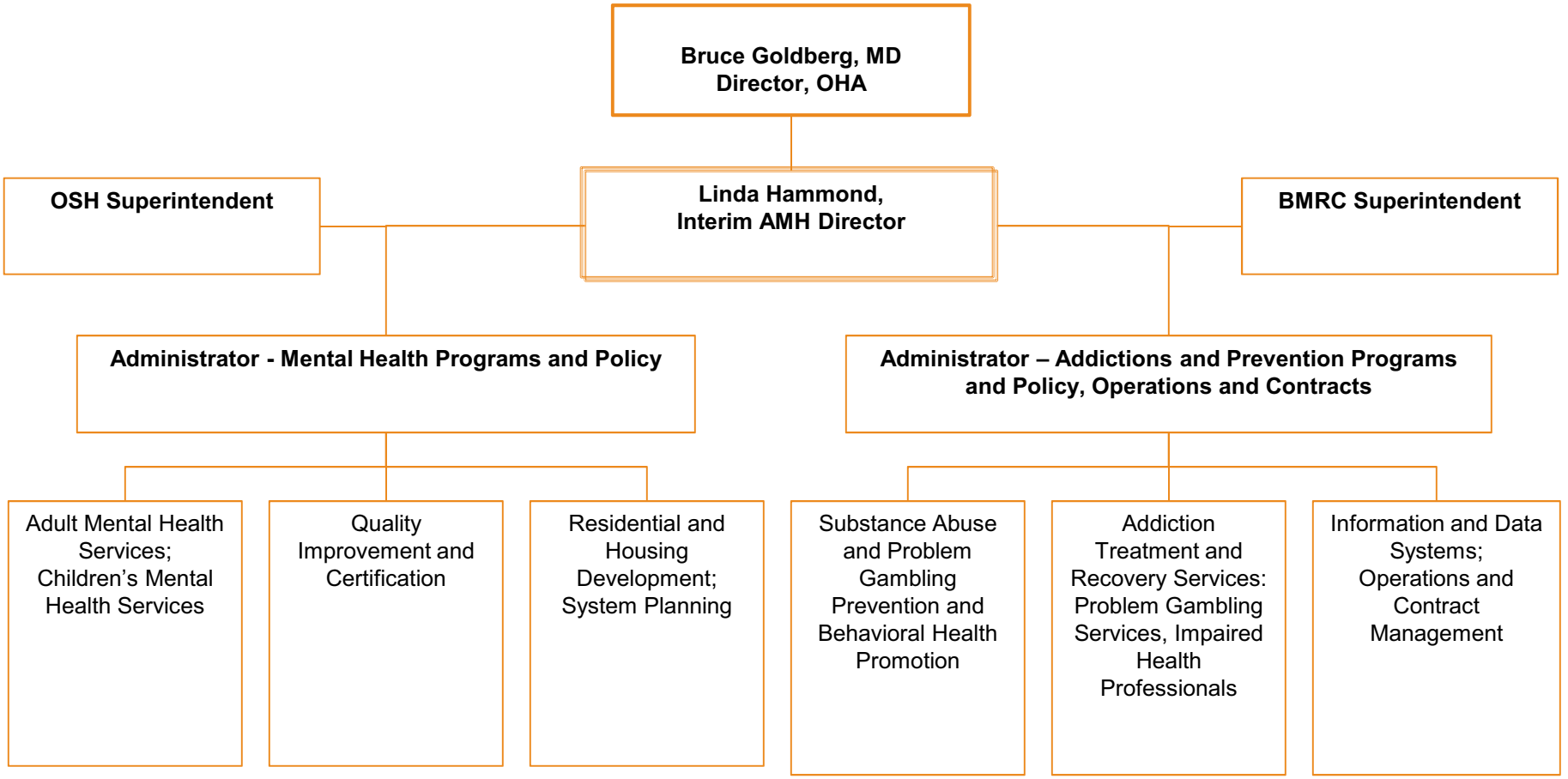
The IEO program is scheduled to close in January 2014 as many of the operational programs it serves close, and enrollees move to an expanded Medicaid program, the new Cover Oregon, or to the commercial market.

Revenue sources and expenditures

The Information, Education and Outreach (IEO) unit is funded through state General Funds and miscellaneous Other Funds.

The program is supported by one full-time permanent position (1.00 FTE). The program is scheduled to close in January 2014, but the program position and associated operational services and supplies remains budgeted for the entire 2013-15 biennium in the GBB budget. The same ACA provisions that caused the closure of OPHP programs supported by the IEO program are also increasing the workload for staff elsewhere in OHA, in some cases serving the same enrollees that were served by the IEO program. IEO staff has the skills, training, and experience necessary to meet this increased workload, and OHA leadership is working to identify programs most impacted by changes driven by the ACA implementation. The IEO position will be transferred to another OHA division later in the 2013-15 budget process as transition plans are formalized.

2013-15 AMH Organization Structure



2,523 Positions / 2,254.89 FTE

Oregon Health Authority

ADDICTIONS AND MENTAL HEALTH

Mission

The mission of Addictions and Mental Health (AMH) is to assist Oregonians to achieve optimum physical, mental and social well-being by providing access to health; mental health and addiction services and supports; to meet the needs of adults and children to live, be educated, work and participate in their communities.

The mission is accomplished by working in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities to fulfill AMH goals.

AMH goals:

- Improve the lifelong health of all Oregonians
- Improve the quality of life for the people served
- Reduce overall health care and societal costs through appropriate investments
- Increase the availability, utilization and quality of community-based, integrated health care services
- Increase the effectiveness of the integrated health care delivery system
- Increase the involvement of individuals and family members in all aspects of health care delivery and planning
- Increase accountability of the health care system
- Increase the efficiency and effectiveness of the state administrative infrastructure for health care

History

Oregon's mental health system has been in existence for 160 years. A portion of the Oregon State Hospital facility, built in 1883, remained in use through 2008. Prior to the mid-20th century, virtually all people with mental illness received treatment in institutional settings. In 1971, the state created the community mental health system and included both mental health and addictions treatment as part of that system. Services are financed and regulated by the Oregon Health Authority (OHA) and delivered through county-based community mental health programs (CMHP), tribes, or their subcontractors.

Mental health and addictions policy, prevention and treatment services have been combined, separated and recombined — most recently in 2001 — and now include problem gambling policy, prevention and treatment.

The emphasis on community-based treatment for these disorders grew in the 1980s based on recommendations by a series of commissions, task forces appointed by the Governor and the Department of Human Services (DHS), and Executive Orders. In the mental health treatment area, more people are treated in the community than in institutions, and approximately 73 percent of public funding goes to community-based services.

The last twenty years have been focused on developing and strengthening community-based services for people with or at risk of developing substance use disorders, problem gambling disorders, and mental illness. The effort to establish systems of care rather than isolated service types has been slow due to economic circumstances that resulted in cycles of major service reductions throughout the 1990s and first 12 years of the 21st century.

Systems of care that are integrated, managed and able to serve people with complex and co-occurring disorders are most effective in producing the outcomes needed for people to be healthy, live independently and contribute to society. The most mature and effective systems of care are for children and adolescents. This is due in part to the fact that the majority of children served in the public system are Medicaid eligible and have a full array of managed, widely available and flexible services as intensive as the child and family needs to be successful. The services range from in-home and in-school supports, traditional therapies to intensive residential and inpatient when needed. Children are served in the least restrictive and most integrated settings and are less likely to be arrested, more likely to be successful in school and have improved family relationships as a result of these services.

The most effective manner of dealing with substance use, problem gambling, and mental health disorders is to identify the issues early and provide proven effective treatment. Two proven effective practices show strong promise for making major changes in the life course of these disorders. When delivered to evidence-based standards, both Screening Brief Intervention and Treatment (SBIRT) and Early Assessment and Support Alliance (EASA) are proven intervention models that mitigate more future costs associated with serious and chronic behavioral and physical health conditions. People are more likely to complete their education, gain

or retain employment, make better choices supporting their physical health, avoid criminal justice involvement and form appropriate social relationships. This will be a major focus of innovation as OHA works with Coordinated Care Organizations in recognizing and serving substance abuse and mental health disorders in integrated settings in local communities.

Young adults who have long histories in various public systems are seldom well prepared for adult independence. This is most true for those young adults who have mental health disorders. AMH has been and will continue to focus on developing services that will help these young people manage their symptoms, learn the skills needed for independence and transition to integrated community settings with the supports needed to be successful. This is a challenge since some of these youth lose Medicaid coverage when they leave the child welfare system and thus have no coverage for needed treatment services.

AMH will continue to emphasize the very effective substance use disorder treatment services for families who have lost or are in danger of losing custody of their children due to these disorders. Since 2010, Intensive Treatment and Recovery Services (ITRS) have allowed thousands of children to reunite with their families or to remain united as a family without child welfare involvement.

Oregon successfully opened a new psychiatric hospital for adults with major mental illness who have been civilly or criminally committed to the state for treatment. The new hospital replaced the Oregon State Hospital buildings in Salem, the oldest of which dated to 1883 and was still in use prior to building the new hospital. The hospital features central treatment malls and secure outdoor spaces for patient and family socialization. The culture is changing and increasing emphasis on recovery, patient experience, and patient and staff safety. All patients have access to at least 20 hours of active treatment each week. Medical and nutritional services have been improved. The hospital is challenged as a result of the poor economy, which resulted in major budget reductions during the 2011 and 2012 Legislative Sessions.

Since 2010, AMH has focused on moving adults with major mental illness who live in structured residential settings to the appropriate level of care with the emphasis on independent, integrated community housing with the supports necessary for success. The goal is to ensure that adults with major mental illness live in the most integrated independent setting possible. Since September 2010,

more than 1,000 people have transitioned to lower levels of care. More than half of these people transitioned to independent living.

Following the 2011 Session, AMH has been working to improve both the entry to the state hospital by individuals who have mental illnesses and have committed minor nonperson crimes and to discharge more rapidly people who have been criminally committed to the state hospital for minor, nonviolent crimes. AMH worked with the Legislature during the 2011 Session to pass House Bill 3100. This legislation focused on increasing the quality of evaluations conducted for individuals who have committed a crime and who may have a mental health disorder that supports a guilty except for insanity defense. The legislation also allows low-level nonperson Class C felonies and misdemeanors to be handled at the community level rather than being sent to Oregon State Hospital.

The 2011 Session also passed Senate Bill 420. This legislation changed the hearing and discharge process at OSH for individuals who have committed lower level, or Tier 2 crimes. Tier 2 crimes were distinguished to separate them from more violent, person directed or dangerous crimes, such as murder, manslaughter, assault, kidnapping and rape, known as Tier 1 crimes. Offenders found "guilty except of insanity" of Tier 1 crimes remain exclusively under the jurisdiction of the Psychiatric Security Review Board (PSRB). Tier 2 offenders are under the jurisdiction of OHA and subject to a State Hospital Review Panel (SHRP) to determine readiness for full discharge or conditional release into the community. Those who are conditionally released are then under the jurisdiction of the PSRB.

The 2011 Session passed HB 3650, which set into motion a major transformation in the delivery of health care in Oregon beginning with the Medicaid population. The goal is to improve the health of Oregonians, improve the quality of care and lower the cost of care. The strategy is to integrate physical and behavioral health, and by 2014, dental care under Coordinated Care Organizations (CCOs). The first CCOs launched in August 2012 and are locally governed. With CCOs, there will be more flexibility in service delivery based on a global budget and increased accountability to deliver outcomes. The overall health system transformation provides the opportunity for AMH to work with county commissioners to define a process and goals for improving the flexibility and increasing the delivery of outcomes for the community-based addictions and mental health system. The community-based addictions and mental health system is funded by state General Funds, Beer and Wine Tax and federal block grants for people and services not eligible for Medicaid funding.

The magnitude of these changes requires that the OHA and AMH rethink the approach to our work and the structure of our organizations. This is also necessary given the financial challenges and the need to flatten the management structure of the organization. Both OHA and AMH are well positioned to accomplish this by building on the foundation of widespread use of Lean principles and Lean Daily Management System. This provides the discipline to be clear about the scope of work projects, the roles and responsibilities of work group members, and accountability to accomplish the work that needs to be done in a timely manner.

Using this foundation, OHA is developing the Core Processes that are essential to accomplishing the key goals of health reform, developing the process and outcomes measures and the accountability structure to complete necessary work, and to become a learning organization that is data driven.

Services

AMH services restore functioning, promote resiliency, health and recovery, and protect public safety by serving adults, children and adolescents with substance use disorders, mental and emotional disorders and problem gambling disorders as well as providing resources to their families. During 2011, 130,000 adults and 43,000 children and adolescents were served.

AMH contracts with county mental health programs, tribes, and private, nonprofit organizations to provide community-based services to Oregonians who have or are at risk of developing mental illness, emotional and substance use disorders, or an addiction to gambling. The services available include:

- Early intervention
- Prevention
- Outpatient treatment
- Day treatment and residential treatment
- Acute psychiatric treatment in local hospital specialty units
- Medications and medication management
- Case management
- Housing and supports
- Peer supports and peer-delivered services

- Employment and education supports
- Psychiatric residential treatment
- Psychiatric day treatment
- Care coordination
- Crisis services
- Skill training
- Intensive community-based treatment services
- Longer term, hospital-level care to adults with mental illness who otherwise cannot be treated safely or successfully in community settings

Programs

AMH provides or contracts for services that help restore people with addiction disorders, including gambling, and people with mental health disorders to a level of functioning that allows them to:

- Be successful at school and work
- Live safely and productively in the community
- Avoid repeated cycles of arrest and incarceration
- Maintain stable relationships and living situations
- Maintain or obtain appropriate parenting skills
- Reduce their risk of infectious diseases and chronic health conditions
- Reduce the use of acute psychiatric hospitals for crisis stabilization

Services aim to promote health by helping Oregonians avoid problem gambling, the use of alcohol and other drugs, enter into recovery when necessary and adopt safe and healthy lifestyles.

AMH has six primary program areas:

- Alcohol and drug prevention and treatment
- Problem gambling prevention and treatment
- Community mental health treatment
- State-delivered secure residential treatment
- State hospital services at the Oregon State Hospital and Blue Mountain Recovery Center (BMRC)

Addictions and mental health community services are provided in all 36 Oregon counties and with the 9 federally recognized tribes. Community mental health programs (CMHPs), tribes and statewide contractors provide evidence-based services to prevent and treat the problematic use of alcohol and drugs, problem gambling disorders, and mental health disorders. These services and supports are based on local needs and developed through periodic comprehensive planning processes. The Oregon Health Plan (OHP) covers mental health and addiction services for eligible people with conditions funded under the Health Evidence Review Commission Prioritized List for all Medicaid and State Children's Health Insurance Program (SCHIP) clients. The state General Fund, Beer and Wine Taxes and federal block grants pay for services and individuals not covered by OHP. The Medicaid service delivery system is undergoing transformation in response to HB 3650 (2011 Session) and SB 1580 (2012 Session). Addictions and mental health services for covered populations were integrated with physical health care and delivered under the management of local Coordinated Care Organizations beginning in August 2012.

Alcohol and Drug Prevention

Alcohol and drug prevention services are designed to promote healthy choices by Oregonians when presented with the opportunity to use drugs or to drink inappropriately. These are critical services for young people who are frequently presented the opportunity to drink in spite of their age. Binge drinking and heavy drinking is dangerous and is frequently linked to increased risk for traffic accidents, risky sexual behavior, violence and suicide. While a major focus for prevention efforts has been underage drinking, it is important that Oregonians of all ages understand the effects on their bodies from the use of alcohol and other drugs. With appropriate information, people can make healthy, responsible choices.

Services provided

Prevention programs help people make smarter life choices and reduce risk factors associated with alcohol and drug abuse. AMH administers prevention services aimed at people who have not yet been diagnosed with alcohol or drug problems. These services reduce the rate of underage drinking and the development of substance use disorder and associated health and social problems.

Who receives services

Services that prevent and end the use of addictive substances are available to all Oregonians, with a focus on youth. The audiences for prevention services include:

- The entire population through public education and awareness campaigns
- Sub-groups of people who are at above-average risk of involvement with alcohol and other drugs through selected prevention services such as family management programs for families with youth who have poor academic performance
- Individuals who show minimal but detectable signs of involvement with alcohol and other drugs, but do not meet diagnostic criteria for abuse or dependence through indicated prevention services such as substance abuse educational programs for youth who receive a Minor in Possession (MIP) violation

More than 126,454 Oregonians were provided access to broad-based prevention information during 2011. In addition, 10,125 people received selected prevention services, and another 1,417 received indicated prevention services.

How services are delivered

Alcohol and Drug Prevention Services are funded in the community through:

- Financial assistance agreements with county governments
- Direct contracts with all nine federally recognized tribes
- A limited number of direct contracts with providers of statewide, regional or specialized services

Community Mental Health Plans, tribes and statewide nonprofit organizations, deliver services.

Why these services are significant to Oregonians

Across Oregon, alcohol and drug prevention plays an important role in creating strategies, policies, and programs designed to promote healthy behaviors among an entire community. Local prevention coordinators and partners prioritize community prevention needs based on local data. Some of the key health issues include substance abuse prevention, tobacco use prevention, violence prevention, problem gambling prevention and suicide prevention. Community prevention includes strategies such as parent training, classroom curricula, and cultural best

practices along with wellness programs and screening tools most often coordinated or delivered by a Certified Prevention Specialist (CPS).

Effective prevention services reduce the incidence of underage drinking, binge and excessive drinking among all age groups, and lessen the risk of alcohol- and drug-related traffic accidents and resulting deaths. These services reduce the risk of youth drug use, violence, youth suicide and risky sexual behavior. Youth who are not involved in underage drinking or other drug use perform better in school, are more likely to graduate, and more likely to avoid contact with the juvenile justice system.

Alcohol and Drug Treatment

Alcohol and drug prevention, and treatment and recovery services, assist people in developing the life-long skills and abilities they need to manage their chronic health conditions. Like high blood pressure, asthma and diabetes, a cure remains elusive, but the disease of addiction can be managed. Those who manage their condition improve their health, enjoy a better quality of life, and reduce and control the cost of their health care.

Addiction treatment holds value to OHA's goal of better health, better care and lower costs. Alcohol misuse and dependence, illicit drug abuse, tobacco use and other health risk behaviors with behavioral health underpinnings are among the top 10 leading causes of chronic illnesses and death. The implementation of coordinated care and person centered primary health homes will better serve members. Integration of preventive services to include the onset of chronic conditions or the severity of these conditions will lead to reduced costs in healthcare.

Health transformation provides an opportunity to integrate addiction treatment into the broader healthcare system in a more meaningful way. Coordinated Care Organizations will be accountable to outcomes related to behavioral health (addictions and mental health) as well as physical health of members.

A recent analysis of a sample of OHP members who accessed additional treatment found significant cost-offsets in physical health expenditures, most notably as it relates to emergency room visits and hospitalization. The cost-offset was more

than $3,000 per person. Addiction treatment and recovery services are cost effective.

Services provided

Services consist of outpatient, intensive outpatient, recovery support services, residential and detoxification services. Arrays of options are needed to help individuals recover from their addictions based on the severity of their illness at various points along their lifespan. Some individuals may need residential services while others may need outpatient services; typically, a combination of services is needed for individuals to successfully recover and manage their disease. Outpatient services include specialized programs that use synthetic medications such as methadone, buprenorphine, and injectable vivitrol as an alternative to chronic heroin and prescription opioid addiction. Education and treatment are available for people convicted of driving under the influence of intoxicants (DUII).

Who receives services

Children and adults of all ages who have a diagnosed substance use disorder may be eligible for services. Any person eligible for the Oregon Health Plan or the State Children's Health Insurance Program (SCHIP) has access to the OHP Chemical Dependency benefit when medically appropriate. Pregnant women and intravenous drug users have priority for services under the federal Substance Abuse Prevention and Treatment Block Grant. There are specialized services designed to meet the needs of women, parents with children, minorities, and adolescents. During 2010, 43,235 adults age 26 and older were served; 14,824 young adults age 18 through 25 were served; and 6,053 adolescents age 12 through 17 were served.

How services are delivered

Substance Use Disorder Services are funded in the community through:

- Financial assistance agreements with county governments
- Direct contracts with all nine federally recognized tribes
- Contracts with Coordinated Care Organizations
- A limited number of direct contracts with providers of statewide, regional or specialized services

Services are delivered by CMHPs, tribes, nonprofit programs and statewide contractors in outpatient programs, school-based health centers and residential treatment programs throughout the state.

Why these services are significant to Oregonians

Because of these services, health care costs related to untreated substance use disorders decrease. Local hospitals experience reduced use of emergency departments. Fewer children are admitted to foster care due to parental substance abuse. State and local jurisdictions see reduced costs to the criminal justice system for adults and juveniles. Individuals locate employment, safe, stable housing, and improve the quality of their lives, which in turn strengthens the communities where they live.

Problem Gambling Prevention and Treatment

Problem gambling prevention and treatment services prevent people from becoming addicted to gambling and assist people who are addicted in recovering from addictive and pathological gambling. People in recovery find or maintain jobs, repair family relationships and stop committing crimes, their mental health improves, and the potential for suicide decreases.

Services provided

Problem gambling prevention and treatment services include evidence-based prevention strategies to decrease the probability that young people will begin gambling at young ages and that adults of all ages will be aware of the addictive nature of gambling, particularly on-line games and video poker. Treatment services include outpatient individual and group therapies, intensive therapies, and statewide access to residential treatment for those who are at risk because of pathological gambling. Treatment to reduce the effects of problem gambling is funded through a statutory one percent set-aside of state Lottery revenues.

Where service recipients are located

Community mental health programs (CMHPs) and for-profit and nonprofit providers deliver problem gambling prevention and treatment services in all 36 counties and in one statewide residential treatment program.

Who receives services

During 2011, 3,543 people made use of the professionally staffed Problem Gambling Helpline. Problem gambling services were delivered to 1,918 people during 2011.

How services are delivered

Problem Gambling Services are funded in the community through:

- Financial assistance agreements with county governments
- A limited number of direct contracts with providers of statewide, regional or specialized services

Services are delivered in every county and provided by a combination of county employees and subcontracted private agencies.

Community Mental Health Programs

Services provided

Mental health services improve the daily lives for Oregonians of all ages with severe mental health disorders such as bipolar, major depression, post-traumatic stress and schizophrenia. Persons experiencing a mental health crisis receive brief treatment consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization. Mental health assessments determine the need for further treatment and whether other supportive services will be provided. These ongoing supports and services improve a person's ability to be successful with their family, education, employment and in their community, often reducing public safety problems and negative health related consequences.

Children with mental health issues are served in their local communities and are linked with other child and family serving systems. Each child can be screened and served within the integrated service array according to a standardized level of need determination for their mental health service and support needs. Services are child and family driven and team-based with a clear focus on providing a broad array of services and supports across a coordinated continuum of types and intensity of care.

Services and supports include those delivered by peers, such as help establishing personal relationships obtaining employment or education, independent living skills training such as cooking, recreation, shopping and money management, residential treatment services or adult foster care, and supervision of people who

live in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB). Services are provided in many settings including local mental health clinics, doctor offices and clinics, schools, drop-in centers and homes. The Oregon Health Plan covers mental health services for eligible persons with conditions funded under the Health Evidence Review Commission Prioritized List for all Medicaid and SCHIP clients. The state General Fund pays for services and individuals not covered by OHP.

Where service recipients are located

Crisis services provided by qualified mental health professionals are available in all communities 24 hours a day, seven days a week. Mental health services are available in all 36 counties. These services include civil commitment procedures, acute inpatient treatment, residential treatment, adult foster care, outpatient therapy, supports needed for successful community living, medications, case management, assistance with finding and maintaining housing and work, and social support.

Who receives services

Community mental health programs provide mental health services for adults and children who have serious emotional and mental health disorders and are a danger to themselves or others, are unable to meet their needs, or are in danger of being removed from their homes due to emotional disorders. During 2011, publicly funded programs served 72,392 adults and 36,161 children and adolescents.

How services are delivered

Mental health services for adults and children are funded in the community through:

- Financial assistance agreements with county and select tribal governments
- A limited number of direct contracts with providers of regional, statewide or specialized services

Services are delivered in every county through the 32 CMHPs and the Warm Springs Tribal Clinic. Services are provided by a combination of county employees and subcontracted private agencies.

Professionally trained staffs – including physicians, nurses, social workers and trained peers – provide:

- Crisis evaluation, stabilization and civil commitment functions
- Medication, counseling, outpatient, and residential treatment to help people recover from their mental health disorders
- Case management, care coordination, housing, and supported employment and education assistance to help people continue to live successfully in community settings
- A range of peer-delivered services and supports

During 2011-13, there will be a major change in the system for delivering mental health services, the first major change since 1995. Services for the Medicaid population will no longer be managed separately from physical health care and addiction services. Beginning August 2012, these service areas were integrated and managed by locally accountable Coordinated Care Organizations. While change of this magnitude will be a challenge, the state expects improved health, improved quality of health care and lowered costs for the Medicaid population.

Why these services are significant to Oregonians

Because of publicly funded mental health services, more children remain in their homes, in school and out of trouble. Adults with major mental illnesses who receive treatment are working more, functioning better, and are less likely to be hospitalized or jailed.

State-Delivered Secure Residential Treatment

Facility Program

The State-Delivered Secure Residential Treatment Facility Program was enacted through HB 5031, the DHS Operating Budget. In passing HB 5031, the 2007 Legislature approved the program authorizing AMH to operate secure residential treatment facilities.

Services provided

State-delivered secure residential treatment services provide long-term treatment for individuals under the jurisdiction of the Psychiatric Security Review Board

who have been deemed ready for conditional release. These individuals actively participate in an array of treatment options while under the jurisdiction of PSRB. PSRB closely monitors the progress these individuals make in their treatment and plays a role in the evaluation process to determine when residents are ready to transition to a lower level of care. Effective 2011, individuals who have been civilly committed or committed by guardians are eligible for placement in order to better use the secured facility resources.

Where service recipients are located

The program opened in Pendleton in early January 2009. The residents come from across the state. At this time, AMH is not planning additional state-delivered programs. The goal is to use current facilities more effectively and to serve more individuals in permanent integrated homes with supports to be successful.

Who receives services

Services are provided to individuals under the jurisdiction of PSRB who no longer need hospital-level care and to those who have either been civilly committed or guardian committed. Providing services to those individuals in the community lowers the census at the Oregon State Hospital. There are 16 people in the program at any one time.

State Hospital Services

A key component of continuing care for those with mental health issues is state hospital services. Mental health services for adults who need long-term psychiatric hospitalization are provided in both extended community care services and the state hospitals with campuses located in Salem, Portland and Pendleton. These services are essential to restoring patients to a level of functioning that allows successful community living. Services in a secure setting promote public safety by treating people who are dangerous to themselves or others, who have committed crimes, and are adjudicated Guilty Except for Insanity.

Key Changes at Oregon State Hospital

New Facility Completed

An historic event took place in mid-March 2012 when the final patient moves occurred. This project began as the vision of key legislators and stakeholders

dedicated to the health, safety and recovery of patients and staff at OSH. The new facility positions OSH well in the pursuit of its vision of Hope, Safety and Recovery for all.

Organizational Structure

In direct response to the findings of the Liberty Healthcare consultation in September 2010, the organizational chart of the Oregon State Hospital was significantly revised in August 2011 to clearly reflect reporting relationships and lines of authority. These changes include the establishment of a Chief Financial Officer/Chief Operating Officer (oversees all support services), a Deputy Superintendent (oversees Clinical administrators, Security and Family Liaison), a Chief Medical Officer (oversees all Clinical discipline heads, including a new position, Chief of Medicine), a Director of Quality Management (oversees Standards and Compliance, Health Information, Technology Services, Data and Analysis, and Performance Improvement), a Director of Forensics and Legal Affairs (oversees the Legal Affairs Department, Risk Management, Informed Consent, and Forensic Evaluation Services), a Treatment Mall Administrator (oversees the operation of the hospital's six Treatment Malls, where active treatment is provided to patients daily), and a Transition Coordinator (oversees the development of and implementation of plans to occupy the new facility in Salem, as well as the Junction City hospital.)

Hospital leadership emphasizes the importance of holding staff accountable for the successful accomplishment of Cabinet-approved goals and objectives. To resolve one of the Liberty Healthcare report's noted deficiencies, issues of performance improvement have been clearly delineated and separated from issues of compliance. Clearly stated position descriptions have been developed, and an emphasis has been placed on performance evaluations for all staff. Thus, excellent job performance is recognized while deficient performance is identified and resolved.

In order to better organize and focus the work of the hospital Cabinet, the hospital's committee structure has been completely revamped (this was also a noteworthy deficiency listed in the Liberty Healthcare report). Each committee's role and charter was clarified and membership reformulated. In addition, a schedule of committee reports on progress or issues to the Cabinet has been established.

To align clinical services with the hospital's vision, all clinical discipline chiefs now answer to the Chief Medical Officer, who is responsible to assure accountability and coordination of these services. Each clinical discipline head is responsible for the services their staffs provide and coordination takes place at regular meetings of the Clinical Executives, in daily morning check-ins, and in regular, project-based meetings with each other and the CMO.

Services provided

With campuses in Salem and Portland, the Oregon State Hospital provides inpatient and residential services with a budgeted operational capacity of 632 beds and a licensed capacity of 712 beds. The Joint Commission accredits OSH. Patient unit, Butterfly 3, which provides neuropsychiatric treatment services, is certified to receive Medicaid Title XIX funding by the Centers for Medicare and Medicaid Services (CMS). OSH is part of the Oregon State Hospital System and is operated by the Oregon Health Authority's Addictions and Mental Health.

Adult treatment services are provided in a 92-bed leased facility in Portland. This program provides hospital-level psychiatric services for adult patients with major psychiatric illnesses who are 18 to 65 years of age. Patients treated in this program are unable to be treated in a less structured environment. They are civilly committed and assigned to hospital-level care. This program provides intermediate and long-term state hospital treatment for patients transferred from community acute care hospitals.

Neuro/medical services are provided in 88 beds in four units of specialized active inpatient treatment for elderly persons with mental illness and a specialty unit for neurologically impaired patients of all ages. Eight beds providing acute nursing care for patients suffering from medical conditions are included on one of the neuropsychiatric wards. Inpatient services are available to older adults who have major psychiatric disorders and adults older than 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive nursing home environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical-surgical hospital.

The forensic psychiatric program provides hospital treatment services to patients committed by the courts for evaluation or treatment in order to aid and assist in their own trials or committed to the jurisdiction of the Psychiatric Security Review

Board or the State Hospital Review Panel under the "guilty except for insanity" adjudication. These services consist of 426 beds on 17 treatment units. A full array of treatment services is offered in maximum and medium security levels. In addition, this program provides services for some civilly committed patients who are either too dangerous or too difficult to manage in the less restrictive secure environment of a general adult hospital program. Specialty services are provided to patients adjudicated for sex offenses or those with histories of sexually inappropriate behaviors.

Forensic residential transitional services provide treatment for approximately 26 patients in four cottages. These are transitional units providing treatment to patients under the jurisdiction of the PSRB or SHRP who have shown substantial improvement in their conditions and require a less restrictive environment in preparation for placement in a community setting.

Where service recipients are located

Clients residing at the state hospitals are admitted from all areas of the state to facilities in Portland or Salem.

Program Administration and Support

AMH, in collaboration with external partners and stakeholders, creates the vision for mental health, substance abuse and problem gambling prevention and treatment systems of care, and sets policy to bring the vision into practice. The Director for AMH supervises the state hospitals and the project to build the second new state hospital in Junction City. The Director works with the leadership of the state hospitals to integrate their services into the statewide system of care for people with mental illness.

AMH Program Administration and Support (PAS) is responsible for:

- Developing state plans for substance abuse prevention and treatment services and mental health services
- Implementing state addictions, gambling and mental health programs and laws
- Directing services for persons with substance use disorders and with problem and pathological gambling
- Directing services for persons with mental health disorders

- Directing services for persons with co-occurring mental health and substance use disorders
- Maintaining custody of persons committed by courts to the state for care and treatment of mental illness

PAS staff shares responsibility with the counties for developing and managing community programs as part of the overall state mental health and addictions system. If a county is unable to operate a program area, AMH is responsible for contracting for services directly with providers. PAS is responsible for protecting the safety of clients and ensuring quality of care.

PAS ensures the efficient and effective functioning of the program office and the necessary supports to the program and policy staff. AMH central administration staff work closely with the department budget staff and contract administration staff to ensure sound financial management of the addictions and mental health services community and state hospital program budgets, and the appropriate implementation of community treatment programs through contractual relationships.

PAS supports all Addictions and Mental Health Programs. The majority of this support is for four community programs — Alcohol and Drug Prevention, Alcohol and Drug Treatment, Problem Gambling Prevention and Treatment, and Community Mental Health. Staffs are responsible for:

- Program development
- Administrative rules development
- Planning and policy development
- Providing leadership and policy direction for mental health and addictions services as the Oregon Health Authority transforms health care for the Medicaid-eligible population
- Strengthening coordination between the state hospitals and the community mental health programs to ensure appropriate admission to and timely discharge from the hospitals
- Conducting site reviews
- Conducting licensing and certification inspections
- Providing training and technical assistance
- Providing administrative oversight
- Overseeing quality improvement

- Developing program management data;
- Providing technical assistance to community programs
- Managing development of alcohol and drug free community housing for individuals with addiction disorders and those with mental illness
- Collaborating with state and local partners to reduce and end homelessness

This structure is based on the March 2012 Structure of AMH. Both AMH, due to major system changes, and OHA, due to health care transformation, are in the midst of looking at organizing work based on critical core processes that directly relate to supporting the new Coordinated Care Organizations and achieving the agency's goals of better health, better care and lower costs. It is expected that there may be structural changes because of this work as well as the need to flatten the structure to accommodate the major budget reductions taken in the 2011-13 biennium during both the 2011 and 2012 sessions of the Legislature.

AMH System Change

The AMH System Change work is designed to integrate addiction and mental health prevention and treatment services, providing greater flexibility to local communities in an effort to promote innovation and improved outcomes associated with behavioral health, and better serve people with behavioral health needs. These improvements will be supported by flexible funding, allowing counties the discretion to put resources where they are most needed to serve people in their communities. Outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve, rather than just the quantity of services provided or the number of people served, will help balance a flexible budget.

From the start, the AMH System Change work engaged community stakeholders and partners. This included drafting system change principles with representatives from the Association of Oregon Counties (AOC) in June 2011, and since has continued with multiple advisory activities with stakeholders and partners. Participants representing consumers of mental health services, individuals in recovery from addictions including problem gambling, outpatient providers for addictions and mental health, acute care hospitals, AOC, Association of Community Mental Health Programs, prevention programs, and other diverse groups continue to advise AMH in the design and implementation of the AMH System Change through structured advisory opportunities and contacts with key

informants with critical expertise. The diversity and longevity of the engagement will result in developing a person-centered, strengths-based system of care in Oregon.

There will be changes in the manner in which AMH conducts business and approaches the work with the counties. There will be a shift in emphasis to contract compliance and technical assistance related to achieving outcomes. One way that AMH is managing the changes from within the agency is by readying the staff to support the new processes required to operate a high functioning behavioral health system. Staff members are examining existing functions, looking at maintaining only what needs to be continued, while developing new, consolidated business practices. The goal is to increase efficiencies and decrease internal and external administrative burdens.

1915(i)

1915(i) Medicaid home and community-based state plan amendment (SPA). The SPA was approved in February 2012 and creates a new approach to community-based treatment for people with serious mental illness and a need for daily service contact. The amendment will make an expanded array of services available in community-based settings to better meet the needs of consumers and allow the state to simplify the billing and documentation requirements for providers. The results of this initiative will support Oregon's efforts to serve people in the most independent setting.

Legislative Initiatives Carried Out

HB 3100

House Bill 3100 passed July 1, 2011, requiring all psychiatrists and licensed psychologists to be certified by January 1, 2012, in order to perform forensic evaluations for the purposes of competency and criminal responsibility. The forensic certification program is under the authority of Addictions and Mental Health and was established by Oregon Revised Statute 161.309-161.370 and 419C.524 and is administered under Oregon Administrative Rules 309-090-0010 through 309-090-0090. These rules identify types and requirements of certification, the required content of evaluations, a Review Panel process for submitted evaluations, and requirements of the Forensic Evaluator Training Program. Currently 110 applicants have been granted temporary certification until they

complete the training and have three redacted forensic evaluations reviewed by the expert review panel. When all requirements are met, full certification will be granted. AMH is currently working with a training team at Pacific University and Northwest Forensic Institute to finalize the training curriculum. Two trainings will be held in July and August. The goal of this certification is to provide standardization to the forensic evaluation process when determining if an individual is able to aid and assist in his/her own defense or criminally responsible at the time of committing a crime.

The legislation allows people found guilty except for insanity of a misdemeanor to be treated in their local community as long as they do not present a substantial danger. In that case, they can be court-mandated to OSH. This process is also a possibility for persons committing a Class C Felony (nonperson crime).

SB 420

Senate Bill 420 (2011) went into effect on January 1, 2012. The law created two tiers of offenders who were found guilty except for insanity. Under SB 420, Tier 1 offenders remain under the jurisdiction of PSRB, and the Oregon Health Authority acquires jurisdiction over Tier 2 offenders who are in OSH. After a Tier 2 offender is conditionally released, jurisdiction of Tier 2 offenders transfers to the PSRB for monitoring and supervision in the community.

The Oregon Health Authority created the State Hospital Review Panel (SHRP) to provide due process to Tier 2 offenders under its jurisdiction. SHRP is made up of a psychiatrist, a psychologist, an attorney, a probation officer, and a public member. The OSH Legal Affairs Director, a paralegal and a legal secretary, supports the hearings conducted by SHRP by: gathering exhibits, arranging for witnesses, sending out notices, and communicating with patients, attorneys, and community partners. SHRP and its OSH staff endeavor to make the process as efficient as possible with the goal of moving patients determined to be ready for discharge and/or safe for release into the community as soon as possible.

After reviewing exhibits and testimony at formal hearings, SHRP determines when it is appropriate to discharge or conditionally release Tier 2 patients. SHRP balances the goals of the Americans with Disabilities Act to place mentally ill people in the least restrictive settings with the goals of public safety. It does this by determining whether the person:

a) Is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others

b) Is still affected by a mental disease or defect and is a substantial danger to others, but can be controlled adequately if conditionally released with treatment as a condition of release

c) Has not recovered from the mental disease or defect, is a substantial danger to others and cannot adequately be controlled if conditionally released on supervision

ORS 161.346(1)

On January 1, 2012, the PSRB transferred 120 patients to the jurisdiction of the Oregon Health Authority's SHRP. Since that time, SHRP has scheduled and conducted hearings in accordance with the statutory timelines.

When a patient is conditionally released, the patient is released into the community and transferred to the jurisdiction of the PSRB. SHRP has conditionally released 12 patients and approved two additional patients for conditional release who will be released when a bed becomes available for them in the community. SHRP has ordered that community evaluations be conducted for 26 patients. Before a patient may be conditionally released, a community evaluation must be conducted.

Occasionally, a person is discharged because SHRP determines that the person no longer meets the statutory criteria for jurisdiction (such as they do not have a major mental illness Axis 1 diagnosis, or they are no longer a danger to others). As of August 2012, SHRP had discharged seven individuals because they no longer meet the criteria for jurisdiction.

As of August 2012, SHRP has 118 OSH patients under its jurisdiction.

COMPASS Project

To adapt and thrive under Oregon's Health System Transformation, Addictions and Mental Health is implementing a comprehensive behavioral health electronic data system that will interface with other health information systems in an effort to improve care, control cost and share information. The COMPASS project is a collaborative information technology approach to the administration, planning and

monitoring of behavioral health programs and supports our ability to track performance outcomes, population served, and the cost effectiveness of services. The three main components of the project – an electronic health record (EHR) system, contracts administration, and data collection – will allow AMH to account successfully for these measures.

AMH piloted EHRs with fourteen providers and will add eleven new providers in 2013. The contracts administration business requirements are defined and currently in user testing. Full implementation of the data collection component is also planned for July 2013. The contracts system replaces technology that is twenty-years-old and is unsupported since the company no longer exists. The data collection component replaces two more-than-thirty-year-old mainframe systems that are inflexible and impractical to reprogram to provide the data needed to manage behavioral health services in the 21st century. This was discussed with the Legislature during the 2011 session.

CAPITAL CONSTRUCTION

Oregon State Hospital Replacement Project

History

Oregon has been in critical need of a new hospital for its citizens with mental illness. The Oregon State Hospital is one of the oldest, continuously used mental health hospitals on the West Coast. It also had the dubious distinction of being one of the most decrepit mental health facilities in the nation. More than 40 percent of the building space was unusable, with water leaks from roofs, crumbling walls and the toxic hazards posed by the presence of asbestos and lead.

For decades, state lawmakers heard from patients, advocates, citizens and staff about the inadequacy of the state hospital. In addition, the state faced several challenges, including legal suits, over a variety of hospital deficiencies. The Governor, Oregon Legislature and DHS/OHA have collectively acknowledged the critical need for new mental health facilities.

During 2003, the Governor established, by executive order, a 21-member Mental Health Task Force to identify key problems in the state's mental health system and recommend improvements. The task force released a report in 2004 recommending changes to OSH.

Ongoing concern about the hospital prompted the November 2004 Legislative Emergency Board to allocate funds to DHS/OHA for an independent examination of the mental health system with a specific focus on OSH.

With those funds, the Governor and Legislature commissioned KMD Architects, a firm with more than 40 years of experience in 15 states, to begin preparing a master plan for replacing OSH.

The May 2005 OSH Framework Master Plan Phase I Report identified significant structural issues, including a potential that the J Building complex on the Salem campus would collapse in an earthquake. In addition, the Phase I Master Plan notes that the existing facilities on this campus have physical limitations that could not be remediated to provide safe and secure treatment environments. Along with these issues, the 92-bed Portland campus lease ends in March 2015, requiring the

relocation of the patients housed there. The Phase II Report on the Framework Master Plan was released on March 1, 2006. That report provided the Governor and legislative leadership with three options to consider for replacing OSH. The leadership directed DHS/OHA to proceed using the configuration listed in the document as Option 2: one 620-bed facility located in the North Willamette Valley, one 360-bed facility located south of Linn County on the west side of the Cascades, plus two non-hospital-level, 16-bed secure residential treatment settings placed strategically east of the Cascades.

Based on recommendations from a Joint Legislative and Executive Branch Task Force, the 2007 Oregon Legislature authorized Certificate of Participation (COP) financing estimated at $458.1 million to build two new state-operated psychiatric facilities. The first Salem hospital residential units opened in January 2011. The Salem hospital was completed in December 2011, and the Junction City facility is scheduled to be completed at the end of 2014 with patients moving in early 2015. Both are designed, along with a strengthened community mental health system, to support healing, recovery and a return to successful community living.

As the project moves forward, the replacement team continues to look for opportunities to improve patient care and reduce state costs. Based on a recent analysis of need for hospital level of care and changes in discharge practice, OHA leadership recommended a reduction in the size of the Junction City hospital from 360 to 174 beds. This reduction is achieved by recommending an additional 186 beds in the community to serve those individuals whose needs can be met at a lower-than-hospital level of care.

Although the historic state hospital was inadequate for long-term, continued care and treatment of those with mental illness, the OSH Salem campus was selected as the best site for construction of the new 620-bed facility. Using legislatively mandated selection criteria developed with public input, this site scored highest among those considered. The Salem site maximizes opportunities to attract and retain quality professional staff and places 55 percent of patients reasonably close to their home communities. In addition, the larger Salem community is accustomed to having a large psychiatric hospital on this site and is generally supportive of the hospital being there.

Historic preservation

OHA is committed to protecting and preserving valued historic and cultural resources while investing and growing a mental health system of care to serve Oregonians now and in the future. Using the current OSH site provided an optimal opportunity to include historic buildings and structures in the design of the new facility and an opportunity to include both an above-ground memorial for cremains and a museum for the history of the West Coast's oldest continually operating psychiatric hospital.

Status

The Salem hospital was completed in December 2011 and the Junction City hospital is scheduled to be completed by the end of 2014. Site preparation work for Junction City construction is under way.

Centralized treatment model

The design of the hospital supports the delivery of centralized services at treatment malls within the secure perimeter.

The entire design of the facility supports patients participating in active psychiatric treatment and having sufficient privacy and personal space.

The hospital, replacement project, through the replacement project's Behavioral Health Integration Project (BHIP), began the use of the Avatar Electronic Health Record in November 2011. The work to complete the full implementation of the hospital management system and full integration into the business flow, treatment care planning, and reporting for organizational compliance, and data-informed decision making will be completed in the 2011-13 biennium. Work will be ongoing with additional systems that work with the electronic health record.

Challenges

There are a number of cost drivers that may affect the financial bottom line of this project. The major one influencing the costs for Junction City is the additional 100,000 square feet of treatment space to support twenty hours per week of active psychiatric treatment and the staff to carry out this mandate.

The Junction City site must meet the requirements of the solar energy bill (ORS 279C.527 to 279C.528) adding costs not included in the original budget approved by the Legislature.

Another cost driver comes as a direction from the Legislature to absorb the cost of furniture, fixtures and equipment (FF&E) into the budget. The rough estimate in 2007 for FF&E was $10.5 million.

In addition to challenges presented by these and other cost drivers, the success of the replacement treatment facilities is dependent on significant investments in the entire mental health service system. These investments must continue to build the community system that prevents individuals from needing hospital-level services. It also must build capacity to help patients transition successfully back to the community. To support the functions of the state hospitals, Oregon has developed more than 1,698 extended care placements provided by counties and a variety of non-profit and for-profit providers.

Funding

The 2007 Legislature passed SB 5504 and HB 5006, which provided the budgetary authority of $458.1 million for DHS/OHA to proceed with construction of facilities in Salem and Junction City.

Construction of the replacement hospital is financed with Certificates of Participation (COP) and General Obligation Bonds (GOB) requiring accurate and specific recording and accountability for expenditures of COP/GOB proceeds. COP/GOBs are a principal means of financing government projects and are used for many state facilities expected to have 40 to 60 years of useful service.

The project has been working diligently to mitigate the various programming and site impacts. From the first evaluation, it was clear that additional needs had the potential to add more than $150 million in additional project costs to Salem alone. Through aggressive management of all areas, from design to individual sub-contractor selection, AMH has been able to reduce this to a request for an increase of approximately $50 million in COP/GOB sales for the project as a whole. We continue to work on this issue by looking for additional construction savings.

Actual operating costs will depend on many factors, including legislative decisions about staffing, salaries, wages, and community supports that relieve pressure on the facilities. Additional pressures on operating costs could come in the form of rising fuel and utility costs and a possible increase in the number of individuals committed under forensic statutes.

Opportunities

Junction City

The major opportunity in Junction City is realized by the analysis, based on more recent data, of the original assumptions that there is a need for 360 hospital beds. In January 2011, OHA presented an analysis that indicates additional patients under the PSRB and those currently served in the neuropsychiatric program could be served in the community with proper investment, leaving a need for 174 beds at Junction City. In addition to the current partnership with Department of Corrections (DOC) for site preparation, AMH is examining opportunities in the design of the Junction City facility that could allow for alternate uses if the future need for state hospital level of care decreases and support for community services increases.

Reusable materials

Throughout the project, OSH staff found many reusable materials from previous construction and maintenance projects were being transferred to the general contractor for use on the replacement project, resulting in a cost reduction for the project of more than $100,000 to date. Examples of such items include fencing materials, electrical wire, drainpipe and electric gates. Some construction materials and equipment purchased for the Salem site will be reused at the Junction City site.

Behavioral Health Integration Project

The completion of the BHIP project with the full implementation of Avatar at the Salem site will make an operational electronic health record and hospital management system available at minimal added cost for Junction City.

Value engineering study

The benefits to the cost-containment of the Salem project will be continued and other value engineering opportunities will be incorporated into the design and construction of Junction City.

Summary

Replacing the Oregon State Hospital is critical to growing a mental health system of care, which has been a priority of the governor, the legislature, and the agency director. By integrating the new facility in Salem with most of the historic buildings within the district, and restoring and putting the Kirkbride U into full use again, OHA created a project that meets its state mandate to build a hospital on the existing OSH Salem site and protects the historic significance of the site. The agency will also continue to develop the Junction City campus as mandated, working with DOC to maximize all co-location efficiencies.

CAPITAL IMPROVEMENT

Oregon State Hospitals

This program funds essential health and safety remodels or repairs for the state hospitals. Without these repairs hospital certification and licensure can be jeopardized and patients and staff subject to less than ideal treatment environments.

Program Description

This limited program provides minimal resources to fund minor remodel or repair project costs in the state hospitals. These projects are essential to maintaining a safe and therapeutic environment in which to serve Oregonians with severe persistent mental illness that cannot be safely treated in a community setting. Funds are used to contract with private entities to make needed repairs in fire suppressant systems, remodel kitchens, repair roofs, sidewalks, elevators and other essential components of state hospital treatment facilities. The work is accomplished through a competitive bidding process with the selection of a private company to do the work. The major cost drivers are the age of some of the existing facilities, (e.g., Blue Mountain Recovery Center) and the damage to the buildings by patients who are very ill and whose symptoms sometimes manifest in violence against the environment.

Enabling Legislation/Program Authorization

This program is not required by statute; however, federal requirements under the Americans with Disabilities Act requires people to be served in a safe, accessible environment.

Funding Streams

100% State General Fund.

Significant Proposed Program Changes from 2011-13

There is no change proposed in the program. The Governor's Balanced Budget continues the base G/F budget support of $679,238.

Oregon Health Authority (OHA)
Addictions and Mental Health Division (AMH)

Report on SB 5529 Budget Note

January 2013

Background

During the 2011 session, a budget note to SB 5529 directed that the Oregon Health Authority convene a statewide workgroup to identify the needs of people who are involved in the criminal justice system for minor violations, who have mental illness and could be placed more appropriately in settings where they could receive mental health treatment. The group was expected to develop recommendations for methods to divert this group for appropriate and effective mental health care in the community. This report is prepared for consideration in the 2013 legislative session.

Workgroup Methodology

The workgroup was comprised of individuals representing addictions and mental health providers, judges, the Psychiatric Security Review Board, Disability Rights Oregon, National Alliance on Mental Illness Oregon, Association of Oregon Community Mental Health Programs, county behavioral health services, municipal police agencies, Oregon State Police, consumers, Oregon Consumer Defense Lawyers Association, Oregon Association of Community Corrections Directors, Oregon Association of Chiefs of Police, and the Oregon Association of Hospitals and Health Systems (please see appendix A for full list of participants).

In order to appropriately respond to the budget note the workgroup focused on recommendations that could be classified in three categories:

- Recommendations related to alternatives to arrest and incarceration.
- Recommendations related to alternatives to incarceration (including 370s, individuals unable to aid and assist in their own defense) once formally charged and/or sentenced
- Recommendations related to services, resources and supports to assist successful transition into the community

Recommendations within these categories were then discussed and placed in the Sequential Intercept Model (SIM) (see Appendix B). The SIM is a visual national model produced by the GAINS Center to aid in the development of a comprehensive plan for mental health and criminal justice collaboration. This model outlines action for system-level change through five intercepts:

- Intercept 1: Law Enforcement

- Intercept 2: Initial Detention/Initial Court Hearings
- Intercept 3: Jails/Courts
- Intercept 4: Reentry
- Intercept 5: Community Corrections

Through each of these intercepts the model aids in outlining the following:

- Understanding the interactions between the criminal justice and mental health systems;
- Identifying where to intercept individuals with mental illness as they move through the criminal justice system;
- Suggests which populations might be targeted at each point of interception
- Highlight likely decision makers who can authorize movement from the criminal justice system; and
- Identify who needs to be at the table to develop interventions at each point of interception

The workgroup identified category headings that would fit into each, or more than one, of the intercepts and the specific recommendations focused on methods, services or programs that would aid in diversion of those with minor violations to other, more appropriate, settings than jail. Please see Appendix C for the full SIM prepared by the workgroup.

Recommendations

As identified in the SIM, each of the recommendations is categorized by the above mentioned intercepts. The recommendations are focused on the overall needs of the person with mental illness as well as of the system. Although in some cases, specific models are identified, none of these models or specific providers are endorsed by the work group. Many of the recommendations are also currently operating in different areas of the state but not on a consistent level. A number of similar recommendations are located in multiple intercepts.

Crisis Services: Many of the recommendations related to crisis services are located in the first two intercepts, this is due to the need to engage in crisis services early to divert an individual from both intercepts two and three, which are focused on the initial detention, court hearing and jail.

- Crisis Outreach Response Team: These teams vary from county to county but can provide a 24-hour Crisis Outreach Response Team consisting of trained

crisis clinicians who are able to respond 24-hours a day to people in need of crisis services. Services can include:

- Crisis evaluations in the community when dispatched by police to eliminate the need of direct involvement by law enforcement;
- Phone crisis intervention;
- Phone assessment and referral to appropriate provider(s) based on insurance/payment source;
- Emergent (same day) or urgent (within 48 hours) intake appointments;
- Brief treatment sessions for crisis stabilization;
- Consultation to peace officers and help locating available hospital beds;
- Meeting with families to initiate a formal pre-commitment investigation; through the 2-Party Petition process;
- Monitoring committed individuals discharged from the hospital on 'trial visits' (allowed to live in the community under certain conditions);
- Community consultation, information and referral to other agencies or services; and
- Consultation with outpatient clinic staff and community members, law enforcement, and local service providers who are involved with individuals in mental health crisis.

- Mobile Crisis Response: These cooperative partnerships are designed to provide comprehensive crisis intervention services to persons in a mental health crisis. Mobile Crisis Response pairs a mental health clinician and/or peers with a police officer to provide emergency police response to persons in need of crisis intervention. Some of the goals of this system are to:
  - Create a partnership with the mental health and police systems;
  - Develop an accessible, coordinated and comprehensive system of psychiatric emergency services;
  - Fill service gaps identified in the emergency system;
  - Appropriately divert persons who have mental illness from the 911 emergency system and hospital emergency departments;
  - Link frequent mental health consumers to the mental health system.
  - Reduce police time on calls associated with mental health consumers;
  - Increase disposition and treatment options for police officers responding to crisis calls; and
  - Increase overall treatment satisfaction for mental health consumers.

- Voluntary Mental Health Database: This database originated from HB 3466 (2009) in which an individual with mental illness can voluntarily request to be added to a law enforcement database that presents identifying and helpful information on an individual's needs during an event.

- Assertive Community Treatment (ACT): The ACT team treatment approach is designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness. Clients served by ACT are those who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. Persons served by ACT often have co-existing problems such as homelessness, substance abuse problems, or involvement with the judicial system.

- Respite Centers: These centers are increasingly being focused on as Peer Respite Centers and can provide an alternative to hospitalization, jail and crisis services. They often focus on wellness and the ability to stabilize an individual.

Training: Training is located in Intercept 1 as both Crisis Intervention Training (CIT) and Advanced Crisis Intervention Training. This is a training program developed to help police officers react appropriately to situations involving individuals with mental illness or developmental disabilities. CIT partnerships can lead to changes in existing systems and possible development of new infrastructures for services.

Within Intercept 2 training is identified as judicial training to ensure that there is consistent knowledge of available services, needs of individuals with mental illness.

Transition Services: Elements of transition services are seen throughout each of the intercepts, each adjusting to the transitional needs of the intercept.

- Wraparound Services: This term has been used in reference to children's mental health but has been expanded in reference to an individualized approach to identifying the services one would need, which are including but not limited to:
    - Mental Health Services
    - Alcohol and Drug Services
    - Employment
    - Housing
    - Medication Management
- Supported Employment: Employment is integral to achieving and maintaining independence. Evidence-based Supported Employment helps clients receiving community mental health services to become a part of the competitive labor market. Approximately half of those who enroll in evidence-based Supported

Employment become steady workers and remain competitively employed a decade later.

- Case Management in Jails: Many jails have resources for on-site mental health staff. They can be actively involved in assessments, treatment, case management and assist in linking individuals to community mental health services upon and prior to release. These case managers can also facilitate continuation of appropriate medications while incarcerated an assist with elements related to transitional services. While many jails are able to provide this type of care, many are not appropriately funded to fully address the mental health needs of these individuals.

Peer Services: Peer services also appear throughout all five intercepts. These are an important part of the delivery system and prove to be both cost effective and a crucial component of success. Within the SIM, these services are specified through peer navigators, mentoring, in-jail supports and coordination with peer support organizations, however, peer services are also a part of other tools previously identified, including crisis and transitional services.

Assessment & Treatment: This component of the system provides for the overlap within Addictions and Mental Health. Identified are a drop off center which law enforcement can utilize and crisis residential and detox centers.

- Detox Centers/Sobering Stations: These centers provide medical detoxification and stabilization. Patients can receive an average of 4-10 days of medical treatment for early withdrawal symptoms. Generally, a team of registered nurses and technicians provide around-the-clock medical care, and a physician provides an examination on admissions. Patients meet with a counselor and are then referred to available treatment services.

Access to Medications: Access to medications is an important component of the first three intercepts. This is related to not only access but also monitoring of medications. It identifies the need for medication stabilization for those in crisis and transition services. There is also an important need for telemedicine in order to assess and address individual needs.

Aid & Assist: Within Intercept 3 there is an overlap with the Oregon State Hospital (OSH) population that if addressed appropriately, could help with some of the system issues currently occurring.

- Continuity of Care: Discharge planning is an important piece of the process for an individual leaving OSH. While there are different circumstances surrounding how discharge planning works, a collaborative effort is important in the continuity of care of an individual.
- Expansion of 370 projects: The 370 Project was created in 2007 for people in OSH who have been adjudicated as unfit to proceed, or unable to aid and assist in their own defense. The project provides case management services to mentally ill individuals who have been court ordered under Oregon Revised Statute 161.370

for detainment to the Oregon State Hospital or to out-patient restoration in the community to be restored to competency so they may be able to aid and assist in their own defense. Currently there are four counties participating in the 370 Project--Lane, Marion, Multnomah and Douglas.
The case management provided in each county includes the provision of funding for rental assistance; assessments; medications; aid and assist training; the creation of diversion agreements with county courts and jails; and assisting OSH in discharging people.

Housing: There are different types of housing that aid in the stability of an individual within the criminal justice and addictions and mental health system.

- Transitional housing: This is generally designed for people who are newly engaged in treatment and recovery, recently released from incarceration, or who have very recently become homeless. This short-term housing combined with intensive case management, provides the stability and support necessary to begin building a new life.
- Supportive Housing: This is a proven approach for providing behavioral health services in integrated community settings. It presents an alternative to hospitals, shelters, and other settings that segregate people by disability, such as nursing homes, board and care homes, and other residential care facilities, in which residency is tied to receiving the particular services the facility offers.

Diversion: Diversion is identified in Intercept 3 and focuses on the expansion of mental health courts and District Attorney (DA) Diversions.

- Mental Health Courts: These courts vary but generally link offenders who would ordinarily be prison-bound to long-term community-based treatment. They rely on mental health assessments, individualized treatment plans, and ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities. There are several focal points for the program, including but not limited to:
    - Connecting participants with mental health, drug, and alcohol treatment resources;
    - Reducing self-harm by limiting the amount of time participants spend in jail and in the hospital;
    - Engaging participants in positive life activities, such as school and work; and
    - Encouraging participants to support the community by paying restitution to victims and completing community service

Effective Communication: This is an important component of all intercepts. Individuals with mental illness must be able to effectively communicate with each person in the

criminal justice system including crisis services, law enforcement, the Court, the defense attorney, the District Attorney, the jail/prison staff as well as parole/ probation. For some individuals, this may require a reasonable accommodation pursuant to Title II of the Americans with Disabilities Act (ADA), 42 USC sections 12131-12165. The ADA's guarantee of equal access to state and local government services, programs, and facilities requires: (1) making reasonable modifications in policies, practices and procedures as well as (2) ensuring effective communications. There is a narrowly defined exception if the reasonable accommodation would cause a fundamental alteration or undue burden. Examples of reasonable accommodations for individuals with mental illness include but are not limited to: scheduling a meeting/ hearing at a particular time of day (due to medications), restricting long dialogue, allowing companion animals, modifying the pace and/ or location of the meeting/ hearing, and allowing a support person. Primary consideration must be given to the preference for accommodation as expressed by the individual with a disability, who is most familiar with his or her disability and in the best position to determine what type of aid or service will be effective. *See* ADA Technical Assistance Manual II-7.1100. People with mental illness may have other disabilities, such is an intellectual disability, that must be accommodated.

Barriers

Some of the barriers related to the implementation of the recommendations above are:

- Funding: Many of the recommendations listed would require additional funding to either start, pilot or expand services.
- Voluntary Participation: The recommendations listed require an individual to voluntary participate or engage in the services provided. While additional resources will fundamentally aid this population in finding and accessing services, it would need to be on a voluntary basis.
- Rural versus Urban: While the recommendations are meant to be an overall model to aid both the state and counties in possible investments and/or development, the workgroup also identified the discrepancies in the ability or each of these elements to function in a rural versus urban area, even if fully funded. A possible recommendation for assessing regional needs was also discussed.
- Health Care: As we move in the direction of the integration of behavioral and physical health care through Health System Transformation, it is important to note that while this workgroup focused on individuals with mental illness who interact with the criminal justice system, there is also opportunity in the collaboration with the physical health system to ensure a person centered approach in its entirety.

Next Steps

AMH will use these recommendations to inform future budget planning, will develop strategies to implement the recommendations identified by the workgroup and continue to engage the participants on the workgroup.

Oregon Health Authority (OHA)
Addictions and Mental Health Division (AMH)
and
Psychiatric Security Review Board (PSRB)

Report on SB 5529 Budget Note: Need for Community Placement of PSRB Patients

January 27, 2012

Background

The budget note directs the Oregon Health Authority (OHA) to determine the need for community placements for PSRB patients at the Oregon State Hospital (OSH) who are no longer in need of hospital level care. This work was completed by the Addictions and Mental Health (AMH) Division in collaboration with the Psychiatric Security Review Board. In order to complete this work, AMH convened a work group to review data on forty-three patients eligible for conditional release and facilities from a snapshot of time of September 1, 2011.

As of September 1, 2011 there were a total of 726 persons under the jurisdiction of the PSRB; 43 of whom were eligible for conditional release but still residing in OSH and 401 who were on conditional release in various settings by the following percentages:

18.3 % - secure residential treatment facilities
3.3% - foster homes in Developmental Disability office
30.5% - residential treatment facilities/homes
8.7% - adult foster homes
17.3% - semi-independent or supported housing
4.6% - intensive case management
17.3% - independent living (alone, with family or others)

The current PSRB-funded residential capacity is approximately 287 beds distributed over four levels of licensed care with additional intensive case management services and supported housing services with a vacancy rate of less than 5% at any given point in time.

Persons under the jurisdiction of the PSRB are determined ready for community living after successfully completing prescribed treatment in OSH as ordered by the PSRB. Upon treatment completion, the PSRB authorizes persons to be interviewed by county staff from the proposed county of residence. Community mental health treatment providers and residential treatment providers also interview the prospective resident. Once agreement is determined by the PSRB, OSH treatment team, community provider, county and person being transitioned from OSH, a conditional release hearing is scheduled with the PSRB to review the conditional release proposal. Although

consensus is not statutorily mandated, agreement by all parties is the goal in order to provide the greatest chances for the conditional release plan to succeed.

Workgroup Methodology

To assure a representation of the mental health community, the workgroup was comprised of consumers, consumer advocates, county mental health directors, community residential treatment providers and staff from the PSRB, OSH and AMH. Data were collected using a standardized patient assessment tool measuring critical domains for discharge. The assessment tool used was the Individual Needs for Discharge Assessment (INDA). The assessment identifies the needs for community placements for PSRB patients at Oregon State Hospital (OSH) for whom a hospital level of care is not necessary on an ongoing basis. The workgroup recommendations were based on a "snapshot in time" of those needs. All the assessments were reviewed by OSH staff to assure reliability and provide consistent chart reviews. Prior to the initial meeting, workgroup members were provided with the results of the chart review showing individual needs as of September 1, 2011, a statewide map of mental health facilities by residential type and size for adults under the jurisdiction of the PSRB, a map of the number of adult PSRB clients on conditional release in each county in the state and a statewide list of facility vacancies for PSRB clients as of September 30, 2011.

The data analyzed included:

- The individualized needs of the 43 persons who were eligible for conditional release as of September 1, 2011. (with identifying information redacted)
- OSH conditional release referral list as of September 1, 2011.
- A statewide map of mental health facilities by type and size for adult residents under PSRB
- A map of the number of adult PSRB clients on conditional release in each county in the state of Oregon
- A statewide list of facility vacancies for PSRB clients as of September 30, 2011

The workgroup met twice (November 1, 2011 and November 9, 2011) and the following recommendations are the result of those meetings. Recommendations were based on this "snapshot in time" of September 1, 2011.

Recommendations

The recommendations of the group are as follows:

1. No additional 16-bed Secure Residential Treatment Facilities (SRTFs) are needed at this time. Based on the data reviewed, there is not a need to add

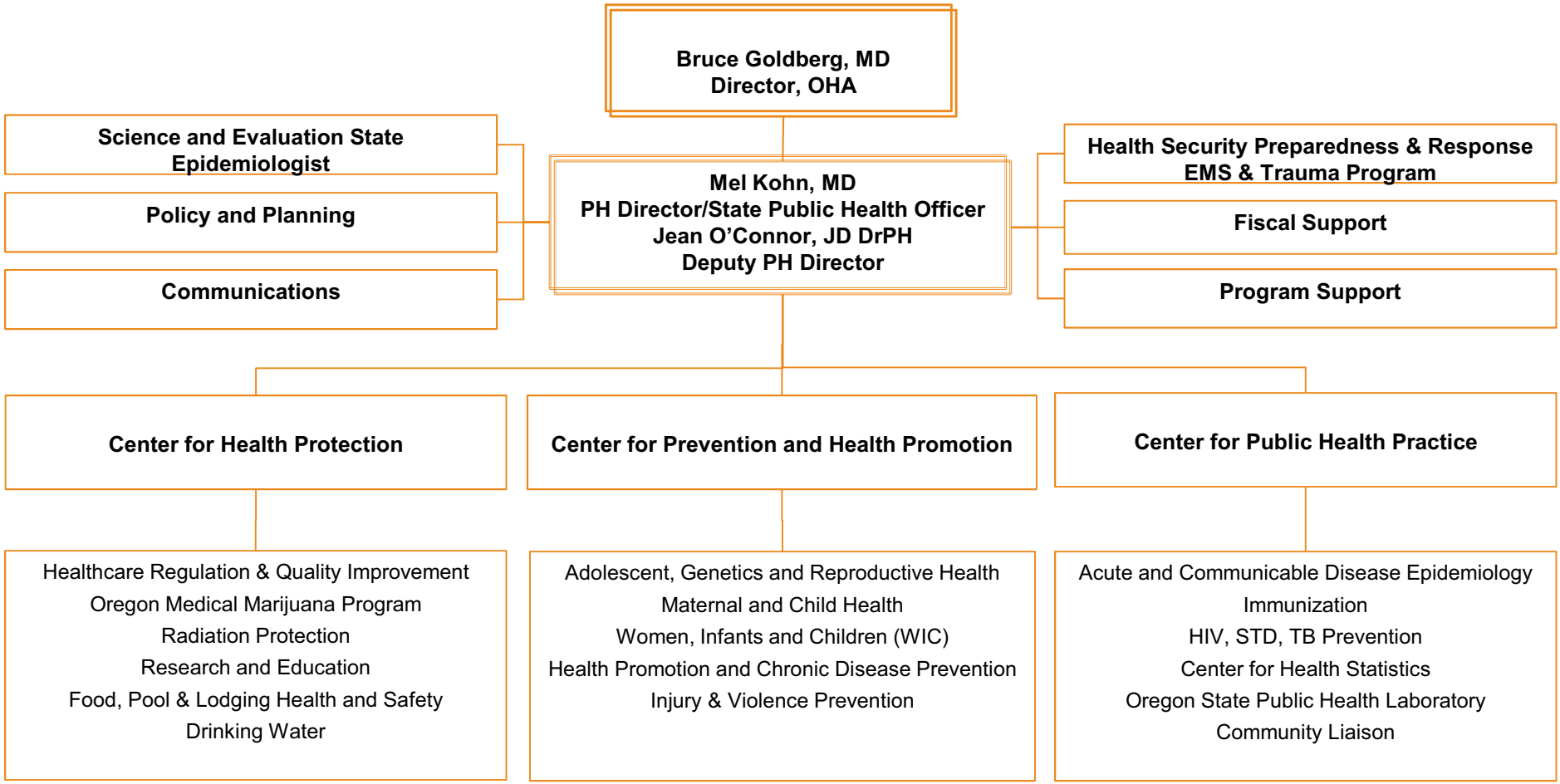
additional SRTFs to the current capacity due to the patients' needs for placement upon discharge.

2. There is an immediate need for additional residential medical facilities to serve those persons who have significant medical needs. Future residential medical facilities will need the appropriate staff possessing the medical skills necessary for treatment of those consumers receiving services. Future development will need to assure that the medical needs of those persons leaving OSH are met, proportionate to the number of those persons moving to community based care.
3. There is a need for development of additional Residential Treatment Facilities (RTFs)/Residential Treatment Homes (RTHs) in proximity to the current SRTFs to assist in moving people to a lower level of care. Currently there are areas in the state where these facilities do not exist.
4. There is a need for current facilities and community residential providers to provide specific and specialized treatment (e.g. sex offender treatment) in facilities that currently treat other mental health needs. This will allow current providers to meet the needs of those being discharged while simultaneously meeting the community demand for services.
5. There is an immediate need for dedicated "crisis respite" facilities as part of the continuum of care located regionally at a minimum and preferably by county in those counties serving the greatest numbers on conditional release. This would allow the PSRB to use these facilities to avoid revocation, thereby maintaining people in the community with the necessary services and supports.
6. There is a need for additional Intensive Case Management and Assertive Community Treatment and the associated community supports and housing.

Next Steps:

AMH will use these recommendations in future budget planning and will develop strategies to implement the recommendations identified by the workgroup.

2013-15 PH Organization Structure



707 Positions / 688.21 FTE

Oregon Health Authority

Public Health

The Oregon Health Authority (OHA) is working to: 1) improve the lifelong health of all Oregonians; 2) increase the quality, reliability and availability of care for all Oregonians; and 3) lower or contain the cost of care so it is affordable to everyone. OHA includes most of the state's health and health care programs, including OHA Public Health, Addictions and Mental Health, Oregon State Hospital, the Oregon Health Plan, employee benefits and public-private partnerships.

The OHA Public Health (PH) supports the agency's goals and transformation of the health care and education systems by promoting population-based prevention initiatives which improve the health of all Oregonians, reduce the demand for costly health care services, and improve educational outcomes.

New and old risks are a constant threat to the public's health, including SARS, West Nile virus, pandemic flu, whooping cough, tuberculosis and E. coli. These risks increase the need for disease surveillance, public education and preparedness. There is also growing concern over the effects of global climate change on the public's health. An altered climate could bring severe storms, drought and changes in patterns of disease — all of which pose challenges for public health. Strong public health preparedness, immunization and disease control systems are in place to control and respond to these threats. However, the greatest health challenges facing Oregonians today are not rare illnesses or natural disasters.

The greatest risk to the health of Oregonians today is the increasing impact of chronic disease and injuries. Tobacco, obesity, and heart disease/stroke are the three leading causes of death in Oregon. Oregon has made significant progress in controlling tobacco and promoting healthy environments. However, more than 80 cents on every health care dollar is still spent on treating chronic diseases. More than 7,000 Oregonians die each year as the result of tobacco. Each biennium, tobacco costs Oregon $4.8 billion, including $748 million to the Oregon Health Plan.

Injury is the number one leading cause of death for children and young adults. Many visits in the Oregon trauma system each year could be prevented through policy and systems changes. Suicide, is the 8th leading cause of death overall.

Public health programs reduce costs by promoting healthy options, creating safe and healthy communities, and preventing the need for acute medical care. Oregon's family planning program, for example, saved more than $28 million in state dollars and $81 million federal Medicaid dollars in 2011 by avoiding unintended births.

In addition, public health programs improve educational outcomes. Optimal health, beginning in early childhood and continuing throughout the lifespan, is critical for Oregonians' educational success in kindergarten and beyond. Public health is essential to meeting Oregon's 40/40/20 goal to improve the number of adults who graduate from high school and complete post-secondary education.

History

The OHA Public Health was founded in 1903 when infectious disease outbreaks — smallpox, bubonic plague and tuberculosis — prompted the Legislature to create a State Board of Health, a public health laboratory, a vital statistics registry and county boards of health. Since then, Public Health has provided leadership and support to the state as it has faced a wide range of health challenges: the growing refugee populations in the 1970s; the AIDS epidemic of the 1980s; radiation exposure from Chernobyl in the Soviet Union; the nation's first bioterrorist event, with the salmonella-contaminated salad bar in The Dalles; the terrorist attacks of October 2001; the 2009-10 H1N1 pandemic; and the Japanese earthquake and nuclear power plant disaster in 2011.

Recognizing these new challenges to the public's health in Oregon and the time of tremendous opportunity associated with the transformation of the health care system and the state's educational goals, Recently OHA Public Health reorganized, carried out a statewide health assessment, and completed a strategic planning process. This will enable Public Health to ensure prevention is incorporated into a new sustainable and transformed model for the state's health care delivery. In the coming biennium, Public Health will also continue to transform itself and the public health system by seeking national public health accreditation. Accreditation is part of becoming a model of excellence and allows our communities to know that they are receiving high quality and equitable services.

Vision, Mission and Values

The vision of the OHA Public Health is lifelong health for all people in Oregon. The mission is to promote health and prevent the leading causes of death, disease and injury in Oregon.

Oregon needs a strong public health system to achieve better health outcomes at lower costs and to transform health care delivery. Public Health works with the public health system and an extensive network of partners to uphold the values of service excellence, leadership, integrity, health equity and partnership.

Strategic Challenges and Opportunities

The challenges before public health in Oregon, as in states across much of the country, are profound. These include shifting demographics and causes of disease, the rising burden of chronic diseases, funding challenges, and changes in the health care system. Never before has Oregon faced such significant risks to its budget for health and at the same time had such profound opportunities to improve health and lower costs through the prevention of the leading causes of death, disease, and injury in the state.

Goals and Priorities

In order to move toward the vision of lifelong health for all people in Oregon over the next five years, the OHA Public Health has established two goals. The first goal is focused on the health of the public. The second goal is focused on improving the public health system, which includes local public health authorities, health care providers, and new emerging partners. Achieving either goal would be a tremendous success for Oregon. Achieving both goals together will create a self-sustaining cycle of improvement in the health of the people of Oregon.

1. Making Oregon one of the healthiest states in the nation

According to America's Health Rankings, Oregon ranked among the top one-third of states overall in 2011 for health outcomes. The Public Health aim is to make Oregon one of the top 10 healthiest states in the U.S. by 2017. To achieve this goal, Oregon must address the leading causes of premature death in the state: tobacco use, obesity and overweight, and heart disease and stroke. Oregon must also reduce suicide, which kills as many people as car crashes in Oregon. And, Oregon must reduce family violence (child and intimate partner abuse), which along with causing immediate injury and psychological harm, is associated with the development of many chronic diseases later in life. Increasing Oregon communities' resilience to emergencies of all kinds also will help to make Oregon

one of the healthiest states. Oregon must also increase vaccination rates and reduce prescription drug misuse and abuse.

2. Making Oregon's public health system into a national model of excellence
To fully achieve its vision of lifelong health for all people, Oregon's public health system must transform itself into a national model of excellence. A system that is a model of excellence will work with emerging health care partners, such as Coordinated Care Organizations (CCO), in new ways; ensure health in all policies; partner with the private sector and other agencies to perform health impact assessments; and maintain disease investigation and data collection capabilities that ensure an accurate picture of the health of the public in Oregon. Public health accreditation, which recognizes health departments that perform all of the core functions, is one mechanism Oregon will use to ensure the system conforms to national standards. Sustaining health protection programs, such as the health care facility licensure and drinking water protection programs, is also a key priority.

In recognition that population health is largely determined by social factors, such as the built environment (roadways, buildings, parks), education, and safe and affordable housing, Public Health also will strengthen collaboration with partners in transportation, education, housing and other sectors.

State and Local Public Health Working Together
Oregon's public health system works every day to prevent disease and injury and promote and protect health. This work is carried out through a collaborative system of federal, state and local agencies, private organizations and communities and diverse partners working together to protect and promote the health of Oregonians. The Oregon public health system is comprised of state, local and tribal public health departments and public and private partnerships. The public health system serves three main functions: 1) assessment of the public's health in Oregon through data collection and investigations of disease; 2) the development of policies and programs that support improved health outcomes; and 3) the assurance that those policy and programs are achieving the intended purpose.

Oregon's public health system comprises federal, state and local agencies, private organizations and other diverse partners working together to protect and promote the health of Oregonians. As the state component of the system, the OHA Public Health plays a unique leadership role in ensuring the health of all Oregonians. Public Health operates some programs directly. Other programs are delivered in collaboration with the 34 local health departments, which have the statutory

authority to protect the public's health in their counties. Local health departments play an important role in the delivery of many public health services, with the state providing technical support and oversight.

Investing in Better Health Outcomes

By supporting education and health system transformation priorities, and focusing on opportunities to reduce the demand for health care, this budget proposes to continue the state's investment in better health outcomes. Public health and prevention have been valuable tools in Oregon for saving health care costs, improving educational outcomes, and ensuring a ready workforce for private sector investment. Efforts to prevent illness and promote healthy living can greatly reduce the burden and cost of disease. Sustaining investments through challenging budget times and making prevention a priority moves Oregon in the right direction.

GOVERNOR'S BALANCED BUDGET

The Governor's Balanced Budget includes funding to support the 2013 – 15 current service level for public health services.

PUBLIC HEALTH ORGANIZATIONAL STRUCTURE

On July 1, 2012 Public Health announced a new structure made up of three Centers overseen by an Office of the State Public Health Director. The Office of the State Public Health Director provides public health policy and direction to the public health programs within the state level programs, and ensures that the disparate programs within and outside the state Public Health create an effective and coherent public health system for the state. The Center for Health Protection provides a consistent, strong approach to protecting health. Programs in this center touch every hospital, drinking water system, and restaurant in Oregon. The Center for Prevention and Health Promotion houses community-oriented prevention and clinical prevention services, working with community partners, health care providers, and Coordinated Care Organizations. The Center for Public Health Practice houses programs that work with local public health authorities, particularly related to communicable disease control.

Two broad and long-standing areas of public health practice — maternal and child health and environmental health — are woven throughout this structure. This

structure enables Public Health to achieve its vision, mission and goals while supporting the broader efforts of health care transformation and creates a structure that can support emerging areas of importance, such as human exposures to toxins. The structure reduces duplication and focuses the development of our work with communities around evidence-based interventions and consistent administrative practices.

OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR (OSPHD)

Key programs

The Office of the State Public Health Director (OSPHD) provides leadership on public health approaches to achieving lifelong health for all Oregonians, serves as a resource on public health policy issues in the State, and manages the public health programs within the state structure. It provides leadership on prevention activities in support health system transformation and education policy priorities, and ensures that state public health achieves excellence in its scientific and epidemiology functions. This office seeks to ensure that the disparate programs within and outside Public Health create an effective and coherent public health system for the state. This includes extensive interactions with a range of federal, state and local and in some cases, international, agencies and organizations. These entities include Transportation, Education, Emergency Management, Agriculture, and Forestry.

Policy, planning, performance management, and operations staff are responsible for responding to requests for public information; leading activities related to health systems transformation; providing leadership on state-wide issues, including supporting the application for national accreditation; developing and implementing Public Health's strategic plan, state level community health assessment, and state health improvement plan efforts; contracting with the local health departments; administrative rulemaking; legislative support and coordination; risk management and safety; information, video and Web technology; volunteer coordination; and business continuity planning. The Public Health Advisory Board is coordinated by this office and provides advice and consultation to Public Health.

Health Security, Preparedness and Response Program (HSPR), which ensures that every community and hospital is prepared for health and medical emergencies, is part of this office. The program develops and tests preparedness plans, provides training and technical assistance, and supports collaboration of emergency

response systems across communities and adjacent states. Staff work closely with Oregon Emergency Management. The adjoining Emergency Medical Services and Trauma Systems (EMS/TS) program provides regulatory oversight for emergency medical service providers and emergency medical service agencies throughout Oregon. Together, these programs support Oregon communities in detecting and responding to health emergencies.

Major funding sources for this office include:

Federal funds

Centers for Disease Control and Prevention:

- Public Health Emergency Preparedness Cooperative Agreement;
- Strengthening Public Health Infrastructure for Improved Health Outcomes Grant;

Department of Health and Human Services Hospital Preparedness Grant
Health Resources and Services Emergency Medical Services for Children Grant

Fees and other funds

Oregon Medical Marijuana Program fees are transferred from the Center for Health Protection to support the trauma components (i.e., hospital designation and trauma registry) of the Emergency Medical Services and Trauma program.

State funds

General funds are used to meet match requirements on federal grants.

Health Security, Preparedness and Response (HSPR)

Services provided

The Health Security, Preparedness and Response program (HSPR) has two primary roles. The program's first role is to develop emergency-ready state and local public health programs. The program carries out assessments, implements and evaluates state and local public health capabilities to respond to emergencies arising from the 15 national planning scenarios, including natural disasters, pandemic influenza, chemical releases, terrorism and other public health emergencies. These activities include interaction with federal, state, local and tribal governments, the private sector, and non-governmental organizations. The program also works with hospitals and health care systems to assist them in preparing for and responding to emergencies in their communities.

Emergency Medical Services and Trauma Systems (EMS/TS)

Services provided

The EMS/TS program supports and regulates systems that provide emergency care to victims of sudden illness or traumatic injury and encourages improvements in the emergency care of pediatric patients. The program oversees EMS provider training, licensing and continuing education; inspects and licenses ambulances and ambulance services; evaluates emergency response systems; and collaborates with Area Trauma Advisory Boards and State Trauma Advisory Boards to ensure trauma system standards are followed.

Policy and Planning and Performance Management Programs

Services provided

Public Health's policy, planning and performance management activities support statewide planning and public health systems functions. These include the application for national public health accreditation that was submitted in fall 2012, and the implementation of accreditation application pre-requisites, which include an agency strategic plan, community health assessment and state health improvement plan.

These activities also support quality improvement activities at the state and local health department levels, as well as exploring ways that Public Health can better engage with non-traditional and emerging partners. Funds in these program areas also support community health assessment, planning, and accreditation readiness projects in local health departments. These agencies are focused on completing their pre-requisites for national accreditation, as well as conducting quality improvement activities.

CENTER FOR PREVENTION AND HEALTH PROMOTION (Prevention/Promotion)

The Center for Prevention and Health Promotion (Prevention/Promotion) works to prevent disease and promote health by creating environments, policies, and systems that support wellness for everyone, such as access to healthy food, physical activity, and safe, tobacco-free environments. Prevention/Promotion coordinates program areas which support health throughout the lifespan, including pregnancy, early childhood, adolescence, and adulthood.

To make Oregon one of the healthiest states in the nation, Prevention/Promotion provides key leadership on nearly all of the priority areas identified in the Public Health's Strategic Plan, particularly:

- Preventing tobacco use
- Decreasing obesity/overweight
- Preventing or reducing heart disease and stroke, and increasing survivability
- Reducing suicide
- Preventing family violence
- Supporting the Coordinated Care Organizations
- Ensuring health in all policies
- Demonstrating excellence in epidemiology and surveillance

Prevention/Promotion addresses these priorities through both community-oriented and clinical prevention programs, systems, policies, and services. Using this approach, Prevention/Promotion supports the State of Oregon's priorities related to health system transformation and education system redesign.

Prevention/Promotion and Health System Transformation

Prevention/Promotion leads PH's collaboration with Coordinated Care Organizations (CCOs) and supports health system transformation through prevention, health assessment and health equity initiatives. Prevention/Promotion's evidence-based community prevention programs keep people healthy and reduce the need for health care. These programs include tobacco prevention, worksite wellness, policy development coalitions, and home visits to asthma patients and pregnant women. Prevention/Promotion works with CCOs and local partners to connect people to these programs and to ensure that CCOs have proven prevention models, guidelines and appropriate standardization of services.
Prevention/Promotion also routinely measures, monitors and provides formal

health assessments of communities and the state. Prevention/Promotion helps CCOs measure their progress toward achieving better health at lower costs. In addition, Prevention/Promotion, and Public Health in general, has expertise in engaging diverse groups in the community. Prevention/Promotion is helping to guide CCOs in addressing health disparities and improving health equity.

Prevention/Promotion and Education System Redesign

Prevention/Promotion administers early childhood, adolescent health, and school wellness programs which support Oregon's education goals. Early childhood interventions, including home visiting, Women, Infants and Children (WIC) programs, and oral health programs, have been shown to improve child health and contribute to kindergarten readiness. As children progress through primary and secondary school, health is associated with regular attendance, academic achievement and increased likelihood of high school graduation. Adolescent health and healthy school environments are promoted by Coordinated School Health programs, school employee wellness initiatives, and School-Based Health Centers.

Major funding sources for Prevention/Promotion include:

Federal funds:

Department of Agriculture:

- Nutrition and Health Screening for Women, Infants and Children (WIC)
- WIC and Senior Farmers Market Nutrition Programs

Department of Health and Human Services (DHHS):

- DHHS Office of Population Affairs:
  - Family Planning Title X
- DHHS Maternal and Child Health Bureau:
  - Title V Maternal and Child Health Block Grant
  - Maternal and Infant Home Visiting
- DHHS Administration on Children, Youth and Families:
  - Personal Responsibility Education Program Grant (Adolescent Pregnancy Prevention)
- DHHS Center for Disease Control and Prevention (CDC):
  - Division of Cancer Prevention and Control
  - Breast and Cervical Cancer Program
  - Diabetes, heart disease, stroke, asthma, tobacco prevention, arthritis risk reduction and management
  - Injury prevention and surveillance

    - Oregon Violent Death Reporting System
    - Rape Prevention and Education Program
- DHHS Center for Medicaid and Medicare Services:
    - Oregon Contraceptive Care (family planning Medicaid waiver)
    - Medicaid administrative match in oral health

State Funds:

- State General Fund match requirement for Oregon Contraceptive Care
- State General Fund and provider tax School-Based Health Center program
- State General Fund match requirement for WIC and Senior Farmers Market Nutrition Programs

Other funds:

- Suicide prevention
- Prescription drug monitoring
- Tobacco Use Reduction Account (Ballot Measure 44)
- WIC infant formula manufacturer rebate

Prevention/Promotion Programs and Initiatives Focused on Policy, Systems and Environmental Change

Prevention/Promotion promotes policies and practices that foster healthy behaviors in a variety of settings, including worksites, health care systems, schools, childcare settings, and communities. Together, these efforts support PH's priorities, promote optimal health for CCO members during time spent outside of care, and foster environments where children learn better both inside and outside of school.

Tobacco Prevention and Education and Healthy Communities Programs
Services provided

The Tobacco Prevention and Education Program (TPEP) and Healthy Communities programs serve as models for how Prevention/Promotion works with local public health authorities, federally recognized tribes, community-based organizations and community leaders to create healthy communities statewide. Programs conduct community health assessments and implement plans to decrease tobacco use and secondhand smoke exposure; increase physical activity and healthy eating; promote low-cost, preventive health care services, such as cancer screenings; and encourage participation in community wellness and prevention programs.

Using this approach, Prevention/Promotion helps support optimal health for all Oregonians where they live, learn, work, and play, including:

- Worksites, through the promotion of policies that support tobacco-free environments; healthy food choices at meetings and events and in cafeterias and vending machines; flexible scheduling and worksite shower facilities to encourage employees to incorporate physical activity into their day; access to private rooms and refrigerators for breastfeeding mothers; health benefits for tobacco cessation, obesity prevention, and disease self-management
- Health care systems, through expansion of tobacco-free health care campuses; nutrition standards for food served to patients and visitors; policies that encourage the initiation and continuation of breastfeeding by patients and staff; and promotion of low-cost preventive health care services such as breast, cervical, and colorectal cancer screening
- Schools and childcare settings, through expanded tobacco-free college campuses; nutrition standards for schools; policies to reduce time in front of a TV or video screen each day; and ensuring that schools meet physical activity standards
- Communities, through expanded tobacco-free public places; promotion of ready access to parks, trails, and sidewalks to encourage recreation and active transportation through walking and cycling; and community-wide social marketing campaigns to encourage healthy behaviors

Performance measures

KPM 27: Tobacco use

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. Use of tobacco during pregnancy is associated with serious, and 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 to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality, contributing substantially to OHA's goal "People are healthy" in both the short-term and long-term.

Among Oregon adults, the prevalence of smoking was 16.4% in 2010. The prevalence of smoking among 8th grade adolescents was 6.6% in 2011. Among pregnant women, the prevalence of smoking was 11.3% in 2010. The designated target was reached for youth, but not for adults or pregnant women.

KPM 28: Cigarette packs sold
Reductions in the number of cigarette packs sold per capita results from two distinct phenomena — a decrease in the number of current smokers and a decrease in the quantity of cigarettes smoked among continuing smokers.

Prior to the program's creation in 1997, Oregon had higher per capita sales of cigarette packs than the rest of the country. In fiscal year 2011, 46.5 packs of cigarette packs were sold for every Oregon resident, slightly higher than the nation's 46.1. This measure was above target for 2011, and represents an increase from fiscal year 2010. Cigarette tax receipts from the Oregon Department of Revenue indicate that this coincided with Washington's cigarette excise tax increase from $2.025 to $3.025 on May 1, 2010 (Oregon's tax has been $1.18 since 2004). The interstate differential appears large enough to have compelled some Washington smokers to purchase cigarettes in Oregon during fiscal year 2011. It is likely that Oregon's prior downward trend will resume in fiscal year 2012.

KPM 32: Overweight and Obese Prevalence
The prevalence of overweight and obesity is an urgent public health issue in the U.S. and in Oregon. It is critical to monitor trends so the scope and growth of the epidemic is understood. 21.4% of Oregon youth were overweight or obese in 2011, and 60.2% of Oregon adults were overweight or obese in 2009.

Prevention/Promotion Programs Focused on Pregnancy and Early Childhood

Services provided

Public Health Nurse Home Visiting is a core program within Oregon's home visiting system that provides case management, consultations, health and development assessments, and education to at-risk and high-risk families with health problems and other concerns. Home visiting is one of the most commonly used and effective approaches in serving families with pregnant women, newborns and young children. Rigorous longitudinal studies demonstrate the long-term outcomes of evidence-based home visiting programs. Compared to high-risk children who do not receive nurse home-visiting services, children served are healthier because they more likely receive regular well-child visits, immunizations,

developmental screening, nutrition assessments, and breastfeeding support for mothers. Nurse home visiting also has been linked to improved school readiness and performance, including improvements in cognitive and language development and higher scores on achievement test scores in reading and math.

Prevention/Promotion, in collaboration with state and local partners, is leading efforts to develop an integrated home visiting approach in Oregon. Oregon has several home visiting models with varying costs and levels of effectiveness. For example, the Nurse Family Partnership program is estimated to cost $9,600 per participant and result in long-term benefits of almost $23,000 per participant (Washington State Institute for Public Policy). Existing programs lack the capacity to meet the need for services; the potential unmet need may be as much or more than twice the number currently being served.

The Women, Infants and Children (WIC) program, a public health nutrition program designed to improve the health of low-income pregnant women and children, supports early learning by promoting children's healthy brain development and strengthening overall child and family health. WIC provides leadership in development of health and nutrition policies; promotes the use of quality nutrition standards in the community; and ensures healthy WIC-approved foods are available in local grocery stores. In addition, the program collects and analyzes health and nutrition status data of pregnant women, infants and young children and supports state and local breastfeeding and nutrition coalitions.

In local communities, WIC clinics provide individual assessment of growth, and health, along with education and counseling on nutrition and physical activity, including promotion of a healthy lifestyle and prevention of chronic diseases such as obesity. Local programs also provide breastfeeding education and support and referrals to other preventive health services and social services, including OHP.

Performance measures:

KPM 26 (2011-13): Prenatal care for women in the first trimester
Early prenatal care (in the first fourth months of pregnancy) is an important strategy for preventing early childhood disease and conditions and promoting healthy growth and development. Low-income infants are at higher risk for poor health outcomes. The indicator of early prenatal care reflects how well the health and social systems perform in reaching low-income pregnant women to promote healthy babies. Currently, 79.9 percent of low-income women in Oregon receive early prenatal care. The goal is that 88.7 percent of women get this care.

Barriers to receiving care include reductions in Oregon Health Plan (OHP) eligibility; lack of presumptive eligibility for Medicaid in Oregon; not knowing pregnancy is an OHP qualifying condition; lengthy Medicaid applications; and required asset testing of pregnant women to process OHP applications.

When low-income women who are not already covered by Medicaid become pregnant, they must apply for OHP after they find out that they are pregnant. It is likely 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. Presumptive eligibility would allow pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed. The Prenatal Care Expansion Program provides OHP Plus coverage for prenatal services in 14 participating counties as of July 2011 to pregnant women who would otherwise be eligible for OHP except for their immigration status. These are women who would qualify for CAWEM coverage. While we do not know exactly the extent of this population, the Hispanic population is the largest community with potential immigration status barriers. The number of Hispanic births in Oregon has stayed relatively constant over the past five years (19.9% in 2005 to 20.2% in 2010).

The Oregon Mother's Care (OMC) program collaborates with the Medical Assistance Programs (MAP), that administers the Oregon Health Plan (OHP), to assist pregnant women in entering early prenatal care. OMC has expanded from five sites serving fewer than 1,000 low-income women in 2000 to 29 sites that served 4,817 women in 2010 with 17,942 referrals to prenatal care and other services. Prevention/Promotion also supports SafeNet, the toll-free hotline for referrals to local prenatal services. In addition, MAP expedites applications for OHP from pregnant women.

Oregon leads the nation in the number of mothers who begin breastfeeding and continue to nurse at six months and beyond. Oregon also enjoys the smallest disparity between WIC mothers and non-WIC mothers in relation to breastfeeding. Nationally, the difference in breastfeeding initiation is about 20 percent, while in Oregon it is less than 10 percent. Breastfeeding is associated with a reduced risk of many negative health conditions for both mother and infant (including ear infections, diabetes and breast cancer).

Prevention/Promotion Programs Focused on School-Aged Children, Adolescents, and Young Adults

Prevention/Promotion Programs focused on adolescent health include the School-Based Health Center (SBHC) program, Healthy Kids Learn Better program, youth sexual health, and suicide prevention.

Services provided

Dental disease is the most common chronic condition among children. Preventing decay during this period significantly increases the likelihood that an individual can remain caries-free and avoid dental disease throughout adulthood. Poorer oral health status is associated with dental pain, missed school and lower school performance among children.

Prevention/Promotion programs support Oregon's education goals by working to increase access to fluoridated water. Oregon ranks 48th in the nation for having a low percentage (22.6%) of people who receive fluoridated water (Centers for Disease Control and Prevention, 2010). Fluoridation produces a median decrease in caries of 29.1% to 50.7% among children ages 4 to 17 years (Community Preventive Services Task Force).

In addition, three key programs target children from birth into elementary school. Project "First Tooth" is an early childhood cavity prevention program that trains pediatric medical providers to conduct oral health risk assessments, provide education, and apply fluoride varnish during well child visits for children under age 4. The school-based dental sealant program serves first and second graders, preventing decay in the first permanent (adult) molars where about 85 percent of decay normally occurs. School-based fluoride tablet and rinse program is administered to K-6 grades in elementary schools with 30 percent or more of the students eligible for the Federal Free and Reduced Lunch Program.

The School-Based Health Center (SBHC) program provides access to over 52,000 youth, through a system of 63 certified SBHCs in 21 counties, to a comprehensive set of developmentally and age-appropriate preventive health, primary care and mental health services. The Healthy Kids Learn Better Program works on policies that support the integration of health and education to reduce chronic absenteeism and improve high school graduation rates. In the area of Youth Sexual Health, four Local Public Health Authorities are funded to implement ¡Cuídate!, an evidence-based program for Latino youth, in an effort to reduce disparities in Hispanic birth rates among youth.

Reducing suicide and family violence are two of Public Health's priority areas for the 2013-15 biennium. Suicide prevention key activities planned include:

- increasing prevention through Nurse-Family Partnerships and evidence-based parenting programs
- increasing classroom programs in elementary and middle schools
- partnering with schools to implement a coordinated and comprehensive school health approach that supports the social, emotional and behavioral health of students in school improvement planning documents
- promote and strengthen use of positive youth development and youth engagement policies and practices
- develop a suicide prevention plan that spans all ages.

Performance measures:

Because preventive and early intervention services relate to so many other health indicators for school-aged youth, performance measures from a wide variety of agencies are relevant, including teen pregnancy, teen suicide, tobacco use, preventive services for children, safety net clinic use, child mental health services and 8th grade use of alcohol or other drugs.

KPM 28 (2011-2013): Teen pregnancy

Teen pregnancy is closely linked to a number of other critical issues, including poverty, income disparity, high school graduation, and overall child and family well-being. In Oregon, the estimated annual cost associated with teen pregnancy (ages 15-19) is $110 million (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011). Reducing teen pregnancy would reduce the risk of negative social, education, and health outcomes and lead to cost savings. The most recent data indicates a trend downward which meets or exceeds both the state target and the Healthy People 2020 goals.

KPM 23: Teen suicide

The Prevention/Promotion strategy is to encourage local organizations and agencies to integrate best practices and evidence-based practices in suicide prevention into existing infrastructure in schools, non-profit organizations and agencies. Projects include public health surveillance, evaluating projects, and disseminating results broadly. The projects also include development of interventions that will reduce risk factors and increase protective factors identified by data in individuals, families, communities and on the societal level. Reducing suicides among youth will require implementation of multiple strategies over time.

Oregon's youth suicide rate (ages 10-24) ranks 34th among states. The state rate of 7.20 per 100,000 (2010 most recent national comparison data) is about same as the national rate of 7.57 per 100,000.

Prevention/Promotion Programs Focused on Adults and Seniors
Key Prevention/Promotion programs targeting adults and seniors include: Chronic Disease Self-Management programs, older adult falls prevention, Breast and Cervical Cancer Screening, and reproductive health.

Services provided
Chronic disease self-management programs support Oregonians living with chronic conditions in achieving optimal health and quality of life. Public Health supports self-management programs that have been shown to improve quality of life, health outcomes, and reduce health care costs. Living Well with Chronic Conditions and Tomando Control de su Salud, the Spanish culturally competent version of Living Well, are the flagship programs of Oregon's self-management offerings. Public Health is currently expanding the portfolio of programs it supports to include Walk with Ease and the Diabetes Prevention Program. Living Well can result in gains in quality-adjusted life years, reduced emergency department visits, and reduced hospital days. The Diabetes Prevention Program has been shown to significantly reduce the risk of someone with pre-diabetes developing Type 2 diabetes. Between 2006 and 2011, almost 8,000 Oregonians participated in one of Oregon's chronic-disease self-management programs. In addition to broadening the types and reach of programs, Public Health is in the early stages of implementing a business plan for chronic disease self-management programs that will ensure the continued availability of these programs to Oregonians into the future.

Falls are a leading cause of injury death and disability among adults aged 65+. In the U.S., the cost of fatal fall injuries for those 65 and older totaled $28.2 billion in 2010. In Oregon, falls are the leading cause of hip fractures and traumatic brain injuries in seniors, and nearly 60% of seniors hospitalized for falls are discharged into long-term care. The Injury & Violence Prevention Program is one of three states awarded a 5-year grant from CDC to prevent falls and fall injuries. Oregon is assisting health systems to integrate clinical practice with evidence-based falls prevention programs. Goals include: educating clinicians on screening, assessments, and referrals through a CDC toolkit to three evidence-based programs; establishing community and home-based programs; and increasing public awareness of falls as a preventable public health problem.

Currently, the Injury and Violence Prevention Program is assisting five health systems to plan and implement falls prevention into outpatient care tailored to sustainable business models; several health plans are providing falls prevention activities as part of member benefits.

The Breast and Cervical Cancer Program provides clinical breast examinations, mammograms, Pap tests, diagnostic testing after an abnormal screening result, surgical consultations, and referrals to treatment. Clients also are provided screening for heart disease, stroke, tobacco use, obesity and diabetes through the WISEWOMAN (Well-Integrated Screening and Evaluation of Woman Across the Nation) program.

The Reproductive Health program provides a range of health services, counseling, and education to help Oregonians plan the timing and spacing of their children. Client services are supported by Oregon Contraceptive Care (CCare) and the federal Title X family planning program, which expand access to a broad range of family planning and related preventive health services for low-income and uninsured Oregonians.

Performance Measures

KPM 25: Percentage of births where mothers report that the pregnancy was intended.
The most recent data (2010) may indicate a slight increase in the % of births that were intended and is meeting the state target. National Healthy People 2020 goals measure % intended pregnancy rather than % intended births. Oregon's 2010 intended *pregnancy* rate is lower than the Healthy People 2020 goal. The Alan Guttmacher Institute ranks Oregon ninth in the nation for its efforts to help women avoid unintended pregnancy.

Key Registry Data Systems

Prevention/Promotion maintains a number of data systems that track key data on the health status of people in Oregon across their lifespan. These data systems draw from medical records, survey data, and program service delivery records. These systems are essential to health system transformation and the state's educational goals. They contain data that supports the metrics and accountability framework of the CCOs and data regarding the health status of children in our schools, and these data are essential to understanding barriers to good health and educational outcomes and tracking Oregon's progress. Some of these systems are registry data systems, which come with unique challenges and opportunities.

Services Provided

Three key registry data systems for Prevention/Promotion in 13-15 are the Prescription Drug Monitoring Program, the Oregon Violent Death Reporting System, and the Oregon Trauma Registry, all of which are administered by the Injury and Violence Prevention Program (IVP).

The Prescription Drug Monitoring Program (PDMP) is an electronic Web-based data system that collects information on all Schedule II – IV controlled substances dispensed by Oregon-licensed retail pharmacies. Medical providers and pharmacists can use the prescription history information to improve patient care and prevent some of the problems associated with controlled substances. After the first year of operation, 95 percent of pharmacies are reporting weekly as required by law. More than 5,200 providers and pharmacists are enrolled system users. The Injury and Violence Prevention (IVP) section of Prevention/Promotion is using aggregated de-identified data from the Prescription Drug Monitoring Program to target high rate prescribers for enrollment efforts; provide lists of high rate prescribers to local health officials for use in educational and outreach efforts aimed at improving patient care; and measure program performance on operational metrics and program objectives.

The Oregon Violent Death Reporting System (OVDRS) works with more than 250 law enforcement agencies and medical examiners that voluntarily report every case of violent death including suicides, homicides, undetermined deaths, unintentional firearm shootings, and legal interventions. The system collects incident-based case information on about 850 cases each year. The data are analyzed and made available in a variety of formats for policy makers, the public, academics, the media, and for prevention practice. Oregon is one of 18 states with this type of system, and the information about the circumstances surrounding violent deaths have led to the identification of increased suicide rates among veterans, the development of an older adult suicide plan, and assisted in the development of an Intimate Partner Fatality Review Team.

The program also oversees the Oregon Trauma Registry, which monitors and provides information necessary to evaluate trauma patient outcomes and assesses compliance of pre-hospital care providers and hospitals with state standards. The program is working with hospital stakeholders to develop metrics for trauma care in emergency departments and hospitals in this biennium.

CENTER FOR HEALTH PROTECTION (Protection)

Key programs

The Center for Public Health Protection (Protection) protects the health of individuals and communities through establishing, applying and ensuring reliable compliance with regulatory and health-based standards. The diverse programs work closely with other federal, state and local agencies, regulated entities and active stakeholder groups. The work emphasizes continuous process improvement, technical assistance, scientific assessment, ongoing monitoring and risk communication to protect the health of all people in Oregon. Enabling and promoting innovation, where that innovation can be demonstrated to be in support of good health outcomes, is a key aspect of Protection's approach to its regulatory functions.

Protection houses programs that lead the state's effort to protect Oregonians from environmental health hazards in areas as diverse as drinking water, radiation, recreational waters, lead, food, occupational safety, indoor and outdoor air quality, consumer products, clandestine drug labs, and toxic chemical releases. These programs partner with local health departments, private businesses, state agencies, community groups, academic institutions, scientific and medical experts, and others to provide technical assistance, case management, public information, scientific expertise and regulatory oversight.

- The Drinking Water Services section works to ensure safe drinking water by reducing the risk of waterborne disease and exposure to chemical contaminants in Oregon's 3,600 public drinking water systems.
- The Radiation Protection Services section protects both workers and the public from unnecessary and unhealthy radiation exposure, and provides Oregon's sole public resource for radiation-related incidents, whether accidental or intentional.
- The Food, Pool and Lodging Health and Safety section is home to Oregon's food-borne illness protection program and provides leadership for local health departments to ensure safety in Oregon's 23,000 full service and temporary restaurants, 3,400 public pools and 2,300 tourist accommodations.
- The Research and Education Services section prevents or minimizes human health effects from hazardous working conditions, injuries and exposure to hazardous waste and other environmental dangers.

Protection also promotes access to high-quality, health care by collaborating with a variety of public and private partners on policy development and program implementation. Through its regulatory activities, Protection ensures that hospitals, other health care facilities and agencies, and hospital trauma systems meet established standards.

- The Health Care Regulatory & Quality Improvement Section facilitates patient safety efforts and quality improvement activities across all provider types in Oregon; regulates acute care facilities, community-based providers, and certain caregivers to ensure safe, high-quality health care; and regulates statewide programs and systems that provide emergency and definitive care to victims of sudden illness or traumatic injury.
- The Oregon Medical Marijuana Program administers a registration system for patients, caregivers and growers eligible to participate in the Oregon Medical Marijuana Program.

Major funding sources for Protection include:

Federal funds

Environmental Protection Agency (EPA):

- Drinking water primacy
- Drinking Water State Revolving Loan Fund
- Beach safety
- Indoor radon outreach and education
- Lead abatement training and certification

Department of Health and Human Services Food and Drug Administration (FDA):

- Mammography facilities inspection
- Grants from DHHS Centers for Medicare and Medicaid Services

Centers for Disease Control and Prevention (CDC):

- Environmental Health Network
- Childhood Lead Poisoning
- Environmental Public Health Tracking
- Adult Blood Lead Epidemiology and Surveillance
- Worker Illness and Injury Prevention
- Hazardous Substances Emergency Event Surveillance
- Environmental Health Assessment

- Harmful Algal Blooms Surveillance
- Health Impact Assessment
- Unregulated Drinking Water Initiative
- Climate Change Initiative
- Brownfields Initiative

Centers for Medicare & Medicaid Services (CMS):

- Medicare

Fees and other funds

Fees for regulatory licensure, certifications and inspections:

- Drinking water operator certification
- Drinking water system plan review
- Cross connection/backflow certification
- Water system inspections
- Radioactive materials licensing
- X-ray equipment licensing
- Tanning devices registration
- Food borne illness prevention
- Public swimming pool and spa licensing
- Tourist accommodation licensing
- Lead based paint certification
- Renovation, repair and painting
- Clandestine drug laboratory
- Medical marijuana cardholder registration

General funds-*None*

Drinking Water Services (DWS)

Services provided

Drinking Water Services (DWS) assures the safety of drinking water provided by all public water systems in Oregon. The program carries out the mission of Protection by reducing the incidence and risk of waterborne disease and exposure of the public to hazardous substances potentially present in drinking water supplies. The program administers and enforces state and federal safe drinking water quality standards; prevents contamination of public drinking water systems by protecting drinking water sources; assures that public water systems meet

standards for design, construction, and operation; inspects public water systems and assures that identified deficiencies are corrected; provides technical assistance to public water suppliers to solve operational problems; provides financial assistance to communities to construct safe drinking water infrastructure; and certifies and trains water system operators.

Performance measures

The Environmental Protection Agency (EPA) has established two national performance measures that the program uses to report on progress: 1) the percentage of population served by community drinking water systems that meet health-based standards continuously during each year, and 2) the percentage of community drinking water systems that meet health-based standards continuously during each year.

Recent performance on the first measure shows that Oregon nearly always meets the EPA-established goal of 91% of community population served safe drinking water each year. This is because most large water systems have the necessary technical, managerial, and financial resources needed to reliably meet safe drinking water standards. Oregon has more difficulty meeting the EPA-established goal for the second measure of 90% of community systems served safe drinking water each year. This is because ninety percent of public water systems in Oregon serve fewer than 500 people, and most instances of unsafe water occur in these smaller water systems. Smaller water systems have more difficulty meeting safe drinking water standards because many lack the technical, financial and managerial resources that larger water systems have. As a result, many of these small systems need considerable regulatory and technical assistance to successfully and reliably meet safe drinking water standards. The program uses these measure results and the specific data underlying the results to focus its available resources on designing and providing services to meet those needs.

Quality and efficiency improvements

Since 1975, the EPA has adopted 18 major safe drinking water regulations, addressing 91 specific drinking water contaminants. A variety of additional EPA regulatory efforts are scheduled over the next five years. In order to improve services, improve results, and meet federal requirements here in Oregon, Drinking Water Services implemented federal drinking water standards beginning in 1986 through an agreement with EPA called Primacy. The program has also worked with local communities since then to improve public water systems and has dramatically reduced the number of community acute waterborne disease

outbreaks that occur. The program has improved access to and use of water supplier drinking water testing data by posting these on a website for water suppliers, the consuming public, and state and local agency partners. The program also improves drinking water safety by training and certifying water system operators, by making loans to communities for safe drinking water construction projects, and by assessing and protecting sources of drinking water to prevent future contamination. Since the beginning of the federal Safe Drinking Water Revolving Fund in 1996, the program in partnership with the Oregon Infrastructure Financing Authority awarded over $260 million to 130 Oregon communities for safe drinking water construction projects, including $28 million in American Recovery and Reinvestment Act Funds. EPA recently recognized Oregon for its outstanding utilization rate of SRF funds.

Radiation Protection Services (RPS)

Services provided

The citizens of Oregon are continuously exposed to natural occurring radiation generated within the environment. Radiation Protective Services (RPS) protects the public from additional radiation exposure. RPS regulates radioactive materials and devices that increase the public's exposure to radiation by developing and enforcing state and federal regulations. RPS assures best practices in the safe handling, use and control of materials and devices, and holds the industry accountable if unnecessary exposure and contamination occurs to the public or radiation workers. RPS prevents excessive radiation exposure to medical patients by ensuring that X-ray devices are delivering the lowest possible radiation dose to generate quality medical imaging.

Subsequent to the terrorist events of September 11, 2001, RPS assures that enhanced security requirements for the industry are in place and that radiation workers are trustworthy in preventing the loss or misuse of radioactive materials, and that storage facilities are secured from unauthorized access.

RPS mitigates and establishes command and control for radiation emergencies stemming from transportation and industry accidents, or intentional exposures designed to threaten public health and livability. RPS provides the State of Oregon with readied emergency response teams utilizing members of the program and collaborating with the U.S. Department of Energy and the Oregon National Guard, to provide emergency response, establish protective action guidance, and assist local public health programs with community recovery after the event has been stabilized.

Performance measures

The Radioactive Material licensing program's performance is measured by the Nuclear Regulatory Commission's Integrated Materials Performance Evaluation Program. This program graded RPS as satisfactory (highest level) for its regulatory practices. RPS now has the challenge to design a regulatory system to better understand emerging technologies. The Nuclear Regulatory Commission's audits are performed every four years to ensure compatibility with federal regulations and security measures that affect public health and safety.

The X-ray machine regulatory program is measured by the reduction of radiation exposure received when medical imaging is necessary for patient diagnosis. During calendar year 2012, RPS inspection staff reduced radiation exposure from devices by 38% by identifying devices delivering excessive radiation dose levels.

A new concern for RPS is the potential link between tanning and the development of skin cancers from increased exposure to sources emitting ultra violet light. RPS needs to develop performance measures to monitor how regulations reduce the number of cancer victims within Oregon. The program follows the Food and Drug Administration regulations for the design and construction of tanning devices.

Quality and efficiency improvements

Facility inspections are usually scheduled with registrants to decrease business impact. Unannounced inspections are performed to ensure compliance with state and federal standards. Enforcement has become more effective because of recent legislation that standardized enforcement authority and penalties for noncompliant licensees and registrants, and gave the agency the authority to impose civil penalties. This enforcement tool has provided for better regulatory standardization and improves oversight of problematic facilities.

Staffing efficiencies are in place by providing cross training to inspectors to regulate both radioactive materials and devices emitting radiation. Projects designed to improve RPS staff efficiencies through web based services have been initiated for electronic field reporting and licensing, and online registration payments.

Food, Pool and Lodging Health and Safety Section (FPLHSS)

Services provided

The Food, Pool and Lodging Health and Safety Section (FPLHSS) implements and maintains intervention and regulatory strategies to prevent illness and injury of the public as a result of patronizing Oregon's food, pool and lodging facilities.

The Foodborne Illness Prevention Program works in partnership with local public health authorities, the food service industry, businesses, academia, and state and federal agencies to reduce or eliminate known common causes of foodborne illness.

The Public Pool and Tourist Facility programs work in partnership with local public health authorities, industry and businesses to reduce or eliminate the risk of waterborne illness and accidental injury and death from public use of pools or tourist facilities.

Performance measures

A significant key performance measure for this program is the reduction in the rate of occurrence of foodborne illness risk factors in restaurants. Often the ability to report these measures is hampered by the current licensing and inspection data system. However, the section is in the final phases of completing a rewrite of its integrated licensing and inspection data system. Upon completion of this project in July 2013, the section will have real time access to the inspection and risk factor data.

Quality and efficiency improvements

In order to improve the quality of services provided to clients, the following county inspection programs were reviewed in 2012: Marion, Benton, Polk, Jackson, Morrow, Douglas, Crook, Wallowa, Grant, Jefferson and Columbia. Performance and trends are tracked to create a record of improvement in efforts to eliminate the known causes of foodborne illness.

Research and Education Services (R&E)

Services provided

Research and Education Services (R&E) is the state's primary point of scientific and technical expertise on health concerns pertaining to the built and natural environments. Staff in the R&E program identify, assess and report on threats to human health from exposure to environmental and occupational hazards. R&E

advises the people and communities of Oregon to best understand potential risks where they live, work and play in order to remain healthy and safe.

R&E's efforts range from monitoring risks to children and their families from exposure to environmental risks in their homes and schools, to monitoring illnesses, injuries and fatalities that occur in the workplace to providing consultative assessment services to communities with hazardous chemicals, to issuing advisories pertaining the health and safety of Oregon's waters.

Quality and efficiency improvements

In addition to rates of environmental exposure and risk to the public's health from lead, pesticides, radon, hazardous waste, household and consumer products, drinking and recreational water-based hazards, plus many other sources of environmental risk, R&E monitors and evaluates several programmatic indicators. The section's diverse programmatic areas depend on collaborative relationships with federal, state and local agencies, and stakeholder groups. R&E work emphasizes continuous process improvement in our work. We regularly measure the effectiveness of our monitoring and surveillance, technical assistance, assessment, outreach and risk communication work through program evaluations efforts, partner and stakeholder interviews, and implementation of policy and programmatic recommendations.

R&E is almost entirely dependent on federal grants, contracts and cooperative agreements. Each of the 14 federally funded efforts is awarded through a competitive application process, has its own set of requirements, which are reported on quarterly or annually, and each is dependent on continuation funding which must be applied for every 1-5 years. Therefore, one of the process measures R&E tracks is the application to award ratio, which is at 100% for the 2011-13 biennium.

We also monitor the completion or "closure" rate for the calls we receive from the public, academic centers, nongovernmental organizations, elected officials, and other state programs and agencies seeking consultation on environmental public health concerns. We currently receive an average of 250 calls per month on a wide range of topics and concerns and we track the rate at which we are able to satisfy these requests for information.

Health Care Regulation and Quality Improvement (HCRQI)

Services provided

The Health Care Regulatory & Quality Improvement Section (HCRQI) ensures that Oregonians have wide access to the health care they need and that it will be safe and of high quality. HCRQI meets the mission of the Center by regulating, licensing and/or providing Medicare/Medicaid Certification or other form of approval for the health care facilities such as:

- Hospitals
- Ambulatory Surgical Centers
- Birthing Centers
- Dialysis Facilities
- Home Health Agencies
- Hospice Agencies
- In-Home Care Agencies
- Rural Health Clinics
- Trauma Hospital programs
- Patient-Centered Primary Care Medical Homes

The section is responsible for routine on-site inspections and reviews, construction plans review, ongoing compliance support, complaint investigtions and much more for each of the above-listed entities. HCRQI also administers the review process for adding new hospitals and nursing homes through the Oregon Certificate of Need program.

Performance measures

Examples of some program review measures include: percent of facility complaint investigations completed on time; percent of routine licensure and certification surveys completed on time; and percent of initial in-home care agency surveys completed within 45 calendar days.

Quality and efficiency improvements

HCRQI streamlined the trauma hospital site review process, updated and improved the report letters, and created an online application submission process. HRCQI also substantially redesigned the in-home care licensing program to handle the growing number of new applications and relicensing workload and the relatively high need for consultative services.

Oregon Medical Marijuana Program (OMMP)

Services provided

The Oregon Medical Marijuana Program (OMMP) administers the registration program of the Oregon Medical Marijuana Act (OMMA), which was as approved by Oregon voters in November 1998. The program actively pursues administrative streamlining processes in an effort to better serve patients while maintaining the highest level of confidentiality. The program processes applications and provides legal protection for individuals who comply with program requirements to grow and use marijuana as an alternative medicine. Multiple states have requested information on Oregon's program to use as a model for their own medical marijuana initiatives and registration systems.

Performance measures

The OMMP has two measures that are mandated by statute: 1) the number of days to issue a registry identification card once an application is considered complete; and 2) percentage of time verification system is available to authorized law enforcement personnel. Oregon statute requires that OHA shall approve or deny an application within 30 days of receipt of a completed application. A registry identification card shall be issued within five days of verification of the completed application. Oregon statute requires a system by which authorized employees of state and local law enforcement agencies are able to verify at all times whether a person is either a lawful possessor of a registry identification card or the designated primary caregiver of a lawful possessor of a registry identification card, or an authorized marijuana grow site.

Quality and efficiency improvements

The program actively pursues administrative streamlining processes in an effort to better serve patients while maintaining the highest level of confidentiality. The program implemented processes and rule changes that significantly reduced the number of interim changes made by cardholders while simultaneously increasing revenue.

The program implemented a new database system for its registry. The new database system has assisted in maintaining consistent processing time, improving search capabilities for providing information to cardholders, and enhancing report capabilities.

CENTER FOR PUBLIC HEALTH PRACTICE (Practice)

Key programs

The Center for Public Health Practice (Practice) supports a strong public health system by strengthening the partnership between the state public health and local public health departments, and by ensuring core public health functions are sustained and strengthened in the areas of infectious disease prevention and control, laboratory services, and vital records. Practice includes the State Public Health Laboratory, the Acute and Communicable Disease Prevention Section and the Immunization Section as well as the Center for Health Statistics (Vital Records), the HIV/STD/TB Section, and the Community Liaison Section.

Programs and services funded through Practice include:

Federal funds

- HIV/AIDS prevention, and disease monitoring;
- Sexually transmitted disease (STD) control and prevention;
- Tuberculosis (TB) control and prevention;
- New and Emerging infections (like MRSA);
- Epidemiology and laboratory capacity;
- DHHS Center for Disease Control and Prevention (CDC)
    - Immunization and Vaccines for Children;
- Behavior Risk Factor Surveillance System (BRFSS);
- State Preventive Health Block Grant;
- Clinical laboratory certification (CLIA/CMS);
- Social Security Administration (SSA) Vital Events;
- National Center for Health Statistics (NCHS);
- Ryan White (AIDS) Services Base; and
- Housing Opportunities for Persons with AIDS

Other funds:

- Laboratory Testing Fees;
- Vital Event (birth, death and marriage certificate) Fees;
- Council of State and Territorial Epidemiologists (CSTE); and a
- One-time Settlement Award through the Department of Justice

State funds are used to support:

- Activities at Local Health Departments; and
- Portions of seven key positions at the State level

Community Liaison (CL)

Services provided

The Community Liaison (CL) ensures day-to-day support of the local public health departments, an essential component of the public health system. CL conducts technical assistance and quality assurance site visits to local health departments. These reviews ensure compliance with State contract, minimum standards, and federal requirements. The CL Section provides workforce consultation, training and professional development assistance to local health departments. The CL Section also serves as the state's resource for the Conference of Local Health Officials (CLHO), assisting and coordinating local efforts around national accreditation, coordination with CCOs and health systems transformation.

Oregon State Public Health Laboratory (OSPHL)

Services provided

The Oregon State Public Health Laboratory (OSPHL) is a critical component of a strong Public Health System. Lab results are essential to state and local public health programs in controlling communicable diseases and to medical providers in identifying metabolic disorders of newborn infants. The lab also assures the quality and accuracy of medical and environmental laboratory tests statewide.
Under Oregon's healthcare reform, cost effective laboratory services will be critical to the success of Coordinated Care Organizations and other community oriented clinics. A list of important OSPHL services includes:

- Communicable disease testing (virology/immunology and microbiology);
- Newborn metabolic screening (formerly called inborn errors or "birth defects");
- Rapid response to health threats and emergencies;
- Environmental testing (food and water);
- Laboratory compliance monitoring and accreditation; and
- Technical assistance and consultation to local health departments.

Performance measures

The work of OSPHL is critical to several KPMs, including:
KPM 26: early prenatal care for low income women, which is supported by the lab's prenatal testing for hepatitis B, syphilis, *Chlamydia*, and rubella;

KPM 19: safety net clinic use, which is made feasible through lab services for local health departments, community and migrant clinics and other safety net providers.

Recent quality and efficiency improvements

. To lower cost while increasing quality, OSPHL has modernized and automated several of its testing methods. Improvements this biennium in HIV, STD and TB-related tests have resulted in more output per staff position and greater accuracy of test results. In addition, the lab has sought sustainability through adopting: high-efficiency management practices, procurement discounts and point purchasing; new revenue streams; contractual services; regionalization of testing; and cost-saving technology.

Furthermore, in 2012 a new Laboratory Information Management System (LIMS) was implemented to improve the tracking and reporting of samples and results, and enhance accuracy. It increased efficiency and reduced paperwork. The new LIMS improves data sharing with other PHD programs and CDC, and gives clients Web-based access to test results.

Oregonians expect and deserve high quality public services. In alignment with the Public Health strategic plan, OSPHL is a national model of excellence. It conducts a comprehensive quality management system and maintains external accreditation by the College of American Pathologists (CAP). In 2012, due to our continuous improvement efforts, OSPHL was reaccredited by CAP through May 2014.

Acute and Communicable Disease Prevention

Services provided

Infectious diseases are not currently the leading cause of death in Oregon in part due to efforts by Acute and Communicable Disease Prevention (ACDP) staff and local health officials to prevent and control them. The section monitors communicable disease occurrence throughout the state; guides local public health department staff in investigating and controlling communicable diseases; investigates communicable disease outbreaks; and helps ensure that communicable disease threats, including manmade (bioterrorist) threats, are responded to appropriately. Early intervention to control disease outbreaks reduces the economic burden on CCOs and medical care providers to treat patients. In addition, the section provides information to the public, media and policy makers about communicable diseases, helping Oregonians stay healthy.

Immunization

Services provided

The Immunizations Program (IP) provides a coordinated, population-level approach to vaccine-preventable diseases, which is critical to making Oregon one of the healthiest states in the nation. In 2012 the Immunization Program (IP) coordinated the purchase, management and distribution of $46 million in vaccines to both the public and private sectors.

To manage these perishable and expensive resources, State epidemiologists partner with local health department staff for disease prevention, surveillance and outbreak control. Health educators and public health nurses provide model vaccine standing orders, health education materials, plus training and technical assistance on vaccines to providers. They provide consumer vaccine education to ensure the public understands the benefits and risks of vaccinations and vaccine preventable diseases. To support early childhood learning, the school law team coordinates the efforts of schools and child care centers to protect children from vaccine-preventable diseases. In addition, the program provides technical assistance to CCOs in support of health systems transformation.

The ALERT Immunization Information System (ALERT IIS) receives immunization information from vaccine providers statewide, maintaining accurate, timely and complete immunization records for clinical, school and community use. This data will be especially helpful to CCOs undertaking preventive medicine.

In a transformed health care system, the new comprehensive Immunization Information System (IIS) will help CCOs and other adult immunization providers increase immunization rates across the lifespan. IIS will help the public health system measure progress, evaluate interventions and identify vulnerable populations.

Performance measures

KPM 29: The percentage of 24 to 35-month-old children who are adequately immunized.

The Vaccines for Children program supplies vaccine and technical assistance to private and public providers who serve eligible children. ALERT IIS maintains a clinical database of all reported vaccine for provider reference and identifies all shots due. Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Education and training opportunities are held for providers throughout the year to provide up-

to-date information about vaccine efficacy, safety, reporting, as well as storage and handling.

In 2011, 72.5% of children were up-to-date with 4 or more doses of diphtheria, tetanus and pertussis vaccine; 3 or more doses of polio vaccine; 3 or more doses of Haemophilus influenzae type b (Hib) vaccine; 3 or more doses of hepatitis B vaccine; and 1or more doses of Varicella vaccine (4:3:1:3:3:1 series).

KPM 30: The percentage of adults aged 65 and over who receive an influenza vaccine.
Strategies include promoting adult immunizations through the DHS-funded Oregon Adult Immunization Coalition, promotion of hospital standing orders, and technical support to public and private provider. Additionally, influenza vaccinations are promoted and supported by local health departments.

In the 2011-12 influenza season, 58% of adults aged 65 years and older received the influenza vaccine.

Human Immunodeficiency Virus (HIV), Sexually Transmitted Disease (STD) and Tuberculosis (TB)

Services provided

The HIV, STD and TB section (HST) monitors the occurrence of these diseases in the state; works to prevent their spread; and provides direct services to low income HIV positive persons and people with tuberculosis and sexually transmitted diseases. Reducing the number of new infections reduces the burden of treatment for CCOs and primary care settings. HST also helps reduce health care costs. Each case of HIV prevented saves an estimated $291,565 in public sector medical costs (Holtgrave, 2012). This program's interventions complement clinical interventions with important tools that prevent the spread of these diseases. Examples of interventions include surveillance; testing, counseling, case management and treatment; identifying, interviewing and counseling patients with reportable STDs; and providing rental assistance and other housing-related assistance for persons with HIV. HST also provides information to the public and stakeholders about HIV, STDs and TB in Oregon.

Performance measures

KPM 31: The proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment.

This KPM aims to reduce the number of new HIV/AIDS cases in Oregon. Centers for Disease Control and Prevention recommends that all people with newly reported HIV be interviewed and offered partner notification services. No explicit industry standards exist for this measure. A 2001 national survey indicated that fewer than a third of newly reported HIV cases were being interviewed or offered partner notification services. In 2006, HST began redirecting some prevention resources to focus on direct interviews of people with newly reported cases of HIV to identify and test exposed partners. Due to challenges in locating patients, interviewing 100% of all patients will most likely never be achieved. HST aimed to interview at least 90% of case patients by 2010 and sustain that level during 2011–2013.

In 2008, approximately 64% (up from 21% in 2005) of newly reported cases had been interviewed. The proportion of newly diagnosed cases interviewed increased to 84% during 2010 and 2011, falling short of the goal of 90% but having increased steadily since resources were directed to this goal in 2006.

Center for Health Statistics

Services provided

The Center for Health Statistics (HS) is responsible for registering, certifying, amending, and issuing Oregon vital records. Oregon law requires that certain vital events (e.g., births, marriages, divorces, registered domestic partnerships, dissolution of registered domestic partnerships, fetal deaths, and deaths) be permanently recorded and registered. These records are critical to the functioning of other state programs, such as child support functions, family services, and Medicaid.

The center retains and manages legal records documenting such vital events. In the case of birth certificates, Health statistics records are the primary documents used to establish identity. During 2012, the center registered 122,000 vital events and issued 169,000 certificates. In addition to playing an essential role as legal documents, these records make it possible to collect statistics related to these events.

Data managed are the primary source used for measuring key health indicators found in the Healthy People 2020 objectives, national accreditation community health assessments, OHA Key Performance Measures, and many other health indicators projects.

The program also administers the Oregon Healthy Teens Survey and the Behavioral Risk Factor Surveillance Survey, two important sources of data about health risk behaviors. Survey information is readily available to serve the public, the media and policymakers.

To support health systems transformation and a strong public health system, national, state and local data are used for evidence-based program planning and policy development. Public health epidemiological health data and data provide the basis for community health assessments required for local health departments, CCOs and non-profit hospitals. Data also is essential to measuring success for nearly all of the public health-related KPMs.

To improve efficiency, the program has undertaken improvements in 2011-13 that will continue to 2013-15 to the Oregon Vital Event Registration System (OVERS), which includes the Electronic Death Registration System, Electronic Birth Registration and Fetal Death System. OVERS is a fully electronic secure web-based vital records system. It allows all aspects of the vital records process, from registration at the data source to issuance of certified copies in the counties and state, to be electronic rather than paper-based. The implementation of this system provides for more timely, accurate and secure processing of these important documents for Oregonians.

2013-15 Policy Option Package

Agency Name: Oregon Health Authority/ Department of Human Services
Program Area Name: Medical Assistance Program/ Aging and People with Disabilities
Program Name: Medicare Buy-in/ Post Acute Services
Policy Option Package Initiative:
Policy Option Package Title: Medicare Buy-in/ Post Acute Services Transfer to OHA
Policy Option Package Number: 201-01
Related Legislation:
Program Funding Team: Healthy People

Summary Statement:

This Policy Option Package transfers budgetary authority for Medicare Buy-in and Nursing Facility post acute services from the Department of Human Services to the Oregon Health Authority.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$125,761,280**	**$0**	**$218,620,495**	**$344,381,775**

Issue

Should the Department of Human Services continue to manage the budgets for Medicare Premiums, Medicare Skilled Nursing Facility Coinsurance and OHP Post Hospital Extended Care?

Information and Analysis

The Department of Human Services and the Oregon Health Authority will begin operating as separate agencies for the first time in the 2011-2013 biennium. In general, all health care related budgets are now under the management of the Oregon Health Authority. A few notable exceptions exist, however. Those exceptions include:

Medicare Buy-in: This budget pays the Medicare premiums for low-income individuals who, because of their low income, have difficulty making those premium payments. This is a required payment for those individuals who are under 135% of the Federal Poverty Level (FPL) as they are eligible for a Medicare Savings Program. It also contains payments for OHP clients who receive Medicare and are over 135% of FPL. If these premiums were not paid, the Oregon Health Plan would become the first payer on all health claims, resulting in significantly higher costs. These payments are critical to reducing overall expenditures in the Oregon Health Plan. Pooling these resources for Coordinated Care Organization (CCO) contracts may provide additional leverage and purchasing power that would not otherwise be available if the budget remained with DHS.

Medicare Extended Care (Medicare Skilled Nursing Facility coinsurance): Currently, DHS manages the budget for this benefit. This is a Medicare health-related benefit intended to rehabilitate individuals after a period of hospitalization. Medicare pays days 1-20 in full and imposes a coinsurance amount on days 21-100. Transferring this budget to the Oregon Health Authority will give Coordinated Care Organizations the incentive to ensure cost shifts do not occur (e.g. premature hospital discharges) and provide oversight of overall health outcomes.

Oregon Health Plan Post Hospital Extended Care: This benefit mirrors the Medicare skilled nursing facility benefit for individuals without Medicare coverage. The Oregon Health Plan benefit provides for 20 days of

nursing facility coverage after a qualifying hospital stay. Again, transferring this budget to the Oregon Health Authority will give CCOs the incentive to monitor and manage the full continuum of health-related care.

Recommendation: Transfer the following budgets from the Department of Human Services to the Oregon Health Authority:

Categories	Clients	Cost Per Case	Total Funds (24-months)	General Funds
Medicare Buy-in (Part A)	5,178	$469.98	$58,406,125	$21,915,280
Medicare Buy-in (Part B)	107,220	$106.06	$272,911,118	$97,888,421
Nursing Facilities Extended Care	125	$4,608.40	$13,825,200	$5,186,305
Nursing Facilities OHP PHEC	10	$10,872.88	$2,609,492	$978,526
		DHS Total	**$347,751,935**	**$125,968,532**
NOTE: OHA POP adjusted in GBB		**OHA Total**	**$344,381,775**	**$125,761,280**

Transferring these expenditures will allow the Oregon Health Authority to pool these resources and leverage greater purchasing power with the initiatives under consideration. Additionally, it will incent CCOs to manage the full continuum of care for individuals enrolled in their organizations.

Approved:

Erinn Kelley-Siel Director Department of Human Services	Bruce Goldberg, MD Director Oregon Health Authority

2013-15 Policy Option Package

Agency Name:	Department of Human Services (DHS)/Oregon Health Authority (OHA)
Program Area Name:	Shared Services
Program Name:	Office of Information Services
Policy Option Package Initiative:	N/A
Policy Option Package Title:	Computer and Network Infrastructure Investments
Policy Option Package Number:	401
Related Legislation:	N/A
Program Funding Team:	Improving Government

Summary Statement:

"This POP reflects changes to allow for balancing the Governor's budget based on recommendations from the Improving Government leadership team. Funding amounts on page 2 have been updated to reflect the reduced amounts in the Governors Balanced Budget."
DHS and OHA will have up to 66% of active computers over five year of age which is beyond industry standard lifecycle and slows down productivity. The State Data Center has also not upgraded DHS/OHA network infrastructure in over nine years in many buildings including the Barbara Roberts and Portland State Office Buildings. Both the Network and outdated computers cause inefficient work processes due to how slow systems operate on these computers and systems. In addition, as modern systems such as HIX and Eligibility Modernization are implemented, a further strain on the performance of DHS and OHA IT systems will occur. The worst case scenario is that some computers will not support these modern applications. Older computers will also not support Windows 7 and Windows XP; support for these systems will be soon phased out by Microsoft. Due to DHS and OHA's reliance on IT systems to provide services and ensure safety of clients, modernizing the IT tools and Infrastructure is critical to the long term success of DHS and OHA in achieving program outcomes and ensuring health and safety of Oregonians.

Total GBB Reduced	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	1,737,806	2,366,211	1,737,806	$ 5,841,823
DHS	$1,070,139	$7,068	$1,071,139	2,149,346
OHA	$666,667	$2,359,143	$666,667	3,692,477

Total Agency Request	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	5,213,417	2,373,125	5,213,417	$ 12,799,959
DHS	$3,213,417	$7,068	$3,213,417	6,433,902
OHA	$2,000,000	$2,366,057	$2,000,000	6,366,057

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

The focus of activity for FY13-15 is on increasing program performance and delivery, caseworker effectiveness and efficiency; and client support. By addressing existing and growing gaps in three key areas (PC refresh, network performance and mobile computing/communications) OHA and DHS will be able to better meet agency and client needs while delivering increased performance through the support of transformation and modernization efforts.

a) PC Refresh—Meeting Client and Caseworker Needs

Establish a program for the regular replacement of agency information technology assets as required by the Department of Administrative Services. The Information Technology Asset Inventory/Management policy IRM 107-004-010 requires agencies to support standard lifecycles for agency Information

Technology (IT) assets. In 2011, DHS began replacing PCs that were incapable of supporting future needs (e.g. Windows 7, Office 2010). The allocation of $1 million by DHS represents a significant investment, but was slightly more than one third of what is needed to simply upgrade platforms that must be replaced. This Policy Option Package represents a long-term effort to fund for the replacement of systems at their end-of-life in order to meet ongoing technology needs for both DHS and OHA.

b) Network Infrastructure—Supporting Modernization, Improving Efficiency

Ensure the building infrastructure across all OHA and DHS facilities is capable of support the next generation of network-centric solutions. As modernization investments continue to place increasing demands on the OHA and DHS information technology infrastructure, a commitment to establishing and maintaining a high-performance network environment will be critical to meeting the needs of human services programs, health insurance plans and medical assistance efforts (i.e. Health Insurance Exchange, Health Information Exchange, Coordinated Care Organization web portals, health care analytics, etc.) will. Maintaining a responsive IT network that meets caseworker/client performance/usability demands is essential to the success of virtually all transformation/modernization efforts.

c) Mobile Computing—Increasing Responsiveness and Productivity

The increasing use of mobile devices—particularly smartphones and tablets—represents a significant shift in the way clients and caseworkers interact with technology. Legacy BlackBerry solutions are incapable of supporting the needs of the OHA and DHS community going forward, and this POP proposes replacement of the entire inventory with more modern hardware (Apple IOS, Windows 8 mobile, or Android). Replacement of the legacy BlackBerry phone infrastructure with a device that functions as a combination email agent, voice messaging agent, telephone (cellular/landline), video conferencing client and remote application delivery platform can provide OHA and DHS users with a range of capabilities unavailable in the current platform.

2. WHY DO DHS and OHA PROPOSE THIS POP?

As new software applications supporting Coordinated Care Organizations, Health Systems Transformation and the modernization of human services programs are released, performance problems associated with aging computer hardware and network infrastructure will become increasingly severe. The need for more processing power and higher network performance has already been experienced by users of two systems: MMIS and OR-Kids (memory in older systems was more than adequate at the time of purchase, but aging systems failed to meet agency needs and MMIS/OR-Kids users required memory upgrades).

During the 2011–13 biennium the Windows 7 operating system and Office 2010 will be rolled out to all users. The operating system and software applications are the current generation of products from Microsoft and will ensure OHA and DHS computers and computer generated products remain compatible across the agencies and with our public and private counterparts as they move in a similar direction. These changes will tax the capabilities of older systems. The resulting poor performance at the desktop PC level will reduce productivity and service delivery.

A 4-year PC lifecycle replacement is the accepted industry best practice for mainstream users to maintain acceptable computer performance for staff productivity. In addition, Microsoft operating system lifecycles typically follow a 4-year cycle from the release to obsolescence. The Windows 7 operating system is the current replacement for the decade old Windows XP platform. As part of the replacement of agency PCs, the technology consulting firm Gartner recommends refreshing the client operating system. This makes the next biennium a critical time for PC upgrades. Failure to replace all systems incapable of running Windows 7 will incur significant support costs to both agencies for the maintenance of the obsolete XP platform.

Maintenance costs on new PCs are covered under warranty, while those associated with an aging, out of warranty inventory are handled as a current expense covered by the business. Current PC vendors provide a 3 to 4-year warranty on systems. Extending the lifecycle beyond the 4-year warranty incurs additional costs (e.g. labor, parts and lost productivity) to maintain increasingly obsolete systems. The lost productivity associated with using and remediating installed systems causes resource issues/impacts, delays client service

delivery and shifts technical resources away from operations and toward remediating failing computers and infrastructure.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Establishing a PC replacement program executed in parallel with efforts to remediate applications to run in the Windows 7 environment is essential. Given the limitations associated with an aging PC inventory and the operational demands of OHA transformation and DHS modernization, outdated legacy systems should be targeted for immediate replacement. Based on industry best practice, software demands, and hardware maintenance needs, DHS and OHA should strive to achieve a 4-year PC lifecycle replacement plan. In practice this would necessitate replacing approximately 2,750 systems per year (5,500 per biennium). Implementing a PC lifecycle refresh program requires significant investment—there are currently over 3,000 PCs that are greater than 5 years old. The replacement of these aging PCs has been deferred several times due to budget cuts.

4. IS THIS POP TIED TO A DHS or OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL DHS and OHA MEASURE THE SUCCESS OF THIS POP?

No.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No statutory changes are required.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

There are no practical alternatives. Windows XP has reached its end-of-life. The average PC in the inventory is already beyond replacement age. Network hardware in many buildings is nearly a decade old. The wide

area network infrastructure is demonstrably incapable of effectively supporting current needs, let alone future demands.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

The risks to OHA and DHS program delivery will be significant if the legacy PC inventory is not replaced, the network infrastructure is not upgraded and a forward-looking mobile communications solution are not implemented. IT functionality for both OHA and DHS with degrade increasingly over time until it is no longer supportable. The results will be severe for caseworkers and clients.

A key part of the caseworker environment is the personal computing platform used by staff. Microsoft's XP operating system has been at the center of OHA and DHS computing for over a decade. The majority of PCs in use are aging and many cannot support migration to Windows 7 or Office 2010. IT industry data indicates it can take 18 to 32 months to completely transition to a new operating system environment. While both OHA and DHS are a generation behind in operating systems and general office productivity applications, the problem will be further compounded when the next generation of products is released in late 2012.

Network infrastructure across the OHA and DHS agencies (both internal to buildings and Internet/SDC connectivity) is aging and in need of upgrade/replacement. A majority of the networking hardware in OHA and DHS facilities is 5 to 9 years old. The current wide area network transport infrastructure has been in place for over a decade at a majority of OHA and DHS locations and performance is sub-standard at many of these sites. Without a concerted effort to increase performance, the network as a whole will be unable to support currently projected demands.

The mobile communications solution that is currently fielded across OHA and DHS is the BlackBerry phone. These phones represent an aging platform, and the communications network run by Research-In-Motion (RIM) that is required to use the phones with email and instant messaging is both proprietary and outdated. The emergence of Apple's IPhone and Android smartphones (from various vendors) has

dramatically shifted the mobile market. In addition to increased usability and functionality, more modern mobile phones can execute applications beyond anything the legacy BlackBerry is capable of supporting.

Transitioning to a more open platform that does not require a proprietary network simplifies the architecture and opens up a range of potential solutions, including "Bring Your Own Device—BYOD." A final and quite serious concern is the viability of the RIM corporation (maker of the BlackBerry) going forward. RIM is facing serious challenges that make newer technologies, open platforms, agency specific application storefronts and the risk associated with the current solution critical considerations for OHA and DHS business operations.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

N/A

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2013

End Date (if applicable): _____

a. Will there be new responsibilities for DHS or OHA? Specify which Program Area(s) and describe their new responsibilities.

No new responsibilities.

b. Will there be new administrative impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected. See Addendum A - Administrative Services Division LC/POP Impact Questionnaire (at the end of this document).

No.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

PC Refresh	**# of months**	**Type**
One (1) ISS5 PC Build Team	21 months	Permanent
Four (4) ISS4 PC Build Team	21 months	Permanent
Network Infrastructure	**# of months**	**Type**
Four (4) ISS6 Infrastructure Techs	21 months	Limited Duration
Mobile Computing	**# of months**	**Type**
One (1) ISS6 Tech	21 months	Permanent
Two (2) ISS4 Tech	21 months	Permanent

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

Start-up Cost Estimates

PC Refresh	
Replace personal computers in 2013-15 to achieve 4 yr lifecycle	$702,487
Network Infrastructure	
LAN/WAN Infrastructure upgrades	$300,000
Mobile Computing	
Mobile Phone Replacement	$25,000
Collaborative Infrastructure Servers	$75,000

f. What are the ongoing costs?

Ongoing Cost Estimates

PC Refresh	
Replace 260 PCs each month (6,240 per biennium)	$8,005,920
Mobile Computing	
Mobile Device Management (MDM)	$48,000
Collaborative Infrastructure Servers	$336,000

g. What are the potential savings?

N/A

h. Based on these answers, is there a fiscal impact?

PC Refresh	GF	OF	FF	TF	Position	FTE
Personal Services	$ 0	$ 628,795	$ 0	$ 628,795	5	4.40
Services & Supplies	$ 348,075	$ 343,827	$ 354,412	$1,046,314		
Special Payments	$ 488,862	$ 0	$ 486,386	$ 975,248		
Subtotal	**$836,937**	**$ 972,622**	**$840,798**	**$ 2,650,357**	**5**	**4.40**

Network Infrastructure	GF	OF	FF	TF	Position	FTE
Personal Services	$ 0	$ 609,213	$ 0	$ 609,213	4	3.52
Services & Supplies	$ 150,000	$ 238,300	$ 150,000	$ 538,300		
Special Payments	$ 426,186	$ 0	$ 423,872	$ 850,058		
Subtotal	**$ 576,186**	**$ 847,513**	**$ 573,872**	**$ 1,997,571**	**4**	**3.52**

Mobile Computing	GF	OF	FF	TF	Position	FTE
Personal Services	$ 0	$ 417,351	$ 0	$ 419,094	3	2.64
Services & Supplies	50,000	$ 128,725	50,000	228,725		
Special Payments	274,683	$ 0	273,136	$ 547,819		
Subtotal	**$ 324,683**	**$ 546,076**	**323,136**	**$ 1,193,895**	**3**	**2.64**

Note: OF Limitation is built into this POP to support Shared Services Funding.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	$ 1,655,359	0	$ 1,655,359	12	10.56
Services & Supplies	$ 548,075	$ 710,852	$ 554,412	$ 1,813,339		
Special Payments	$ 1,189,731	0	$ 1,183,394	$ 2,373,125		
Other	0	0	0	0		
Total	**$1,737,806**	**$ 2,366,211**	**$ 1,737,806**	**$ 5,841,823**	**12**	**10.56**

DHS/OHA - Fiscal Impact Summary by Program Area:

	Program Area 1	Program Area 2	Program Area 3	Program Area 4	Total
General Fund	**0**	**0**	**0**	**$0**	**$ 1,737,806**
Other Fund	**0**	**0**	**0**	**$0**	**$2,366,211**
Federal Funds- Ltd	**0**	**0**	**0**	**$0**	**$1,737,806**
Total Funds	**0**	**0**	**0**	**$0**	**$5,841,823**
Positions	**0**	**0**	**0**	**0**	**12**
FTE	**0.00**	**0.00**	**0.00**	**0.00**	**10.56**

2013-15 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: Office for Oregon Health Policy and Research
Program Name: Health Care Transformation Support
Policy Option Package Initiative: Transformation Support Initiative
Policy Option Package Title: Health Care Transformation Support 2013 – 2015
Policy Option Package Number: 402
Related Legislation: ORS 414.655 & 442.210, 2011 OL, Chapter 602 (HB 3650)
Program Funding Team:

Summary Statement:

This Policy Option Package (POP) is vital to transforming health care delivery to support the state's efforts to improve quality, provide better care, and lower costs and assist the efforts of Coordinated Care Organizations. This package will support 1)intensive data analytics using All-Payer All-Claims Data Collection Program that is the statewide collection of health care data from all payers in Oregon for intensive data analytics, 2) The Patient-Centered Primary Care Home (PCPCH) Program with PCPCH's as a key feature of enhanced care coordination, and 3) the Health Evidence Review Commission (HERC) to further develop evidence-based tools for healthcare purchasing decisions

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$2,615,946**	**($311,665)**	**$2,162,916**	**$4,467,197**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This Policy Option Package (POP) is vital to transforming health care delivery and supports the state's efforts to improve quality, provide better care, and lower costs. Details of the three major Program Areas under this Package and how they are to be implemented are as follows:

Program Area #1: All-Payer All-Claims Data Collection Program

The All-Payer All-Claims data collection will be a central data source for the production of metrics to evaluate the performance of Coordinated Care Organizations along with other OHA programs and private carriers. APAC holds the promise to give providers better data to benchmark performance and identify quality improvement opportunities and give consumers better cost and quality information. OHA now has two years of APAC data collected spanning January 2010-December 2011. Data is submitted quarterly and is maintained through contract by Milliman. Currently, the APAC dataset collection is funded through State Health Access Program grant that will end in August 2013. This POP would provide funding to ensure that the APAC is supported for the remainder of the 13-15 biennium and allow for intensive data analytics.

Program Area #2: Patient-Centered Primary Care Home (PCPCH) Program

A strong primary care system through a network of recognized Patient-Centered Primary Care Home (PCPCH) providers is a requirement of newly developed Coordinated Care Organizations (CCOs), to the extent practicable. Without sustainable program funding and a system for recognizing PCPCHs, CCOs will not have this strong primary care base to wrap themselves around nor will the OHA be able to meet its goal of providing access to a PCPCH for 75% of Oregonians by 2015. To date, the program has been funded solely by federal grant funds, which is not sustainable for a program of this scope and size. This POP would allow OHPR to continue working across all OHA divisions to successfully implement the PCPCH program (including Medicaid, PEBB and OEBB) and provide technical assistance to recognized PCPCH providers

and all primary care providers pursuing primary care transformation. More specifically, activities currently underway that require sustainability include:

1. Maintenance and refinement of the PCPCH provider standards, including statewide stakeholder input processes;
2. PCPCH provider application development, review, and recognition;
3. PCPCH provider application verification site visits (audit);
4. Development and implementation of provider technical assistance and learning opportunities;
5. Developing opportunities for multi-payer participation in the program; and
6. Program evaluation (linked to health system transformation).

Sustaining the program and its activities will provide expertise and assistance to the Division of Medical Assistance Programs (DMAP) and the rest of the Oregon Health Authority in the development of state plan amendments and other processes to ensure Oregon complies with federal requirements and maximizes any federal or other funding opportunities. Additionally it sustains the linking of PCPCH and CCO implementation across the OHA, development and implementation of processes for client identification and educational tools that can be used by PCPCH sites statewide, and development and implementation of processes for PCPCH provider payments.

Program Area #3: Health Evidence Review Commission (HERC)

With this POP, the Health Evidence Review Commission (HERC) will be able to further the identification and interpretation of comparative effectiveness research necessary to develop evidence-based guidelines, health technology assessments, and coverage guidance. This work is necessary to provide critical information and guidance for both public and private stakeholders to purchase and deliver health care that is both clinically effective and cost-effective. Specifically, it will provide the tools necessary to support Health Evidence Review Commission (HERC) to:

- Partner with existing state, national and international efforts already investing in clinical outcomes and effectiveness research, supporting high quality comparative effectiveness research and using the best available data and evidence to make public and transparent policy decisions. By using clinical outcomes

and effectiveness research, evidence-based guidance can be developed for use across all of Oregon's healthcare sectors regarding the coverage of new and existing procedures and services.

- Develop standard sets of evidence-based guidelines for all providers serving Oregonians, starting with the treatment of chronic conditions, by reviewing and endorsing existing high-quality guidelines whenever possible, and convening experts to create them when they don't exist. As developed, policies can be written to incentivize providers serving patients in publicly funded programs to follow these evidence-based guidelines. The HERC works with private purchasers and health plans in the development of these guidelines, and common policies can be developed that encourage the utilization across both the public and private sectors.
- Develop health technology assessments of new and existing technologies in cases where systematic reviews of evidence have not already been conducted. These assessments can then be translated into easily understood guidance to purchasers and insurers on appropriate coverage decisions.

2. WHY DOES OHPR PROPOSE THIS POP?

HB 2009, Oregon's health care reform legislation, created the Oregon Health Authority to advance the goals of health reform: a healthy population, extraordinary patient care and reasonable costs. This POP would support specific efforts to advance these goals in the areas of providing quality data analytics, improving effect primary care and enhancing care coordination, and developing evidence-based clinic research and guidance. Each of these efforts are key components to Oregon's health system transformation.

Under Program Area #1, this POP includes resources for the Office of Health Analytics within OHPR to continue the implementation of an all payer data collection program that is a cornerstone data source for measuring the performance of OHA, Coordinated Care Organizations, and larger multi-payer health reform efforts. An all-payer data collection program will mean that cost and quality information will be available to all Oregonians based on the experience of the 83% of residents who are insured. This would allow us to understand how well the health care delivery system in Oregon is dealing with key drivers of costs, such as

chronic illnesses, and how well regions within the state compare to other parts of the state.

The Patient Centered Primary Care Home (PCPCH) Program (Program Area #2) is a model of primary care that has been recognized for its potential to advance the goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs and a patient and family centered approach to all aspects of care. In its Action Plan for Health, the Oregon Health Policy Board charged the Oregon Health Authority (OHA) with providing access to patient-centered primary care for all of its covered lives including Medicaid, state employees, and Oregon educators. The OHA is also currently reorganizing the way care is delivered to Medicaid beneficiaries to a system of Coordinated Care Organizations (CCOs). A strong primary care system through a network of recognized PCPCH providers will be a requirement of CCOs, to the extent practicable. Without sustainable program funding and a system for recognizing PCPCHs, CCOs will not have this strong primary care base to wrap themselves around nor will the OHA be able to meet its goal of providing access to a PCPCH for 75% of Oregonians by 2015.

In relation to Program Area #3, the Health Evidence Review Commission (HERC) was newly created in January 2012 to do the work of the previous Health Services Commission in its management of the Oregon Health Plan's Prioritized List of Health Services (which serves as the basis of benefits in the Oregon Health Plan) and the health technology assessment work of the previous Health Resources Commission. The HERC applies the evidence-based research in its work with an open forum for stakeholders and consumers on state-wide clinical guidelines and evidence-based coverage guidance, as well as analyzing and disseminating information on the effectiveness and costs of medical technologies. If funded through this POP, the HERC can provide better access to clinical outcomes and effectiveness reviews in developing evidence-based clinical guidelines and health technology assessments that will be helpful to state purchasers of health care as well as private health plans, providers, private purchasers, and the health care system as a whole. Systematic reviews are the building blocks underlying evidence-based practice as they focus attention on the strengths and limits of evidence from research studies about the effectiveness and safety of a clinical intervention. Public purchasers of health care should be conducting and supporting research on the comparative outcomes,

clinical effectiveness, and appropriateness of health care services and health technology devices to meet the needs of Medicaid, the State Children's Health Insurance Program (SCHIP), the Public Employees Benefit Board (PEBB), the Oregon Educator's Benefit Board (OEBB) as well as the recipients of any publicly purchased health care to ensure that Oregonians are getting the right care at the right time and place.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

This POP directly support OHA's mission to further the OHA goals of improved health, higher quality of care, and reduced costs through each of the program areas:

#1: Analysis of APAC data will allow Oregon to analyze, report on, and evaluate OHA and Oregon progress toward health transformation.

#2: Continued support of the PCPCH program will allow Oregon to meet the Oregon Health Policy Board's goal of providing access to a PCPCH for all OHA-covered lives and 75% of all Oregonians by 2015.

#3: Evidence-based guideline and technology effectiveness work by the HERC will improve the lifelong health of Oregonians by encouraging the most effective health care services and discouraging the use of ineffective or harmful services. Reducing the use of ineffective and harmful services will lower health care costs and lead to care that is high in quality and reliability, improving health in the communities through evidence-based interventions.

4. IS THIS POP TIED TO AN OHPR PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHPR MEASURE THE SUCCESS OF THIS POP?

Funding this POP would provide the data central to not only monitoring and reporting on the quality, health outcome, and quality measures for Coordinated Care Organizations, but also to assess the impact of health reform across public and private health programs. Transparency in health care cost and quality is central to improvement and is at least indirectly connected to many of the KPMs department wide and provides the

ability to assess the same metrics across private payers as well. There are measures currently included in proposed evaluations of OHA health system transformation directly related to implementation of the PCPCH program and its success. There is also a preliminary program evaluation underway which requires funding outlined in the POP in order to be continued. Further, CCOs are required to report on implementation status of Primary Care Homes within their organizations. More directly, the evidence-based decision tools of the HERC Program Area (#3) of this POP can span all areas of health care services, having the ability to impact all performance measures tied to the effectiveness of treatment depending on the services for which evidence is available for the development of tools; namely KPMs 1-4, KPMs 7-10, KPM 27, KPM 31.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No statutory change is required.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

An alternative to this POP is to continue relying on grant funding for program area continuation. However, current grant funding is either scheduled to end or is unsustainable for the size and scope of these program areas that are an integral to health system transformation. While there is an active process to search for additional grant funding opportunities, none have been identified.

It is also important to note for Program Area #3 that while the use of existing staff could be used to maintain the HERC program at a skeletal level, there would only be a limited number of coverage guidance and likely no evidence-based guidelines or health technology assessments. Work in these areas would also not be viewed as being as credible without involvement of the current contractor, the Center for Evidence-based Policy, or a similarly respected authority on comparative effectiveness research.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Information from the APAC Data Collection program is already beginning to benefit all OHA programs including PEBB, OEBB and Medicaid, as well as the Oregon Health Exchange and private purchasers who choose to use this data as they make purchasing decisions. In addition, the data will support surveillance activities within the Division of Public Health. Not funding this Program Area would result in the elimination of potential significant future savings the Program can provide.

Not funding this POP would also cause current PCPCH Program activities to halt, resulting in several direct impacts on the OHA and its health system transformation efforts. This program has been widely communicated as a priority of the agency and has caused primary care providers to make significant time and resource investments in the types of transformation required for program participation. Discontinuing the PCPCH Program may cause those providers may be required to stop those efforts and view the agency as not following through on its commitment to primary care transformation. More specifically:

1. The OHA would not meet its goal of providing access to PCPCHs to all OHA-covered lives and to 75% of all Oregonians by 2015.
2. CCOs would not be able to meet their contractual expectation of "networking with recognized PCPCHs to the greatest extent possible" since the State would no longer have state standards or a recognition process.
3. The OHA may not experience an overall decrease in healthcare expenditures for its covered lives since assumptions on that experience are based on OHA lives receiving care through this model of care.
4. The OHA may not experience an overall increase in quality of care and patient experience of care since assumptions on that experience are based on OHA lives receiving care through this model of care.

In terms of the HERC, momentum of the use of comparative effectiveness research to inform purchasing decisions would be lost, as would be the use of tools critical in helping to control rising health care costs. OHA clients and state employees would receive care proven to be ineffective or harmful.

In addition, these program areas are the result of significant internal and external efforts. Not funding this POP will result in the agency experiencing a significant decrease in confidence among the provider and stakeholder community.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

No other agencies are directly affected by this POP, except that as these programs are vital to health system transformation, their continued efforts will benefit Oregonians statewide, and support local community efforts across the state.

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): THE POP implementation dates for each Program Area are as follows:

Program Area 1	Program Area 2	Program Area 3
September 1, 2013	July 1, 2013	July 1, 2013

End Date (if applicable): Not applicable; programs will be on-going.

a. **Will there be new responsibilities for OHPR? Specify which Program Area(s) and describe their new responsibilities.**

There will not be any new responsibilities that are not currently in place as implementation has already been in effect. Over the last few years, the programs identified in this POP that support health system transformation have been implemented as a result of significant investment from federal grant funds, the OHA, and stakeholders (including health plans, multiple state and local entities, and providers across the state).

b. **Will there be new administrative impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.**

No.

c. **Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.**

For the HERC program, there will be no impact on client caseloads but it will result in the prevision of more services proven to be effective and less services shown to be ineffective, harmful or not as cost-effective as other alternatives. This could potentially impact any number of clients who receive health care services through state programs (i.e., OHP, FHIAP, Healthy Kids) and state employees receiving health care through PEBB/OEBB plans.

d. **Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.**

Funding of positions within OHPR is required for the continuation of the PCPCH program. Refer to the attached position pricing for details.

e. **What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?**

While the APAC and HERC Program have already been established, they will not be in need of funding for start-up costs or significant computer systems modification. However, the PCPCH program has identified the following costs:

- Provider and client outreach and communications are estimated at $200,000 for 2013-2015.

- Provider technical assistance and learning opportunities will be $2,000,000 for 2013-2015.

f. **What are the ongoing costs?** Refer to the attached spreadsheet for details.

g. **What are the potential savings?** In general, the investment in a fundamental tool for health care analytics and improved use of evidence- based decision making the Medicaid program will decrease total health care system costs. These cost reduction will extend to health care services in other publicly-funded programs such as PEBB and OEBB, and also to private payers and their members/employees.

In addition, the PCPCH program has identified an estimated $99,800,000 in savings as a result of improved care coordination through the use of its services.

By reducing the current and future health and economic costs associated with chronic conditions, literally hundreds of millions of dollars can be saved.

h. **Based on these answers, is there a fiscal impact?**

Yes

TOTAL FOR THIS POP

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$305,305	($280,990)	$316,396	$340,711	2	2.00
Services & Supplies	$2,309,923	($30,675)	$1,846,060	$4,125,308		
Capital Outlay	0	0	0	0		
Special Payments	$718	0	$460	$1,178		
Other	0	0	0	0		
Total	**$2,615,946**	**($311,665)**	**$2,162,916**	**$4,467,197**	**2**	**2.00**

		Total
General Fund	**$2,615,946**	**$2,615,946**
Other Fund	**($311,665)**	**($311,665)**
Federal Funds- Ltd	**$2,162,916**	**$2,162,916**
Total Funds	**$4,467,197**	**$4,467,197**
Positions	**2**	**2**
FTE	**2.00**	**2.00**

Revenue Impact:

Description of Revenue	OF	FF	TF

Licensing fees (Comp Srce 0975)	0	0	0
Medicaid (Comp Srce 0995)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Total	**$0**	**$0**	**$0**

2013-15 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: Addictions and Mental Health
Program Name: Oregon State Hospital
Policy Option Package Initiative: Junction City Hospital
Policy Option Package Title: OSH Replacement Project –Next Phase
Policy Option Package Number: 403
Related Legislation:
Program Funding Team: Healthy People

Summary Statement:

This package will complete the next step in the Legislatively approved implementation of the The Oregon State Hospital Framework Master Plan.

It will allow the hospital to successfully open 125 beds at the Junction City Hospital and adequately fund the staffing and equipment required to care for patients admitted from counties in Southern Oregon.

If this package is not funded, it will not be possible to open the Junction City facility. Additional funding for staff and physical plant modifications will be necessary to keep Portland and BMRC open and reduced lengths of stay will not be achieved.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$2,994,904***	**($209,117)**	**($38,563)**	**$2,747,224**

- **Note: G/F $ adjusted by $5,096 in audit for reconciliation adjustments.**

Also, see the accompanying OHA Capital Construction Narrative under the Special Reports Section of this document which outlines the Other Fund request for Construction authority of $79.4M.

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Funding for this package will allow the hospital to successfully open 125 beds at the Junction City hospital with all supplies, equipment, and fully trained staff upon completion of construction. Construction is projected to be complete in the third quarter of 2014 with patient occupancy scheduled for the first half of 2015.

Based on our experience with moving into the Salem facility, OSH needs a minimum of six months after the building is turned over to the hospital to prepare the facility for occupancy. Occupancy preparation includes the installation of owner supplied fixtures (such as cubicles) supply stocking, safety and security evaluations, critical systems testing, and life/safety training and building orientation for staff. This will ensure that when we occupy the new facility, all necessary safety and security provisions are in place to care for patients. Funding of this package will allow the Junction City hospital to provide quality care for patients admitted from counties in Southern Oregon and achieve the standard of providing 20 hours of active treatment for each patient each week including education, self-improvement and skill-building activities during evening and weekend hours. Further, this package will provide sufficient staffing for the Junction City hospital to successfully operate three 25-bed hospital licensed units and two 25-bed secure residential treatment units, without significant reliance on overtime or contracted agency nurses, to provide sufficient coverage for positions that require continuous coverage on a 24/7/365 basis.

With the closure of 92 beds at the Portland facility and 60 beds at Blue Mountain Recovery Center, positions from these facilities would be utilized in combination with those provided through this package to provide the necessary resources for the hospital to continue implementing the treatment model at the Junction City hospital with smaller wards, single or double rooms, and centralized treatment services aimed at improving outcomes for patients, decreasing lengths of stay and improving safety for patients and staff. This package phases-in the hiring of positions to allow sufficient time for recruitment, orientation, deployment, and training with new technology and systems necessary for the opening of the new Junction City psychiatric treatment facility, in coordination with the construction schedule and closure of the Portland facility and Blue Mountain Recovery Center in 2015.

This package is essential to continue the development of the centralized delivery of treatment services model in Junction City ("treatment mall") with the focus on recovery-based individual treatment care plans for each patient. Patients will reside in residential units, but be scheduled to receive treatment, meals and work away from units throughout dedicated common areas.

The service delivery will aid in meeting individualized needs and security of patients and stimulate the motivation to participate in treatment. The staff hired through funding of this package will support the centralized services model for Junction City and will allow OSH to continue to achieve the goal of providing a minimum of 20 hours of active treatment per patient per week, plus other beneficial activities during evening hours and on weekends.

2. WHY DOES OREGON HEALTH AUTHORITY PROPOSE THIS POP?

Oregon Health Authority (OHA) proposes this package in order to successfully open the new Junction City facility with necessary safety equipment and sufficiently trained staff, to continue to increase the number of hours of active psychiatric treatment per patient per week and continue to improve overall safety for patients and staff. OSH's "treatment mall" approach to treatment and service delivery employs the design of centralized care in which patients' living areas are connected to a "neighborhood" mall that connects to a

larger "downtown mall". This affords patients access to at least 20 hours of active treatment services per week and allows more opportunity for healthy socialization and wellness activities.

The Oregon State Hospital Framework Master Plan focused on the physical condition of the Oregon State Hospital's Salem campus, and also noted that, "Oregon's system of publicly funded care for adults with severe and persistent mental illness (SPMI) needed significant improvement. . . and clarified the role and size of OSH within an improved community-based system." Completion and staffing of the Junction City facility is the next step in the implementation of the approved recommendations made in that plan.
In order to transition patients into the new facility, staff must be hired and join the organization with enough lead time in order to be oriented to technology and systems, and to participate in the development of protocols for patient movement and fire/life safety situations prior to the opening of the facility.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

A new modern state psychiatric facility will help keep people healthy and safe, support them in treatment and recovery, will improve their ability to live independently, and improve the quality of care.

This package will improve patient care and patient services for patients admitted from Southern Oregon Counties that currently reside at Blue Mountain Recovery Center, Portland OSH, and Salem OSH. This would allow the Junction City facility treatment team to deliver a minimum of 20 hours of active treatment per patient per week for all patients while allowing patients to be closer to their home and family support network. The design of the new hospital facilitates the delivery of centralized active treatment, patient privacy, and patient and staff safety.

This package will assist in restoring patients' optimal level of functioning by providing a secure place where individuals will have more independence, choices and responsibilities.

4. IS THIS POP TIED TO AN OREGON HEALTH AUTHORITY PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OREGON HEALTH AUTHORITY MEASURE THE SUCCESS OF THIS POP?

If funded, this proposal is expected to produce the following outcomes, among others:

a. Increased hours of active treatment per patient per week; 20 hours achieved in the 13-15 biennium
b. Reduced hours of seclusion and restraint use per 1,000 patient hours
c. Reduced rate of staff injuries
d. Increased nursing service hours per patient day
e. Reduced number of patient falls
f. Reduced lengths of patient stay
g. Reduced patient to patient assaults
h. Reduced overtime
i. Reduce the reliance and expense of using contracted services

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

The alternative to opening the new Junction City facility is to leave BMRC and Portland open. This would require an additional 128 positions between the two facilities, 84 positions in Portland and 44 positions at BMRC, The additional staff would be required to meet accepted staffing levels at both facilities to deliver 20 hours of active treatment each week for each patient. In addition to the staffing needs, a preliminary estimate of $24 million in remodel expenses would be required between the two facilities to meet the standards of modern psychiatric hospitals. Portland remodel expenses are estimated at $13 million and BMRC expenses

are estimated at $11 million. The current Portland facility lease expires in March of 2015; at this time, Legacy is not willing to extend the lease for more than a month or two.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

If this package is not funded, it will not be possible to open the Junction City facility. Patient and staff safety will be in jeopardy and reduced lengths of stay will not be achieved. Additional funding for staff and physical plant modifications will be necessary to keep Portland and BMRC open. Since the Portland lease is not renewable, it would result in all patients transferring to the Salem campus. The adverse effects of this include; placing OSH Salem well above the 85% recommended occupancy rate, limited bed availability for appropriate admissions from acute care hospitals which could result in longer wait times for admission to OSH, and there would be no additional capacity to accommodate the forecasted future caseload.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

No other agencies will be directly affected by this POP.

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

- Operating costs for the Junction City facility will begin in the last quarter of 2014, when the state takes possession of the building. Preparing the facility for occupancy will take up to six months after the building is turned over to the hospital. (See page 2 for details)
- The staff phase in plan is very compressed and assumes patient occupancy in late April of 2015 which will provide barely sufficient time for recruitment, New Employee Orientation, and discipline/department specific training.
- Five 25-bed units in the Junction City facility will be occupied at opening.
- An 85% occupancy rate between the Salem and Junction City facility will allow for fluctuation in admission rates.
- Neuropsychiatric medically infirm, and ‘fitness to proceed’ patients will be housed in Salem.

- The Junction City hospital will provide 20 hours of active treatment per week on each of the two treatment malls.
- The facility will be staffed at levels capable of delivering 20 hours of active treatment each week for each patient.
- The Patient Centered Care treatment model will be used in Junction City, consistent with the model currently in operation at OSH Salem.
- All equipment and supplies from Portland and BMRC in good condition at opening will be transferred to the Junction City facility.
- 75-Beds in Junction City will be CMS certified

Implementation Date(s): _____

End Date (if applicable): _____

a. Will there be new responsibilities for OREGON HEALTH AUTHORITY Specify which Program Area(s) and describe their new responsibilities.

☒ Shared Services	☒ Addictions & Mental Health
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐

b. Will there be new administrative impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected. See Addendum A - Administrative Services Division LC/POP Impact Questionnaire (at the end of this document).

This package will increase the workload for Human Resources (staff for recruitment and retention) and the Position Management Unit (establish/tracking). An additional 4 positions are required to manage the increased workload.

1	Human Resource Analyst 3's, Oregon Health Authority HR
1	Accounting Tech 3 position, Payroll, Shared Services
1	Human Resource Analyst 2, Classifications Unit, Shared Services
1	Human Resource Analyst 1, OFLA/FMLA, Shared Services
4	

The increased number of staff and technology equipment creates and increased need for Information Services and Security (staff for OIS/Electronic Health Record support, computer/peripherals and security). An additional three positions are necessary for Office of Information Services, Customer Services and Solutions department to manage the increased workload:

1	Info Systems Specialist 4, Desktop Support
1	Info Systems Specialist 3, Service Desk*3*
2	

The increased number of beds and staff at this new facility will increase the need for support from the Office of Investigations & Training. Two additional staff are necessary to manage the increased caseload.

2 Investigator 3
2

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

There are no additional caseload or service changes at this time. Pursuant to the AMH 2010 revised forecast report, the facility capacity is built to accommodate the forecasted caseload growth through 2025.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

An additional 173 full-time equivalents (FTE) will be required for the Junction City facility to open 125-beds and operate safely and to assure that at least 20 hours of active treatment is provided each week.

61 existing positions from Portland and BMRC need modification.

Total Staffing at OSH Facilities

With inclusion of staffing in this Policy Option Package (POP), total staffing for OSH upon completion of the new facility will be 2,382 positions for its Salem and Junction City campuses in 2013-15.

The breakout of the total positions is summarized:

2,240	Positions needed to staff OSH facilities in 2013-15 Policy Option Package (POP)
(1798)	Positions at Salem facility
(105)	Position transfer from the BMRC facility
(164)	Positions transfer from the Portland facility
173	Net need for positions requested in 2013-15 POP
2,128	Total positions for OSH campuses in 2011-13
173	Positions needed for OSH campuses in 2013-15
2,240	Total positions for OSH campuses in 2013-15

Staffing Focus:

August – November 2014:

Administrator hired to lead the effort in staffing the new facility

Nursing managers and supervisors hired to facilitate the hiring, training, and orientation of nursing staff.

Facilities manager hired to facilitate OSH install of owner supplied equipment after construction completion.

December 2014 – January 2015

Housekeeping and facility staff hired to prepare the facility for opening

Clinical positions with extensive orientation needs and the first cohort of nursing positions are phased-in

Nurse and CNA recruitment, hiring, Avatar training, and orientation

February - March 2015:

CNA recruitment, hiring, Avatar training, and orientation

Remaining non-nursing clinical positions phased in to join the treatment teams of the patients who will be transferring to the new facility.

April 2015:

Remaining administrative and security staff phased in.

May 2015:

Orientation and life/safety training for all staff working at Junction City Facility

Closure of Portland and BMRC facilities

Patient and staff occupancy of Junction City facility

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

Operational Capital Outlay	$	173,000
Pharmacy Services Medical Supplies	$	5,800
Essential Security and communication equipment	$	75,242
Recreation and educational supplies for patients	$	37,174
General unit supplies	$	75,000
Warehouse equipment and storage needs	$	10,500
Facility transportation and material movement equipment and supplies	$	34,600
Housekeeping supplies and equipment	$	25,230
Physical plant, maintenance, and grounds equipment and supplies	$	111,200
Kitchen equipment and supplies	$	205,000
Vandal resistant patient pay phones and switches	$	4, 628
Staff equipment and supplies	$	101,122
Total	**$**	**852,696**

f. What are the ongoing costs?

Lease of Pharmaceutical carts (mobile stations with barcode scanners):	$	85,800
Shift Differential Pay	$	32,023
Other Differential Pay	$	88,736
Overtime Payments	$	206,085
Total	**$**	**412,644**

g.

What are the potential savings?

While not entirely quantifiable in the short term, potential savings are expected in several areas when the new facility is complete, OSH campuses approach full staffing levels, and systems are implemented. Assuming the required number of staff is hired, oriented, and trained for OSH campuses, an increase in productivity is expected to translate into streamlined operations, and lower error rates in providing safe patient care without significant reliance on agency staff use and overtime.

Areas generating measurable savings in the long term are expected to result from increased efficiencies resulting from the BHIP hospital management system that includes efficient pharmacy operations, electronic medical records, and automated medication carts with barcode scanners, enhanced dietary delivery systems, and hands-free dictation devices for physicians, and accurate record keeping of treatments and medications provided to OSH patients.

h. Based on these answers, is there a fiscal impact?

Yes

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	2,928,288	(331,163)	(29,077)	2,291,014	278	17.17
Services & Supplies	104,034	(123,278)	(9,486)	(28,730)		
Capital Outlay	173,000	0	0	173,000		
Special Payments	0	0	0	0		
Other	0	0	0	0		
Total	**$2,928,288**	**($454,441)**	**($38,563)**	**$2,435,284**	**278**	**17.17**

NOTE: See the accompanying OHA Capital Construction Narrative under the Special Reports Section of this document which outlines the Other Fund request for Construction authority of $79.4M.

Oregon Health Authority - Fiscal Impact Summary by Program Area:

	Addictions & Mental Health	OHA Central & Shared Services	Program Area 3	Program Area 4	Total
General Fund	**$2,928,288**	**$66,616**	**$0**	**$0**	**$2,994,904**
Other Fund	**($454,441)**	**$245,324**	**$0**	**$0**	**($209,117)**
Federal Funds- Ltd	**($38,563)**	**$0**	**$0**	**$0**	**($38,563)**
Total Funds	**$2,435,284**	**$311,940**	**$0**	**$0**	**$2,747,224**
Positions	**278**	**8**	**0**	**0**	**286**
FTE	**17.17**	**2.15**	**0.00**	**0.00**	**19.32**

2013-15 Policy Option Package

Agency Name:	Oregon Health Authority (OHA)
Program Area Name:	Office of Information Services (OIS)
Program Name:	OIS Policy Team & CareAccord™ Program
Policy Option Package Initiative:	Oregon Health Information Technology
Policy Option Package Title:	OIS Policy Team & CareAccord™ Program
Policy Option Package Number:	406
Related Legislation:	Oregon Health Authority Measure Summary LC 350 - Health Information Technology

Program Funding Team:

Summary Statement:

This POP provides funding for permanent staff to support the expanding needs of health information technology policy analysis and OHA's statewide health information exchange (HIE) program, CareAccord™.

A permanent Policy Team provides strategic planning, policy analysis and governance for health information technology. It also provides staff support for public governance through the Health Information Technology Oversight Council and alignment of state efforts with federal goals.

A permanent CareAccord™ program team provides a means to engage with stakeholders, enroll participants and oversee the trust of secure health information exchange.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$1,004,489**	**$0**	**$999,683**	**$2,004,172**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

POP would be to support the following:

HIT Policy Team

An HIT policy team provides staff support for public committees, strategic planning, stakeholder engagement and policy analysis for health information technology.

- 5 permanent positions in OHA (5 non-management staff)
- policy analysis and development
- external stakeholder engagement
- staff support for Health Information Technology Oversight Council (HITOC)
- alignment of state efforts, such as Coordinated Care Organizations (CCOs), with federal goals
- intrastate, interstate and national coordination
- governance of health information technology

CareAccord™ Program

To support the ongoing evolution of CareAccord™ as a statewide secure mechanism to exchange health information, a program team establishes a means to communicate with stakeholders and participants, and provides program enrollment and oversight.

- 6 permanent positions in OHA (1 management and 5 non-management staff)
- stakeholder engagement

- program development
- engagement and outreach to potential participants, including CCOs
- intrastate, interstate and national information sharing

The work directly supports:

- Healthcare patients in Oregon
- all healthcare providers, including CCOs
- statewide care coordination and care transitions
- statewide secure, trusted health information exchange
- Medicaid providers
- Providers with certified electronic health record (EHR) systems
- Providers without certified EHR systems
- Quality improvement data sharing
- Clinical health information sharing
- Administrative health information sharing
- Administrative simplification
- Public and population health data analysis

The HIT Policy team and CareAccord™ program staff's efforts directly support the Governor's health system transformation goals to reduce healthcare costs, improve health and improve patient care. The CareAccord™ program and health information technology policy teams' efforts support the transformation to provide a secure and trusted bi-directional health information exchange, as well as allowing for more efficient quality reporting, data analysis and administrative simplification. This mechanism allows the healthcare community to improve health information communication and care coordination.

This POP would provide staff support for OHA's statewide health information exchange (HIE) program, CareAccord™, including the development of HIE programmatic services required to support CCOs and health system transformation. The POP would provide policy staff to analyze strategies and policies for OHA leadership and HITOC. This will allow HITOC to carry out its work of improving the health information technology landscape for all Oregonians; and for OHA to address policy, practices and governance for HIT systems that contain or connect to sensitive information about Oregonians. The POP would be implemented through staffing in OHA.

Much of the work to date to support HITOC and the CareAccord™ program—including policy, planning, development, engagement and operations—has been funded by a grant from the Office of the National Coordinator for Health IT (ONC), using federal stimulus funds. That funding stream will end in the fall of 2013, yet policies and coordination regarding statewide, interstate and national coordination will increase over the next two years. CCOs are identifying HIE as a key need for the model to succeed. This POP would provide the staff support that OHA needs to support further analysis, programmatic support and planning.

The CareAccord™ program and other health related initiatives are all affected by the use of HIT. An HIT policy team would support policy and governance work in OHA, providing analysis and support for decision-making about HIT practices and strategies that support OHA in serving Oregonians.

Relatedly, an ongoing policy team is needed to support the HITOC. HITOC, established in House Bill 2009, is comprised of eleven voting members appointed by the Governor and confirmed by the Senate. HITOC members are drawn from the public and private sectors, reflect the geographic diversity of Oregon, and include health care consumers, providers, and privacy and information technology experts. Under ORS 413.308, HITOC has a duty to develop Oregon's strategic plan for health IT (OSP) and oversee the plan's implementation. Using a process with extensive stakeholder input and involvement, HITOC developed the OSP and finalized it in September 2012. Various topics addressed by HITOC include HIE, electronic health records (EHRs), telehealth, HIT workforce development, technical assistance and strategies that promote

public and private health information technology collaboration to leverage resources and avoid duplicative efforts. Ongoing staff support is needed to carry out the work identified in the strategic plan and to support HITOC in providing the governance and transparency required to ensure public confidence in HIT.

2. WHY DOES OHA PROPOSE THIS POP?

This POP addresses policy and planning needs around health IT, program needs for HIE and OIS's strategic planning and policy development. As federal grant funds expire, it will support staffing for existing efforts, as well as expanded service in the CareAccord™ HIE program. Planning and governance, including stakeholder engagement and regular opportunities for public input, are vital to maintaining public trust in health IT systems in Oregon.

Health information technology coordination and collaboration in Oregon is key to the success of Coordinated Care Organizations and achievement of the OHA goals of better health, better care and lower costs. The ongoing health care transformation efforts in Oregon, and at the federal level, have created an environment that fosters innovative ways to coordinate health care. A result is an increasing demand to exchange health information electronically and to use health IT to ensure that health information is available when and where it is needed to improve health and health care.

CareAccord™, OHA's statewide HIE program, provides some of the initial services needed. Staffing is required to operate the program and to develop additional services needed for more robust care coordination. Without staff to engage and register users using a trusted process, connect with stakeholders about needs and public concerns, and continue program development, the program cannot succeed.

Coordination and standardization of HIT and HIE is needed in Oregon for both clinical and administrative health information sharing. The complex layers include:

1. Geography: local, county, state, and regional levels, including secure and trusted electronic exchange of health information across state boundaries and intrastate closed HIE systems;
2. Participants: all combinations of health care providers, hospitals, FQHCs, Indian Health Services, coordinated care organizations, government programs, quality measurement and improvement organizations, individual patients and their families, caregivers, long-term care facilities, behavioral health, public health, schools, social workers, prisons, caregivers, non-profits, case managers, etc.
3. White Space: geographic locations without broadband, populations without means to purchase or access HIT, providers with and without certified EHR systems, providers ineligible for federal programs to encourage adoption of health IT or who need assistance to use HIT effectively.

The HIT policy staff will serve important roles in ongoing efforts:

- Act as a resource for OHA to analyze policies and strategies for HIT.
- Provide planning and policy support for HITOC to develop statewide HIT strategies, including public and private strategies.
- Provide a centralized collaborative place to coordinate HIT service delivery and HIT purchases to reduce duplicative IT purchases and increase data sharing capabilities.
- Develop HIT strategies, and provide policy analysis and IT funding to connect health information within the state, between the state and private entities, across state boundaries, provider to provider, and provider to patient.
- Leverage resources and institutional knowledge across agencies, ensuring that the adoption of HIT will be as cost effective as possible.
- Support OIS leadership and coordinate with other OIS offices on analysis, strategic planning, portfolio management, policy development and oversight and value assessment.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

HIT Policy Team:
Both OHA and DHS have participated in Management System work through Mass Ingenuity, including a separate Management System for the Office of Information Services (OIS) that feeds into the OHA and DHS work. A core operating process of Policies, Practices and Governance is identified within OIS to support the mission, vision, values and goals of both OHA and DHS. The requested OIS Policy Team would support the work within the Policies, Practices and Governance operating process.

CareAccord™ Program:
The CareAccord™ Program supports the OHA mission, vision and values by operating a statewide secure mechanism to exchange health information.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?

This POP does not tie directly to an OHA performance measure.

The work included in this POP ties directly and indirectly to the Coordinated Care Organizations HIT Transformation Plans, quality improvement reporting and meaningful use measures. Performance measurement is to be conducted quarterly to determine the number of participants and usage of CareAccord™.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

This POP does not require a change to an existing statute or require a new statute.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Alternative considered for HIT Policy Team:

Apply for and utilize grant funding to support policy positions. The reason for rejection is that grant funding is time and scope limited. It may satisfy components of HIT policy work, but not fully support the HIT policy needs to support OHA and DHS.

Alternative considered for CareAccord™ Program:

Apply for and utilize grant funding to support CareAccord™ Program positions. OHA will seek grant funding to support CareAccord™ information technology and program development however, the funding will not support the ongoing operational staff to run the CareAccord™ Program.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

HIT Policy Team:

There will not be adequate staff to govern and analyze the various policies and practices for HIT. Key HIT policies will not be thoroughly analyzed, and statewide coordination would not occur regarding health information technology. HITOC would not receive analysis and staffing support to work through Oregon's health information needs.

CareAccord™ Program:
There will not be adequate staff to support the program. As a result, providers will not have the support they need to register for services or services will not develop to meet providers' needs. Stakeholders will not have clear opportunities for input, resulting in a loss of confidence in the program. Oregon will not experience the benefits of HIE for care coordination or reap the return on investments by the state and federal governments and by Oregonians who have contributed long hours to building the program.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

This POP funds the CareAccord™ Program staff who will operate the statewide health information exchange. This provides a service that supports statewide health information exchange including, but not limited to state, tribal and local governments who need a secure mechanism to share health information. It also reduces the burden for these governmental entities to create and operate separate secure and trusted health information exchange programs.

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): October 1, 2013

End Date (if applicable): _____

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

No, there will be no new responsibilities for OHA.

b. Will there be new administrative impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.

No, there will not be new administrative impacts to require additional funding.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This POP will indirectly affect all Oregonians by increasing secure health information exchange and promoting health information technology adoption and meaningful use.

To receive better health information coordination, including:

- Lower health care costs and costs to providers
- Improve patient care and safety
- Health care transitions and care coordination
- Administrative simplification

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

Request is for funding and position authority for 11 full-time permanent positions; 10 for 21 months, and 1 for 15 months to total 9.43 FTE.

PERMANENT POSITIONS and FUNDING REQUEST:

CareAccord™ Program

Position Abbr.	Class.	Working Title	Funding %	# months	Total FTE
Principal Executive/Manager E	MMS X7008 IA	CareAccord™ Program Manager	50% Grant/ 50% GF	21	0.88
Operations & Policy Analyst 4	OA C0873 AA	Program & Engagement Lead	50% Grant/ 50% GF	21	0.88
Operations & Policy Analyst 3	OA C0872 AA	Program Analyst	50% Grant/ 50% GF	21	1.76
Operations & Policy Analyst 2	OA C0871 AA	Business Analyst	50% Grant/ 50% GF	15	0.63
Total					4.15

HIT Policy Team

Position Abbr.	Class.	Working Title	Funding %	# months	Total FTE
Operations & Policy Analyst 4	OA C0873 AA	Lead Policy Analyst	50% Grant/ 50% GF	21	0.88
Operations & Policy Analyst 3	OA C0872 AA	Policy Analyst	50% Grant/ 50% GF	21	3.52
Total					4.4

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

The scope of this POP does not include changes to a computer system or programmatic needs such as materials or outreach travel. The scope is to fund staff positions for policy analysis of the rapidly changing health information technology landscape to determine policy and programmatic needs in Oregon.

f. What are the ongoing costs?

g. What are the potential savings?

h. Based on these answers, is there a fiscal impact?

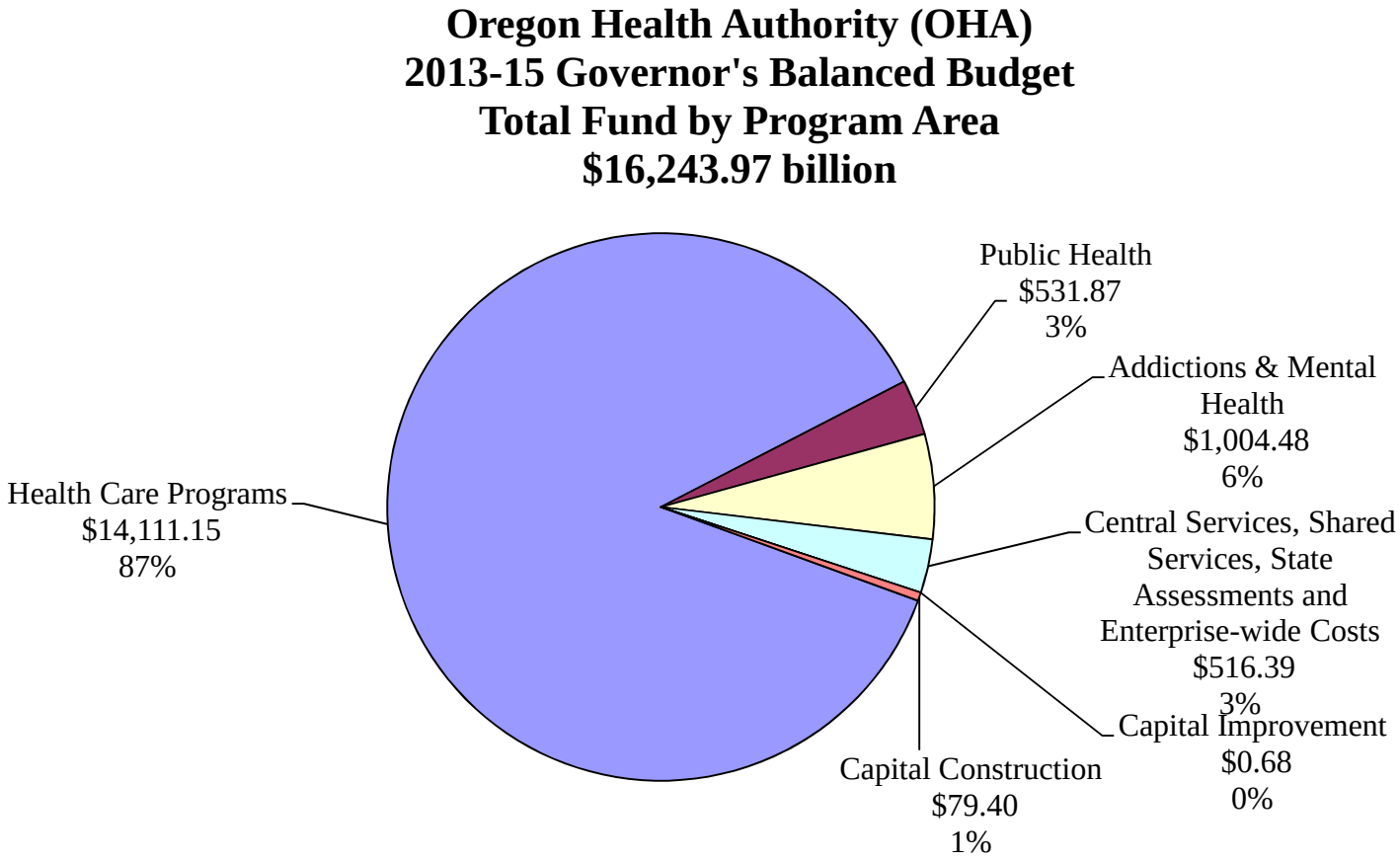
TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$843,732	$0	$840,438	$1,684,170	11	9.42
Services & Supplies*	$43,619		$42,138	$85,757		
Capital Outlay	$0	$0	$0	$0		
Special Payments	$0	$0	$0	$0		
Shared Services	$117,138	$0	$117,107	$234,245		
Total	**$1,004,489**		**$999,683**	**$2,004,172**	**11**	**9.42**

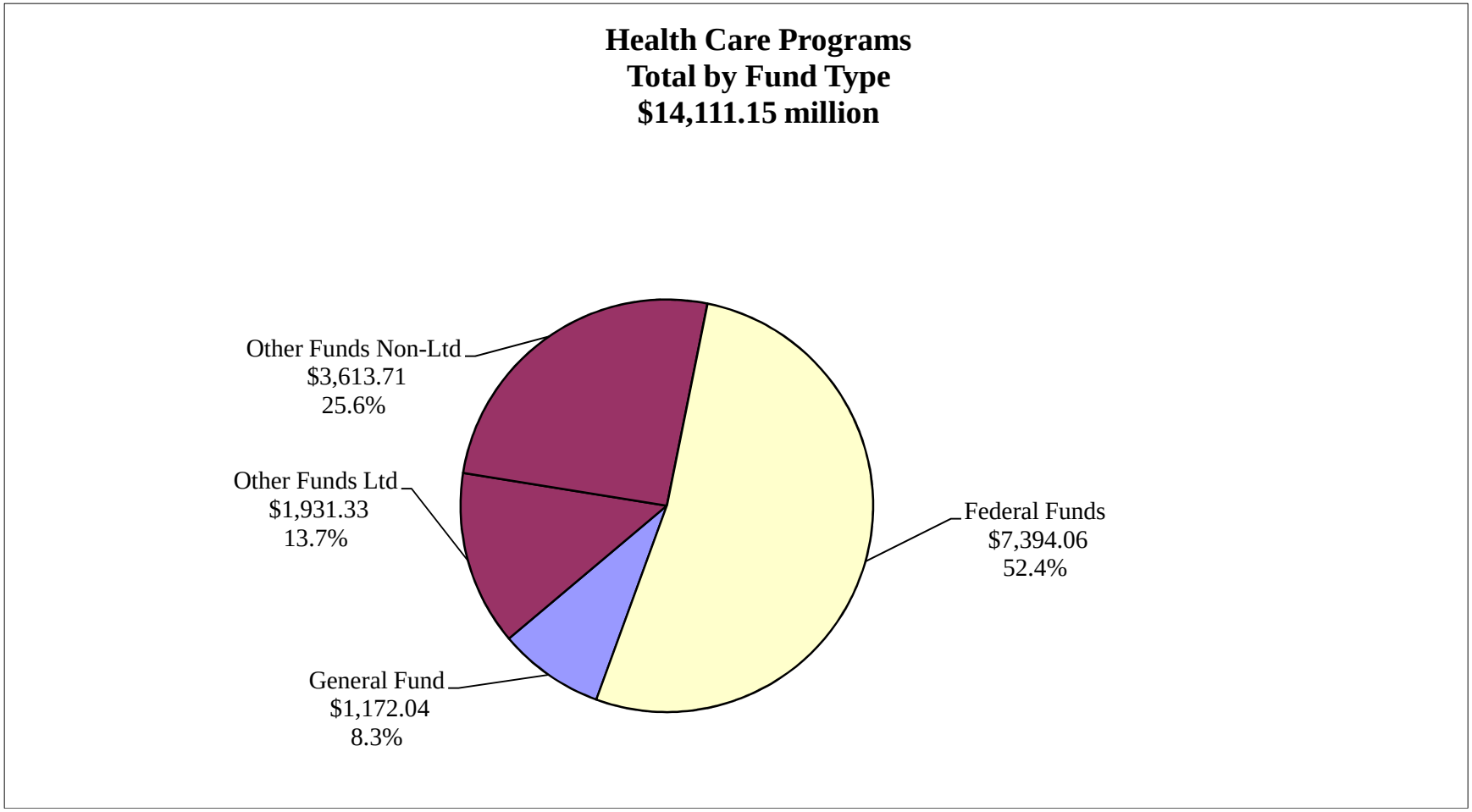
Oregon Health Authority –
Fiscal Impact Summary by Program Area:

	Program Area 1	Program Area 2	Program Area 3	Program Area 4	Total
General Fund	**$1,004,489**	**$0**	**$0**	**$0**	**$1,004,489**
Other Fund	**$0**	**$0**	**$0**	**$0**	**$0**
Federal Funds- Ltd	**$999,683**	**$0**	**$0**	**$0**	**$999,683**
Total Funds	**$2,004,172**	**$0**	**$0**	**$0**	**$2,004,172**
Positions	**11**	**0**	**0**	**0**	**11**
FTE	**9.42**	**0.00**	**0.00**	**0.00**	**9.42**

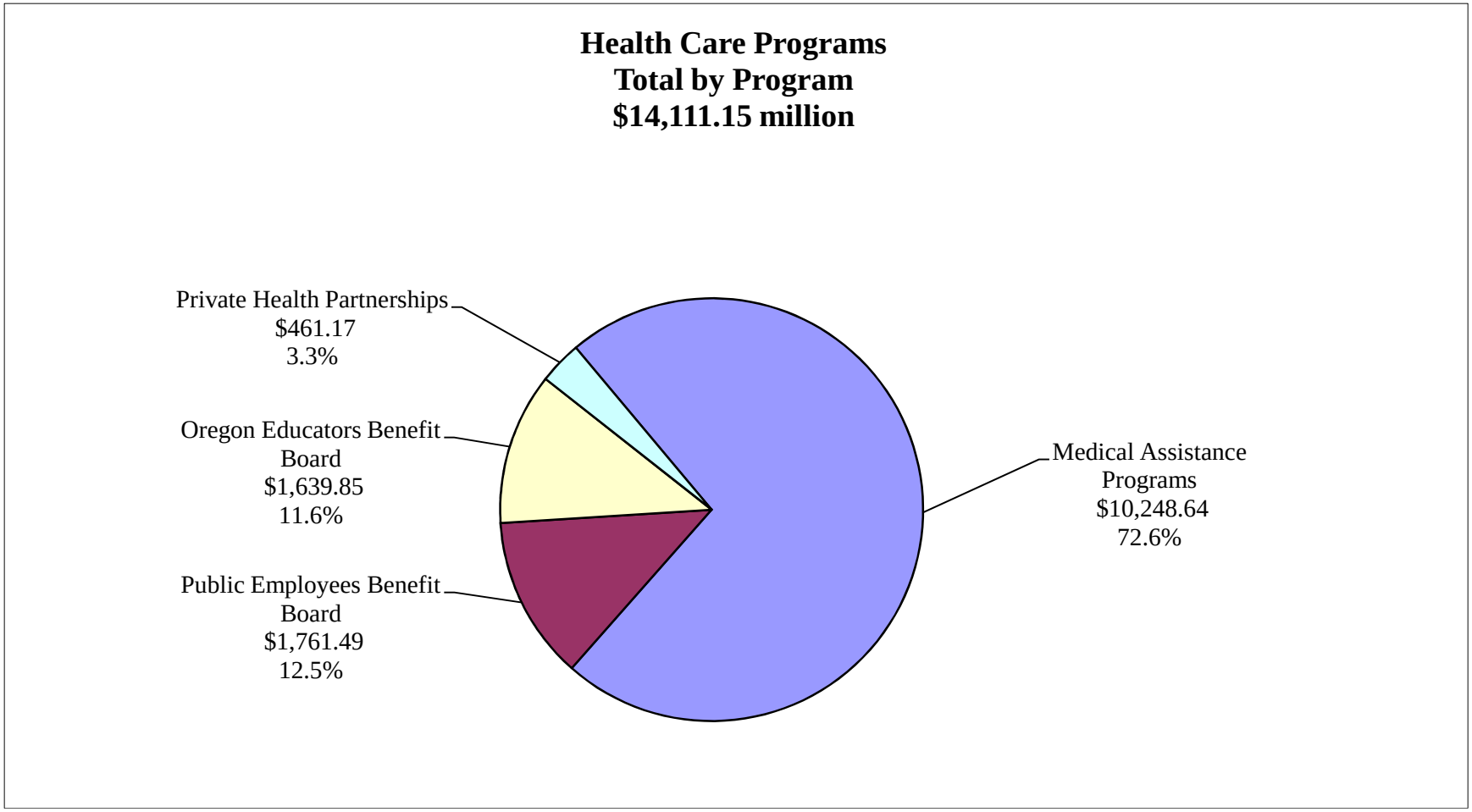
Oregon Health Authority (OHA)
2013-15 Governor's Balanced Budget
Total Fund by Program Area



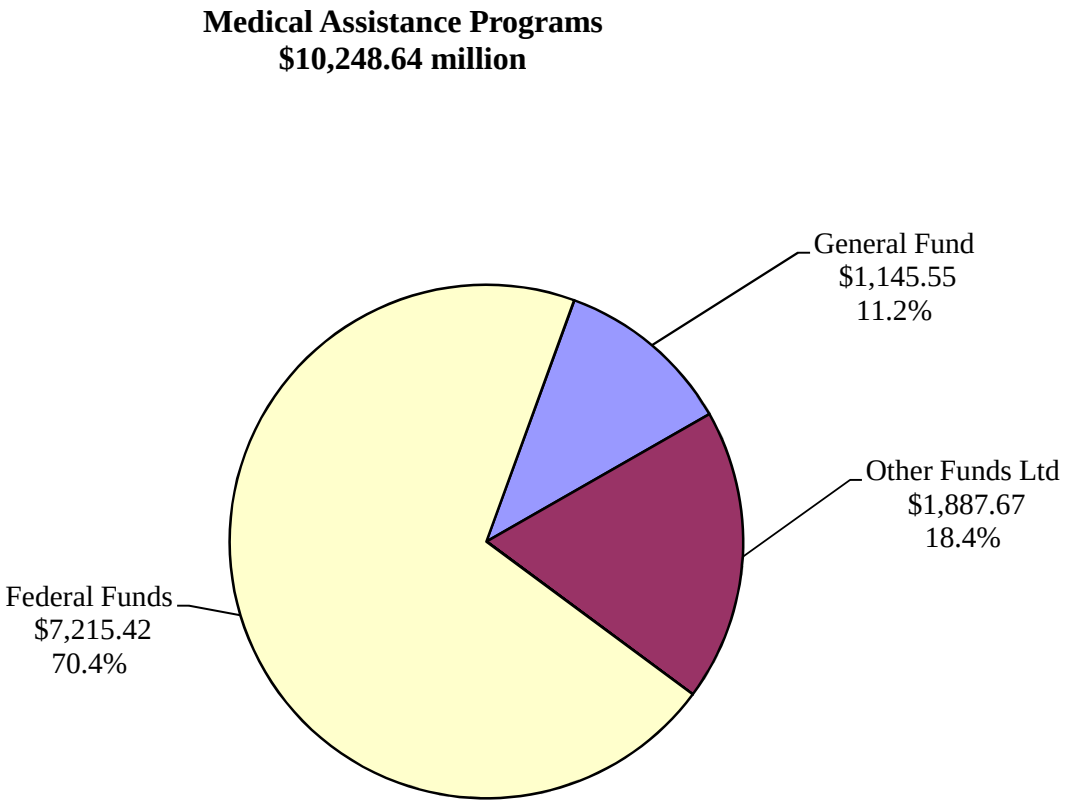
Health Care Programs Total by Fund Type



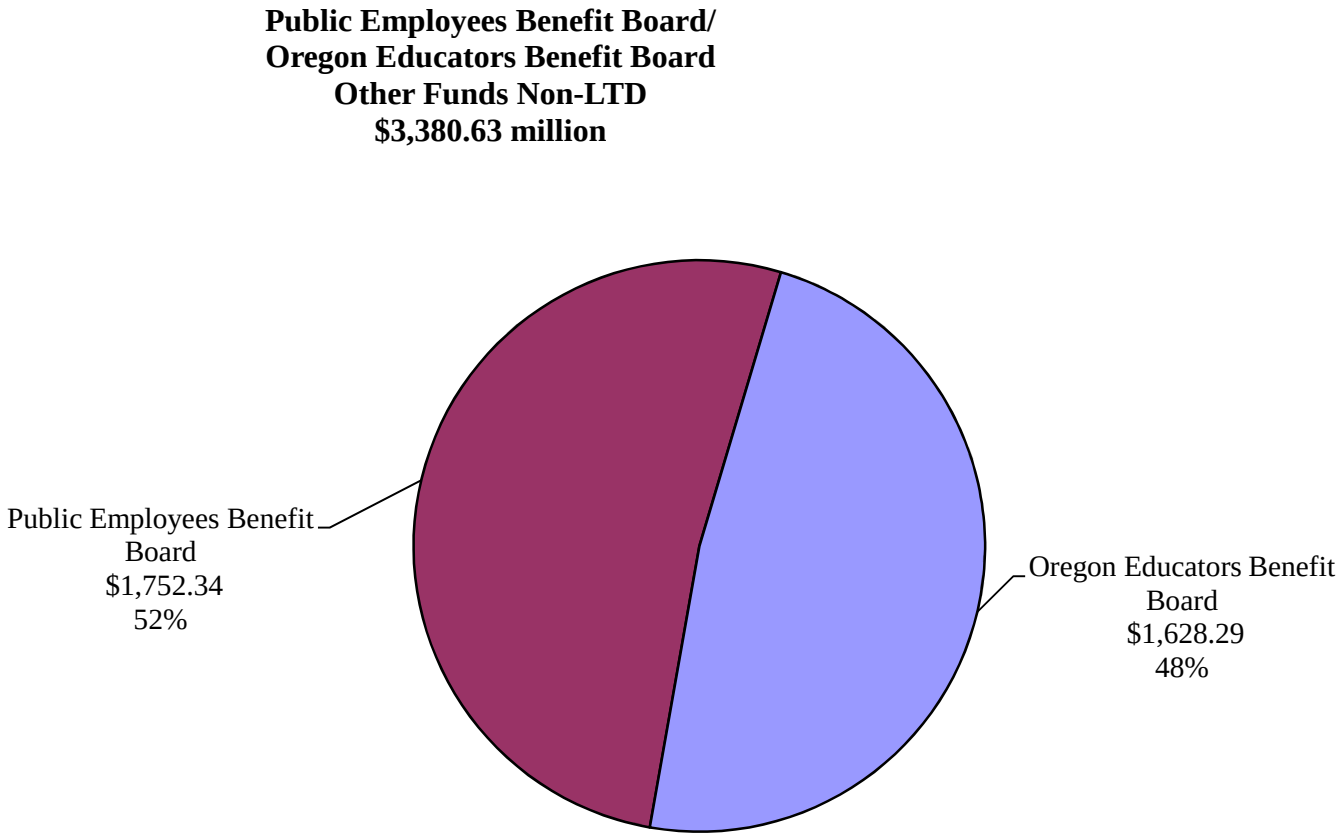
Health Care Programs Total by Program



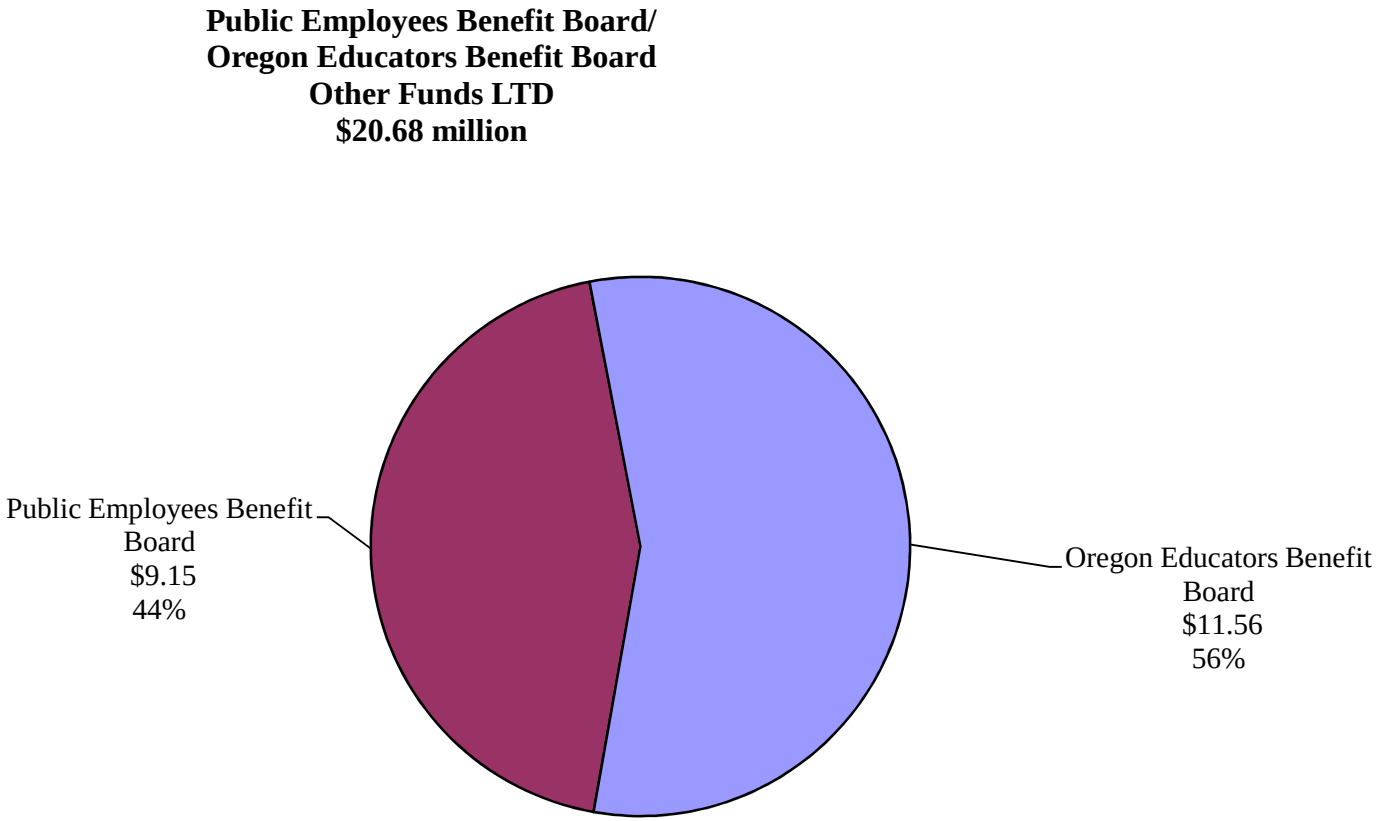
Medical Assistance Programs



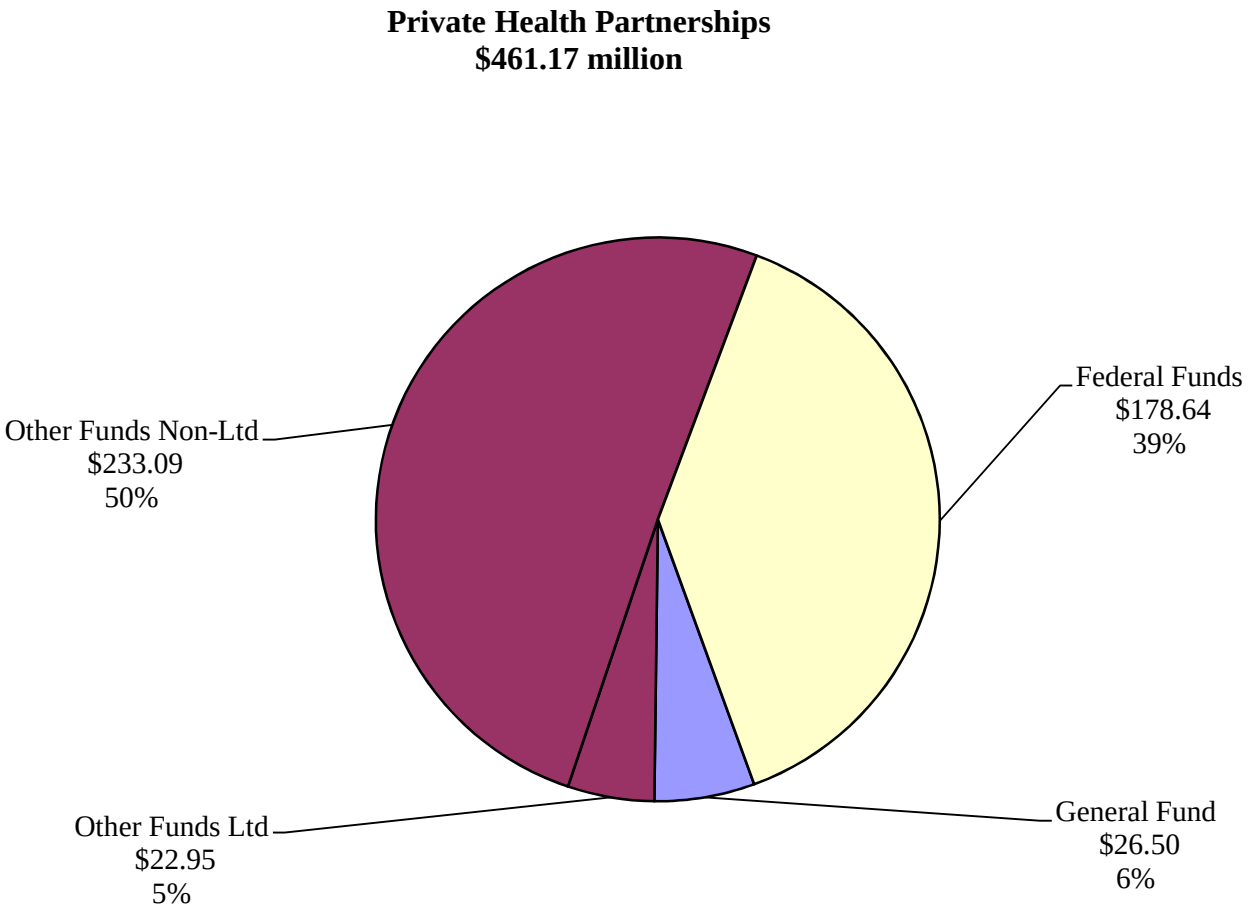
Public Employees Benefit Board/ Oregon Educators Benefit Board Other Funds Non-LTD



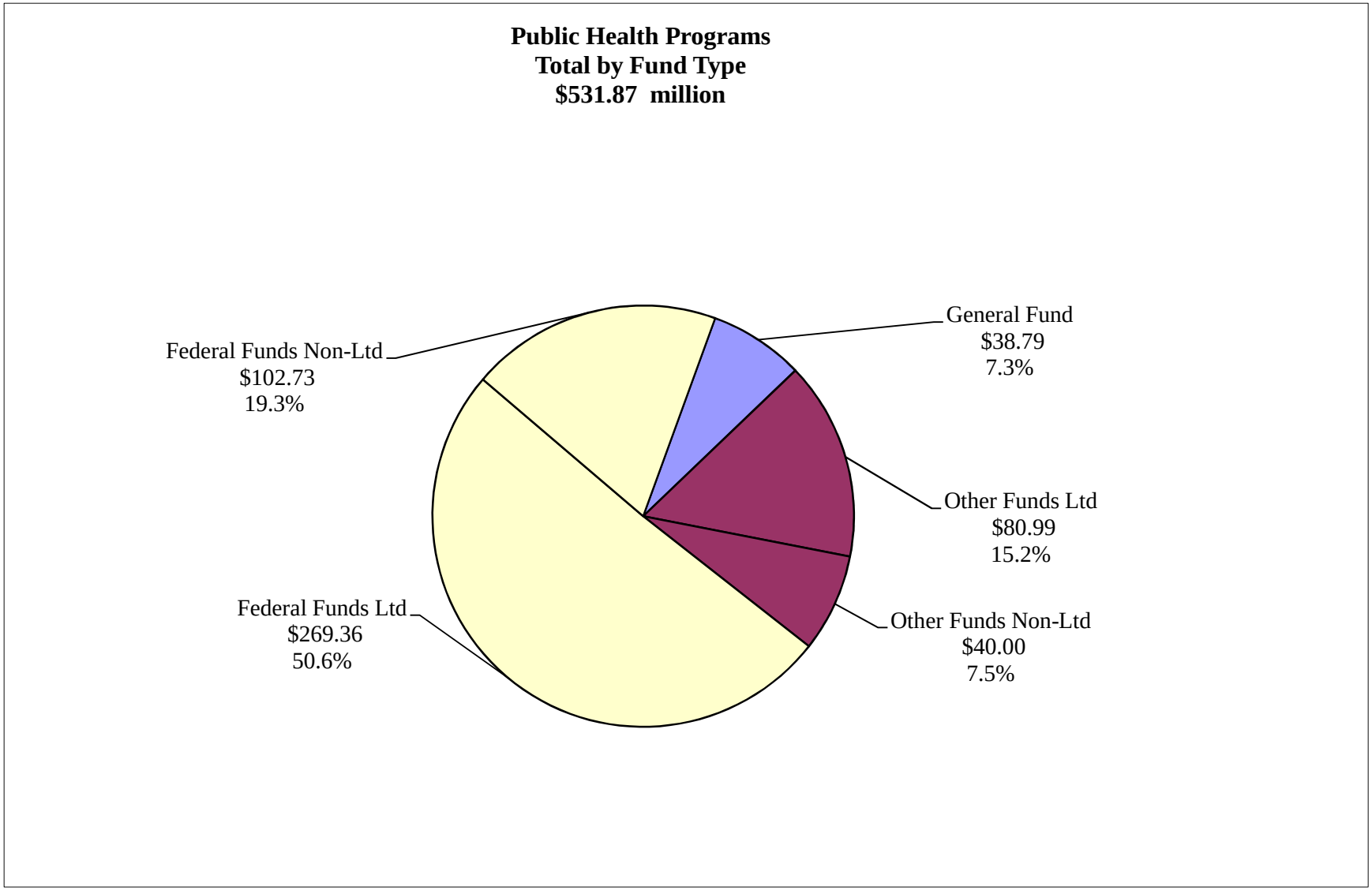
Public Employees Benefit Board/ Oregon Educators Benefit Board Other Funds LTD



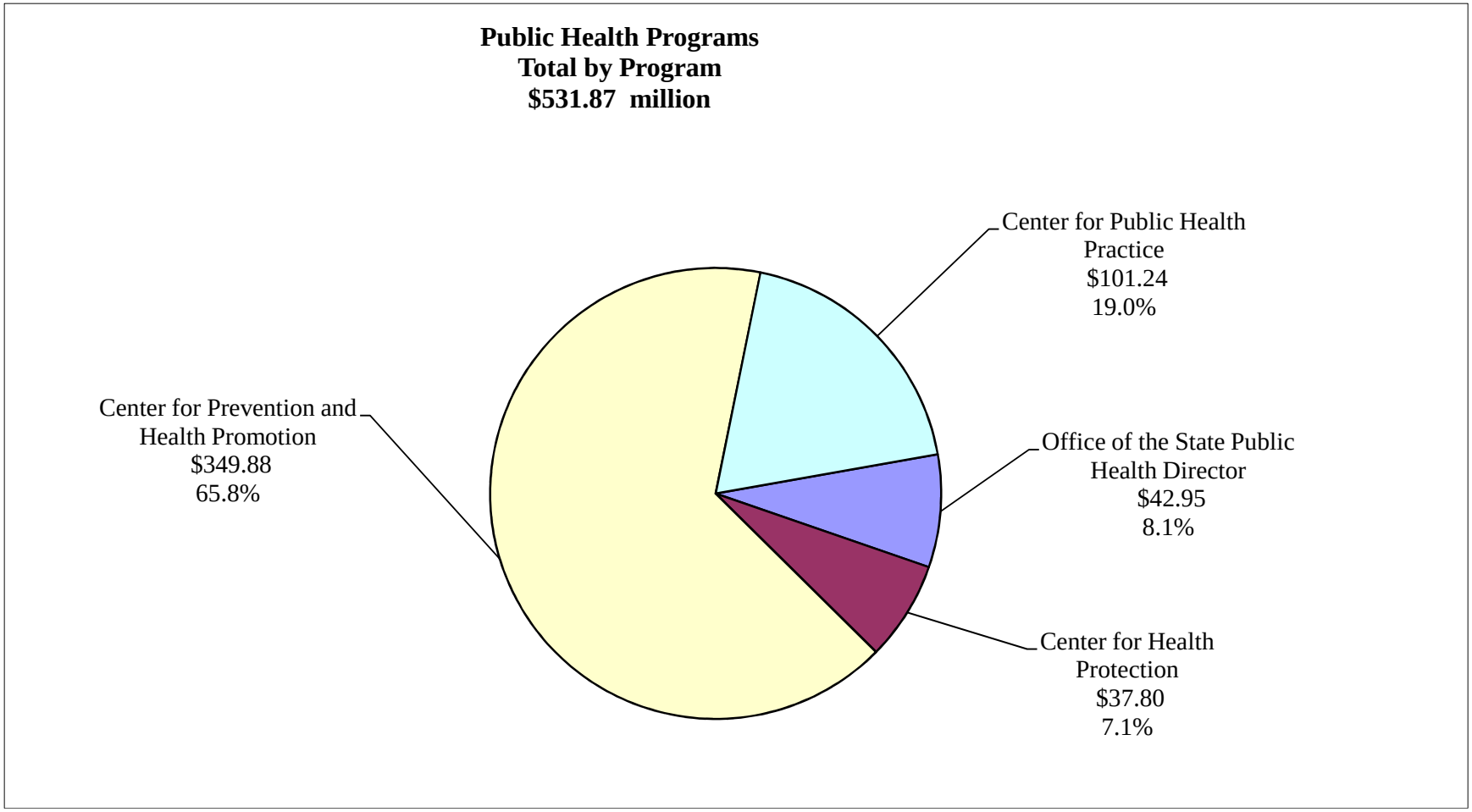
Private Health Partnerships



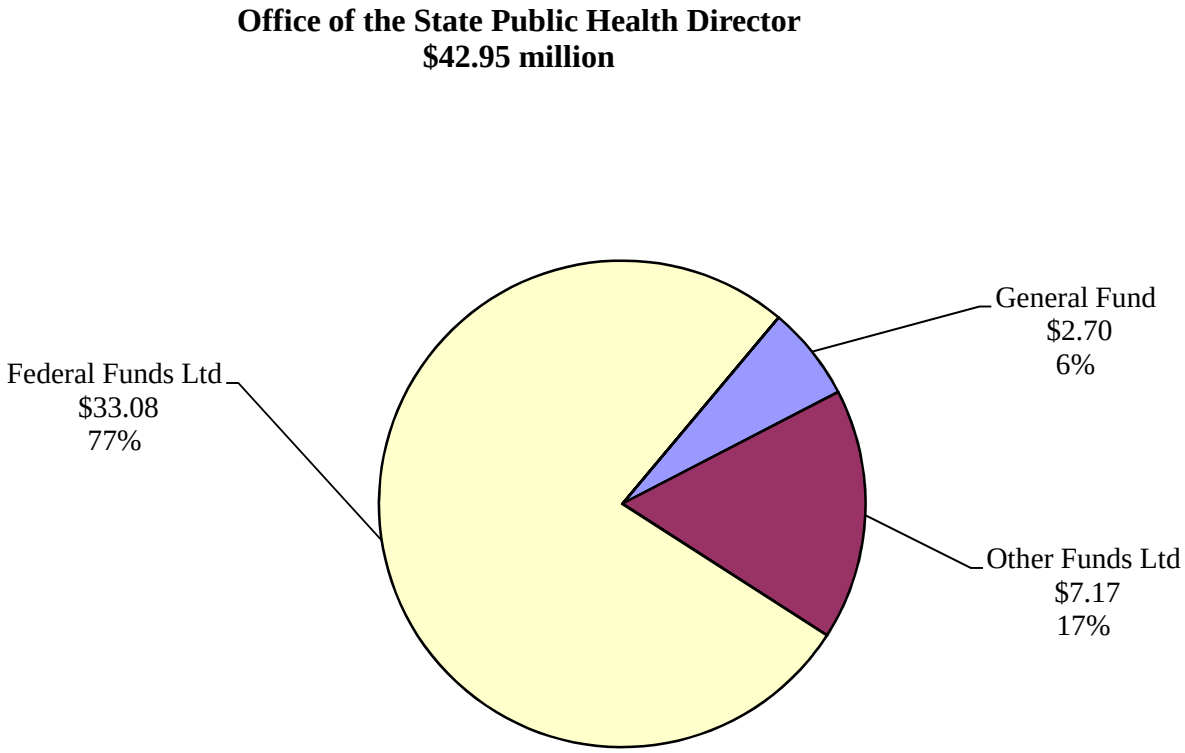
Public Health Programs Total by Fund Type



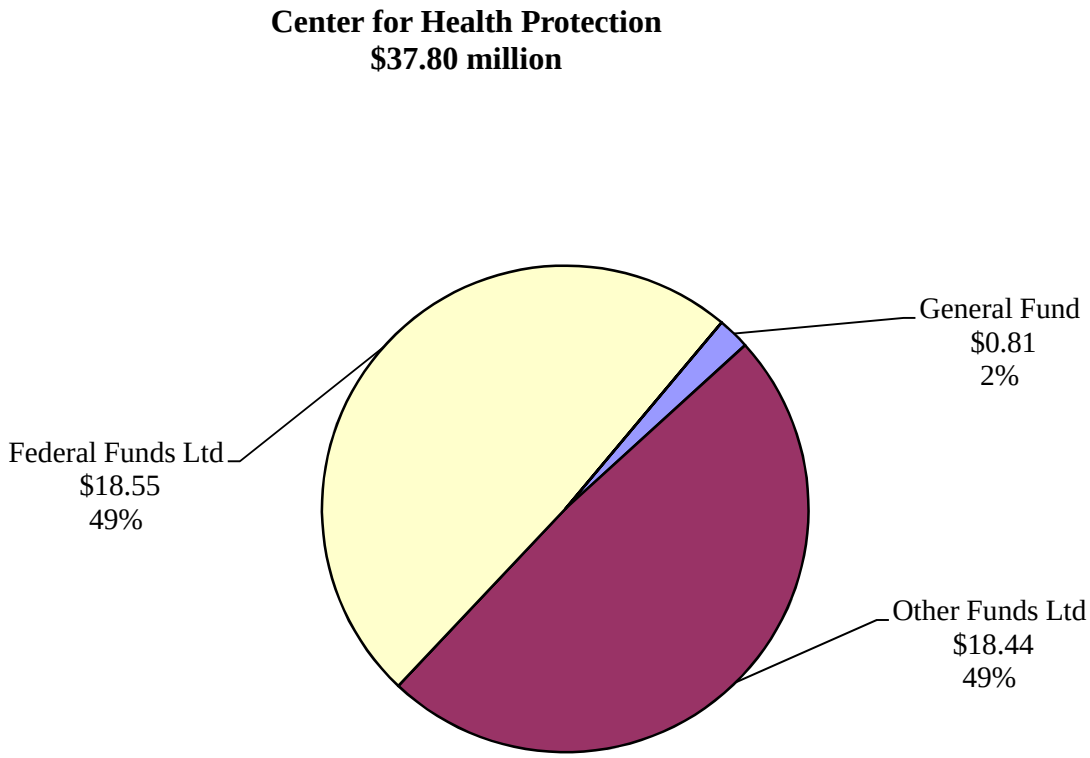
Public Health Programs Total by Program



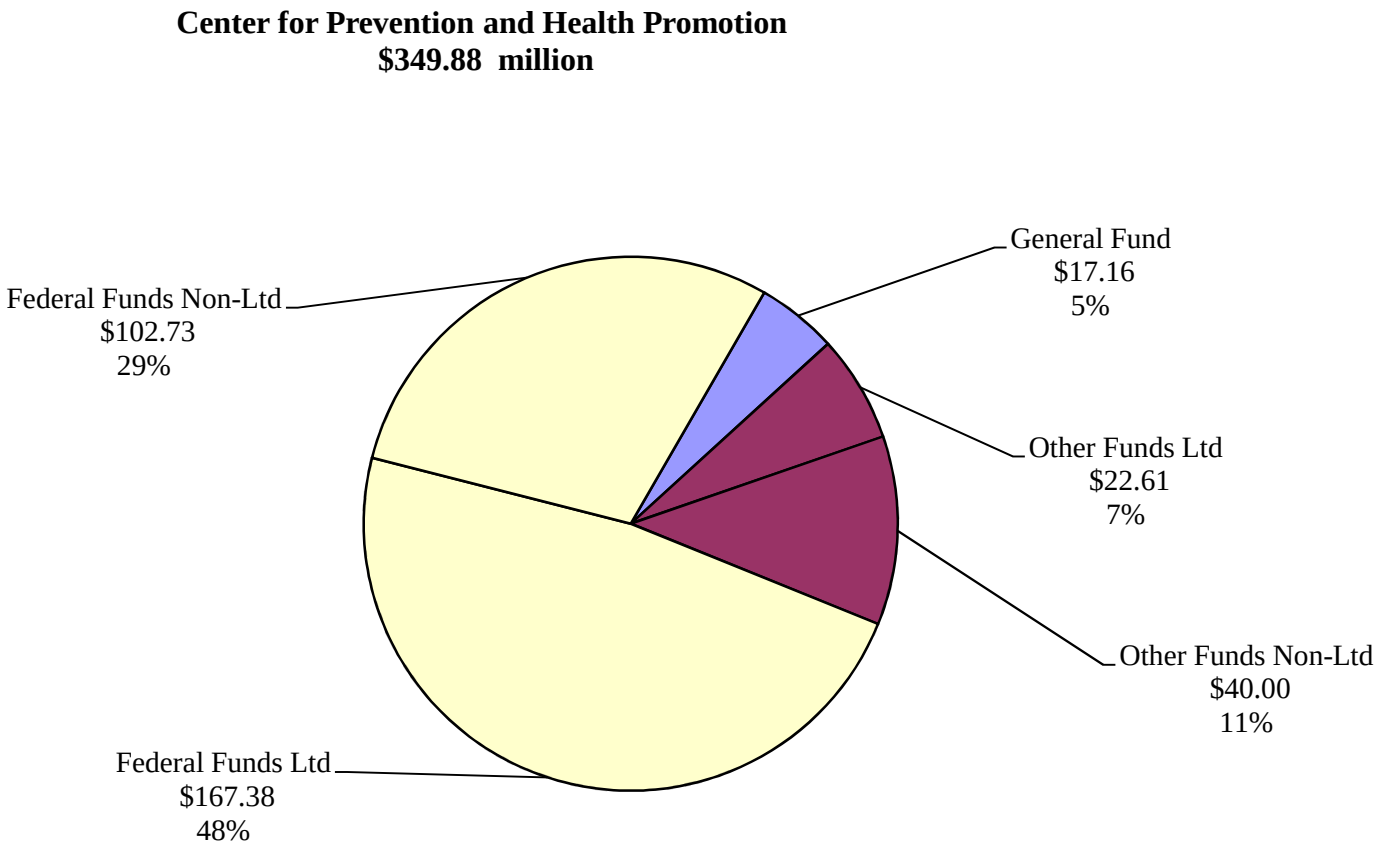
Office of the State Public Health Director



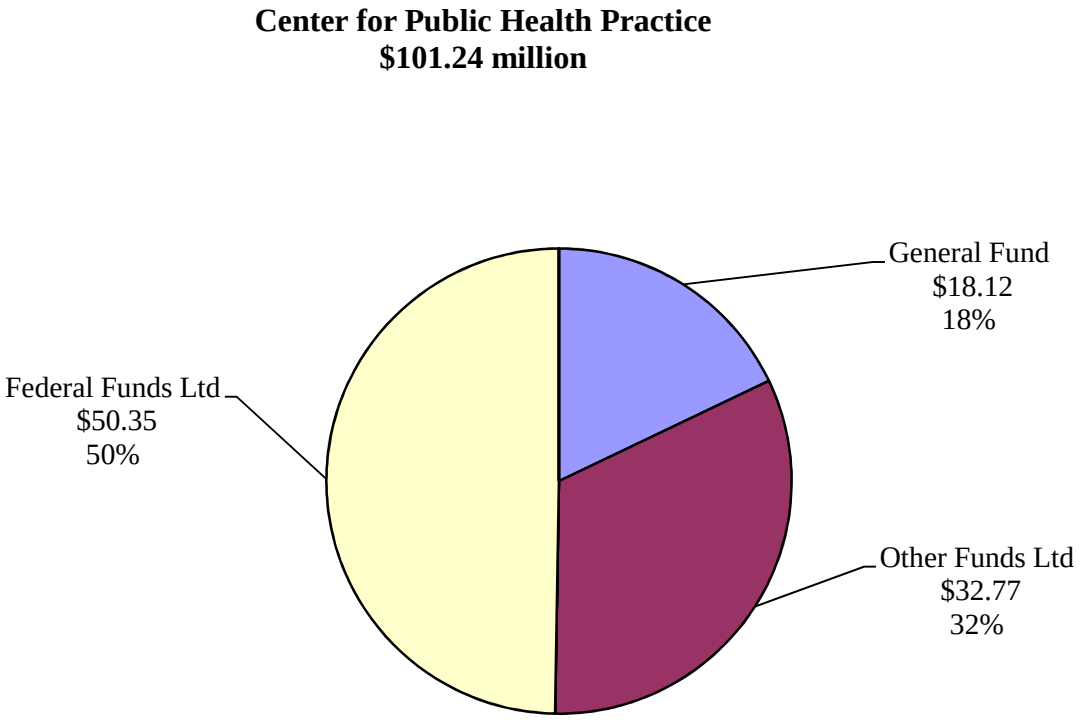
Center for Health Protection



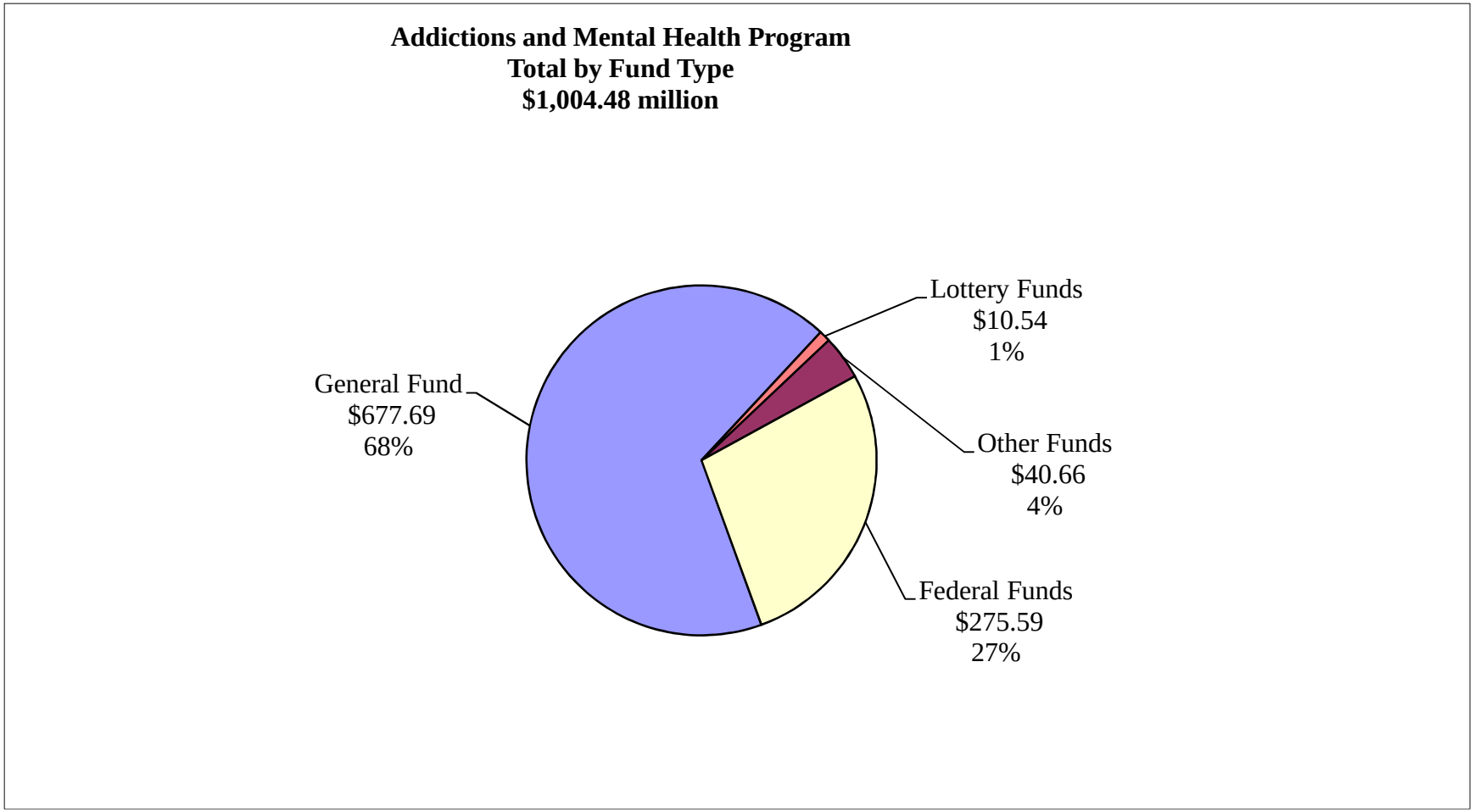
Center for Prevention and Health Promotion



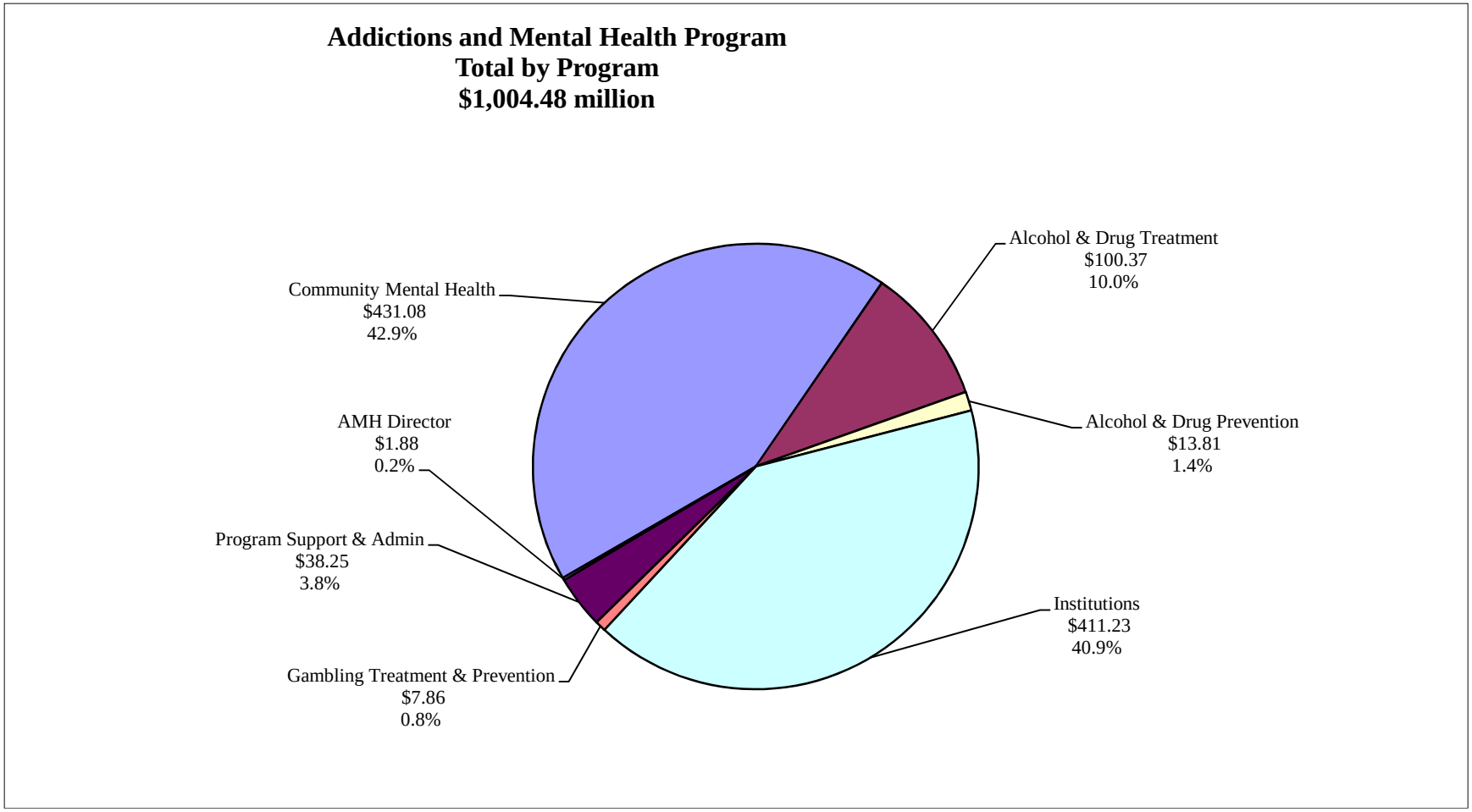
Center for Public Health Practice



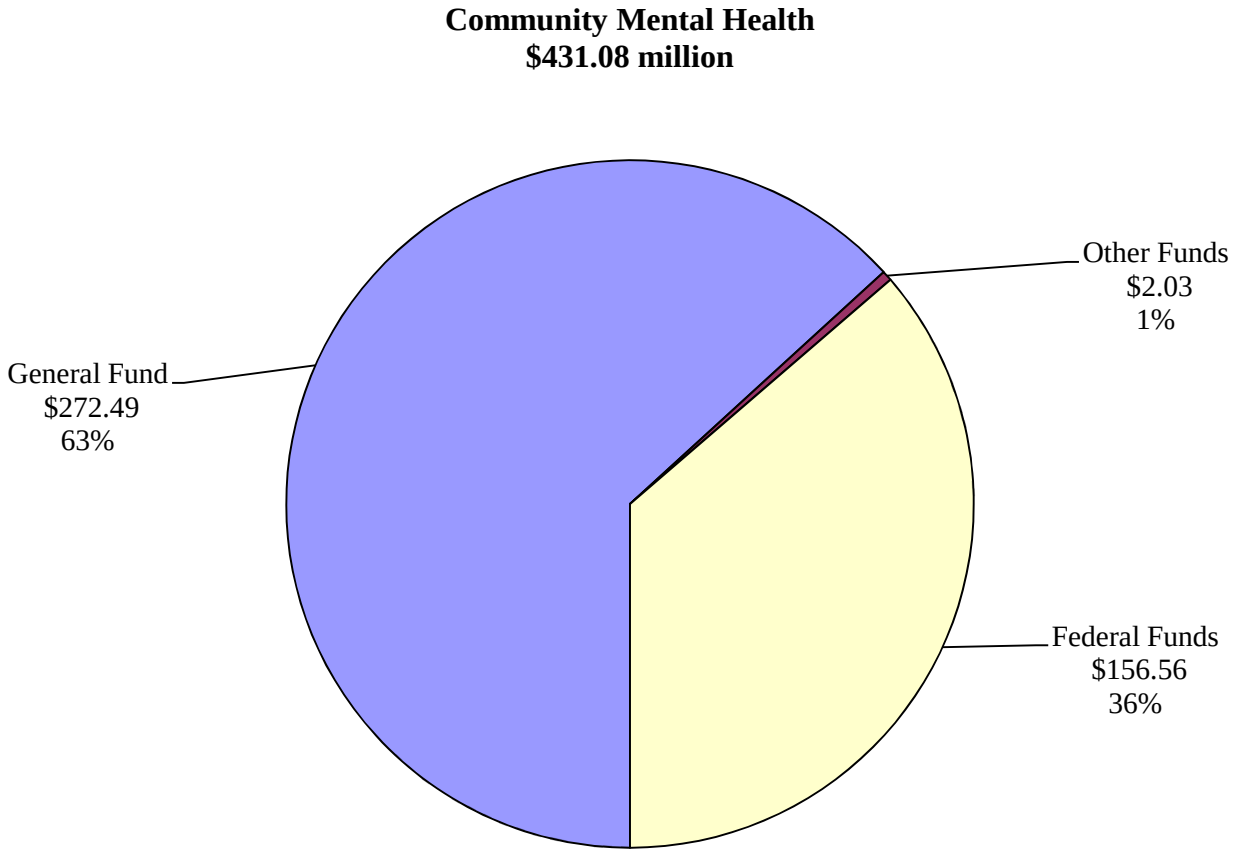
Addictions and Mental Health Program
Total by Fund Type



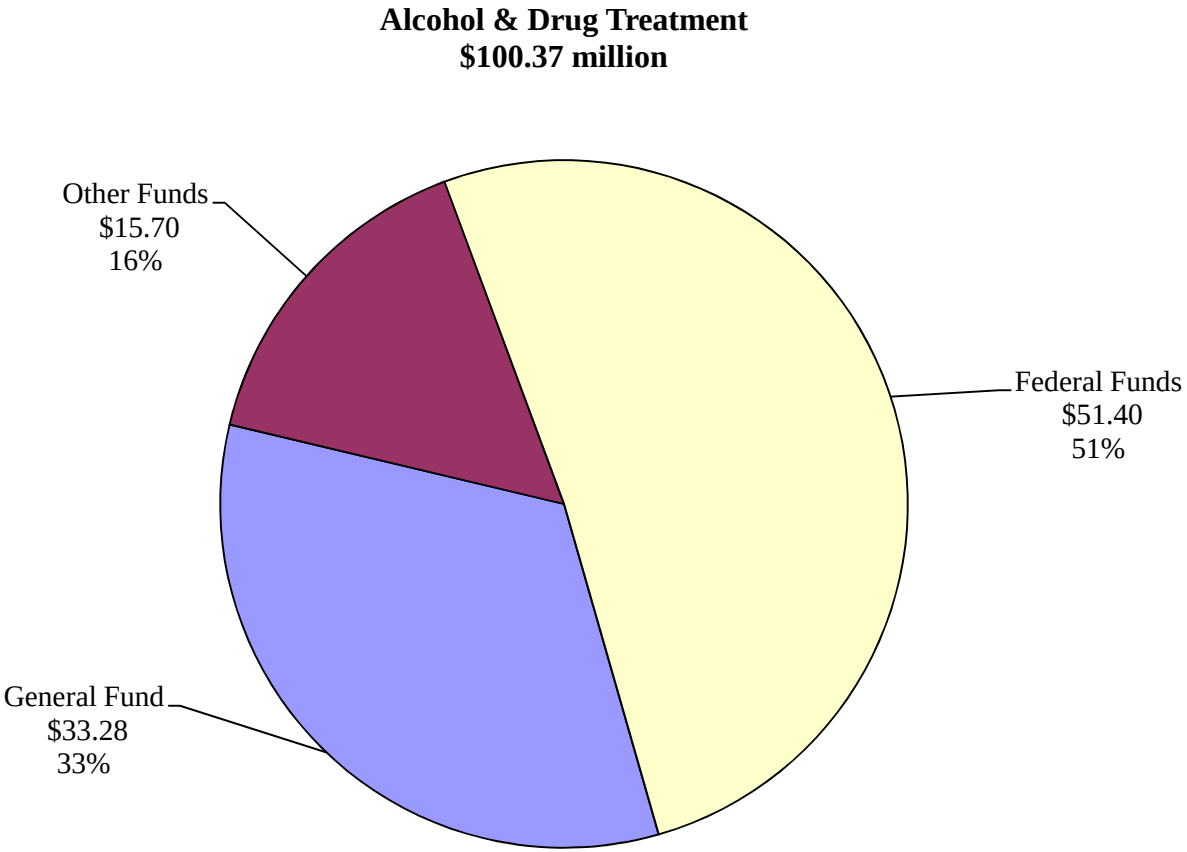
Addictions and Mental Health Program
Total by Program



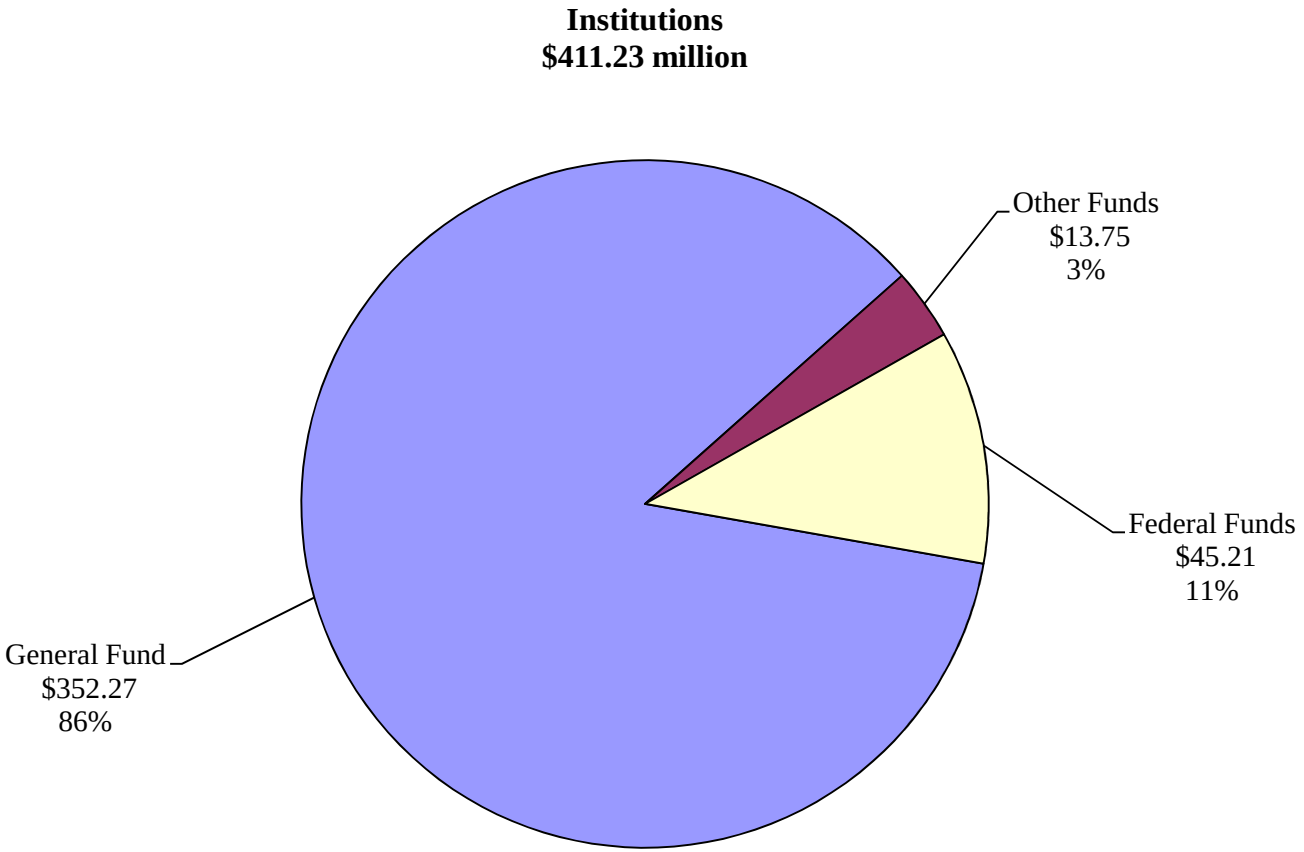
Addictions and Mental Health
Community Mental Health



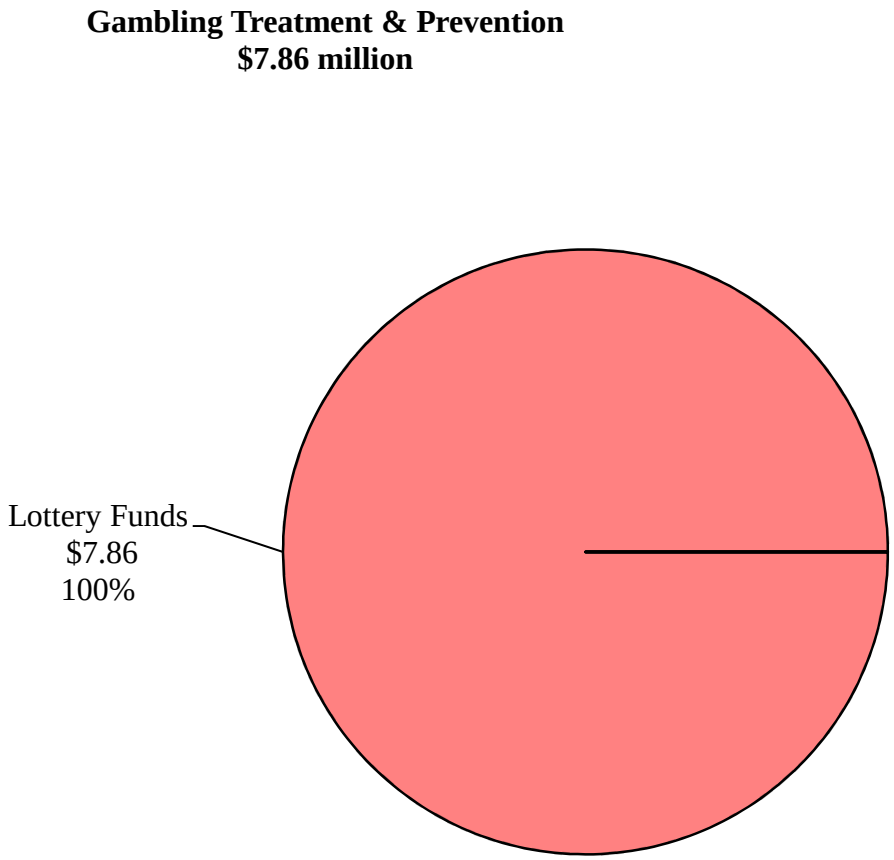
Addictions and Mental Health
Alcohol & Drug Treatment



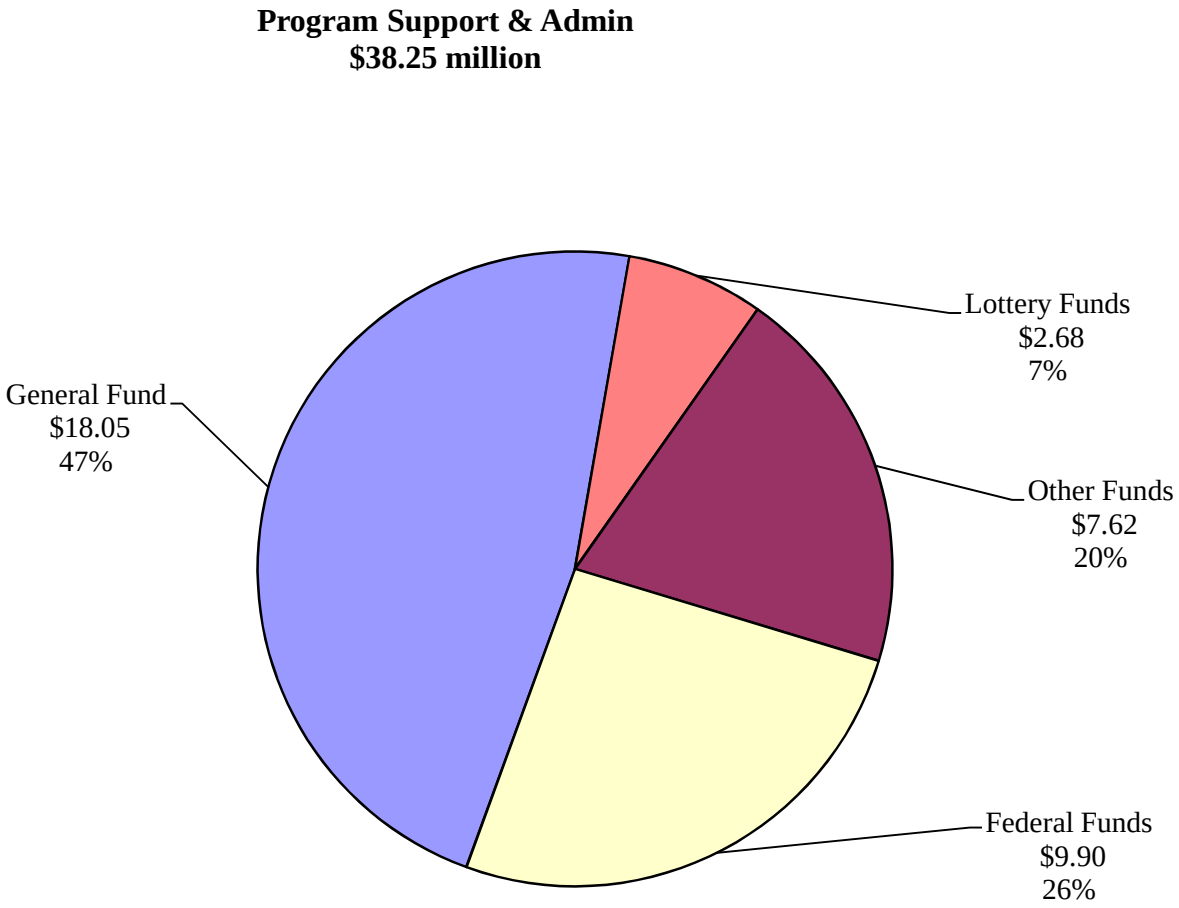
Addictions and Mental Health Institutions



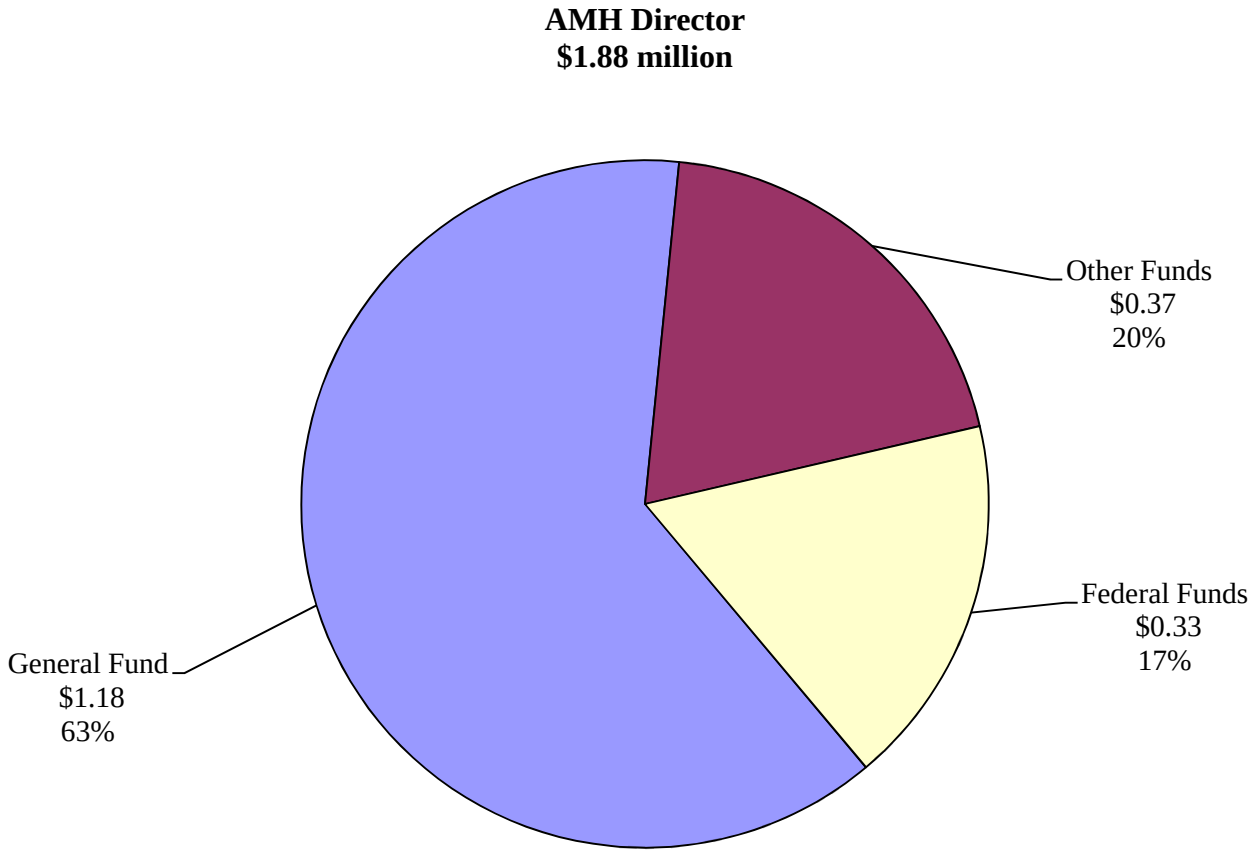
Addictions and Mental Health
Gambling Treatment & Prevention



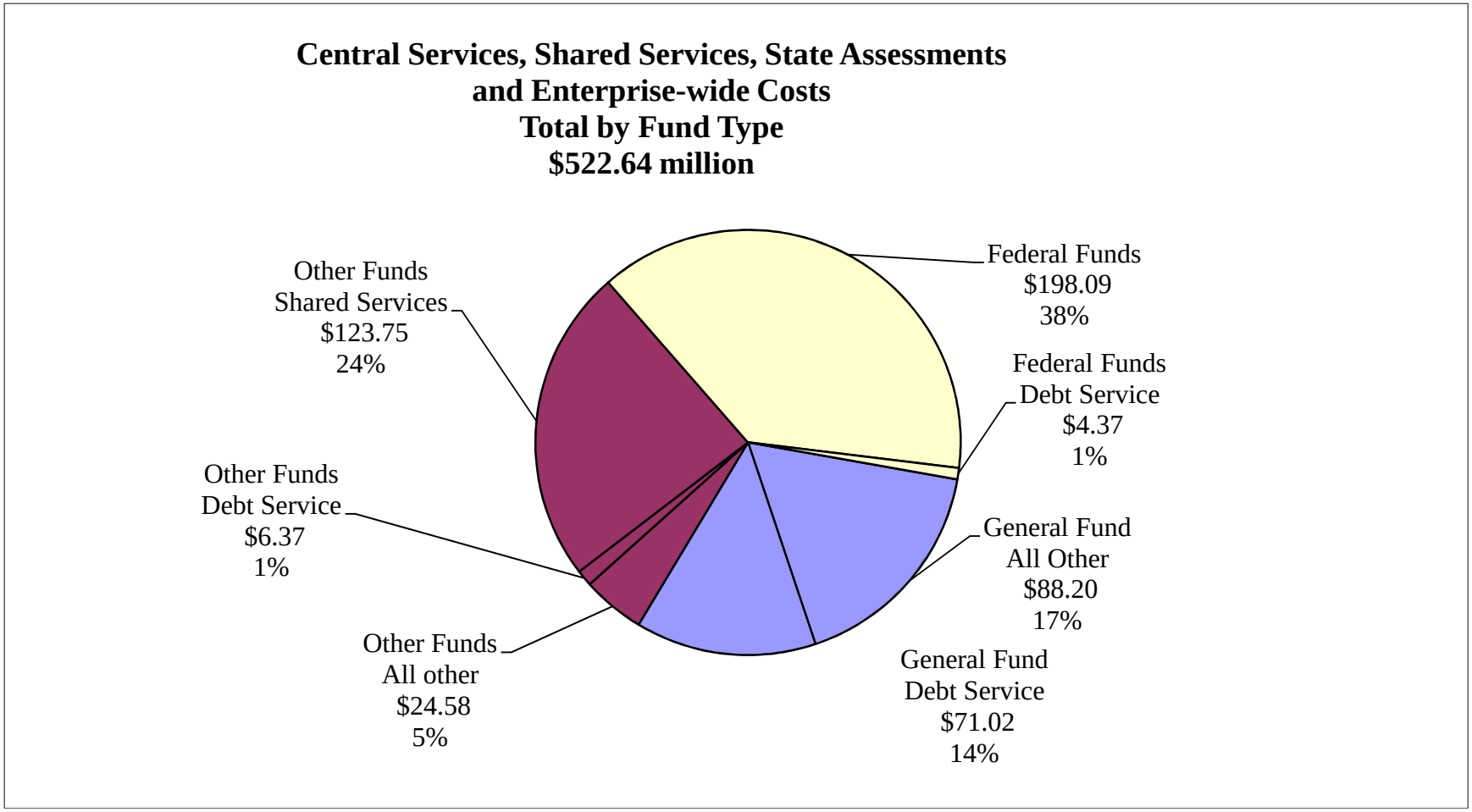
Addiction and Mental Health
Program Support & Admin



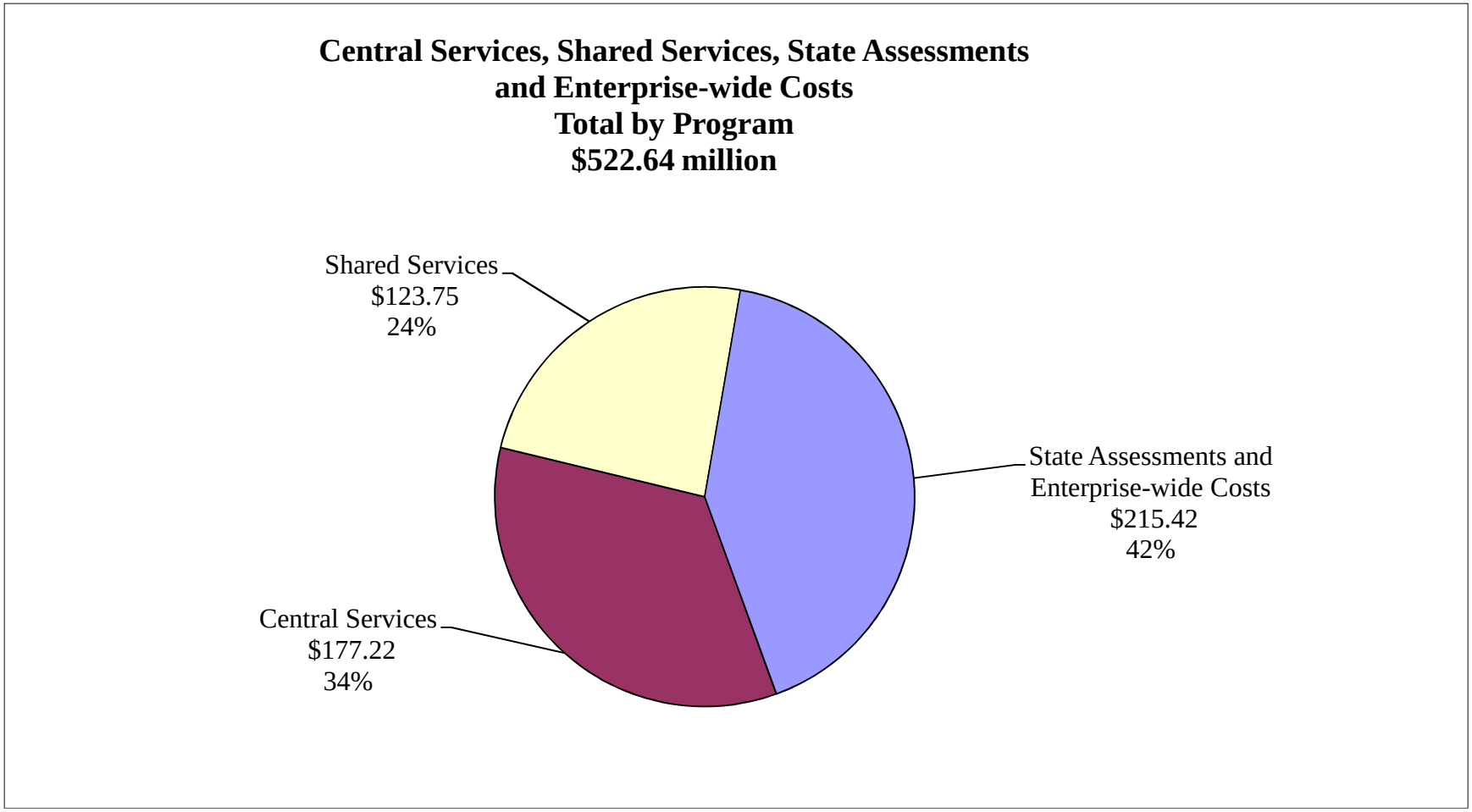
Addictions and Mental Health
AMH Director



Central Services, Shared Services, State Assessments and Enterprise-wide Costs
Total by Fund Type



Central Services, Shared Services, State Assessments and Enterprise-wide Costs
Total by Program



Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Addictions and Mental Health Program **Cross Reference Number: 44300-020-05-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	2,369	2,351.99	959,444,836	645,158,772	10,779,583	42,096,424	261,410,057	-	-
2011-13 Emergency Boards	(35)	(35.00)	11,800,613	3,297,984	(390,969)	5,726,586	3,167,012	-	-
2011-13 Leg Approved Budget	**2,334**	**2,316.99**	**971,245,449**	**648,456,756**	**10,388,614**	**47,823,010**	264,577,069	**-**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(12)	(2.77)	56,914,006	52,516,228	52,545	2,605,441	1,739,792	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**2,322**	**2,314.22**	**1,028,159,455**	**700,972,984**	**10,441,159**	**50,428,451**	266,316,861	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,129,176	958,424	4,801	48,634	117,317	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	2,673,010	2,449,281	1,666	90,084	131,979	-	-
Subtotal	**-**	**-**	**3,802,186**	**3,407,705**	**6,467**	**138,718**	249,296	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	24,702,978	33,619,378	800,963	(5,860,811)	(3,856,552)	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**24,702,978**	**33,619,378**	**800,963**	**(5,860,811)**	(3,856,552)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	17,261,174	10,042,571	230,863	882,686	6,105,054	-	-
Subtotal	**-**	**-**	**17,261,174**	**10,042,571**	**230,863**	**882,686**	6,105,054	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

Addictions and Mental Health Program **Cross Reference Number: 44300-020-05-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	75,139,390	45,140,685	-	-	29,998,705	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	281,921	-	-	(281,921)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	(16)	(16.00)	(188,713,129)	(73,291,007)	-	(20,138)	(115,401,984)	-	-
Subtotal: 2013-15 Current Service Level	**2,306**	**2,298.22**	**960,352,054**	**720,174,237**	**11,479,452**	**45,568,906**	183,129,459	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Addictions and Mental Health Program **Cross Reference Number: 44300-020-05-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**2,306**	**2,298.22**	**960,352,054**	**720,174,237**	**11,479,452**	**45,568,906**	183,129,459	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	(1)	(1.00)	(332,811)	-	-	(332,811)	-	-	-
Modified 2013-15 Current Service Level	**2,305**	**2,297.22**	**960,019,243**	**720,174,237**	**11,479,452**	**45,236,095**	183,129,459	**-**	**-**
080 - E-Boards									
081 - May 2012 E-Board	(17)	(16.50)	(3,370,581)	(2,824,075)	-	(173,860)	(372,646)	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**(17)**	**(16.50)**	**(3,370,581)**	**(2,824,075)**	**-**	**(173,860)**	(372,646)	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	(43)	(43.00)	(57,083,461)	(45,947,956)	(915,008)	(3,568,334)	(6,652,163)	-	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	(1,015,148)	(894,362)	(2,589)	(41,760)	(76,437)	-	-
093 - Other PERS Adjustments	-	-	(8,111,516)	(7,146,378)	(20,690)	(333,681)	(610,767)	-	-
094 - December 2012 Rebalance	-	-	98,982,024	(1,225,822)	-	-	100,207,846	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	278	17.17	2,435,284	2,928,288	-	(454,441)	(38,563)	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	12,625,000	12,625,000	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**235**	**(25.83)**	**47,832,183**	**(39,661,230)**	**(938,287)**	**(4,398,216)**	92,829,916	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

Addictions and Mental Health Program **Cross Reference Number: 44300-020-05-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**2,523**	**2,254.89**	**1,004,480,845**	**677,688,932**	**10,541,165**	**40,664,019**	275,586,729	**-**	**-**
Percentage Change From 2011-13 Leg Approved Budget	8.10%	-2.70%	3.40%	4.50%	1.50%	-15.00%	4.20%	-	-
Percentage Change From 2013-15 Current Service Level	9.40%	-1.90%	4.60%	-5.90%	-8.20%	-10.80%	50.50%	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Capital Construction **Cross Reference Number: 44300-089-00-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	-	-	59,900,000	-	-	59,900,000	-	-	-
2011-13 Emergency Boards	-	-	-	-	-	-	-	-	-
2011-13 Leg Approved Budget	**-**	**-**	**59,900,000**	**-**	**-**	**59,900,000**	-	**-**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	-	-	-	-	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			(59,900,000)	-	-	(59,900,000)	-	-	-
Subtotal 2013-15 Base Budget	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	-	-	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2013-15 Current Service Level	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Capital Construction **Cross Reference Number: 44300-089-00-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
080 - E-Boards									
081 - May 2012 E-Board	-	-	-	-	-	-	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	-	-	-	-	-	-	-
093 - Other PERS Adjustments	-	-	-	-	-	-	-	-	-
094 - December 2012 Rebalance	-	-	-	-	-	-	-	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	-	-	79,401,530	-	-	79,401,530	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**-**	**-**	**79,401,530**	**-**	**-**	**79,401,530**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority
Capital Construction
2013-15 Biennium

Agency GRB Working
Cross Reference Number: 44300-089-00-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**-**	**-**	**79,401,530**	**-**	**-**	**79,401,530**	-	**-**	**-**
Percentage Change From 2011-13 Leg Approved Budget	-	-	32.60%	-	-	32.60%	-	-	-
Percentage Change From 2013-15 Current Service Level	-	-	-	-	-	-	-	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Capital Improvements **Cross Reference Number: 44300-088-00-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	-	-	663,318	663,318	-	-	-	-	-
2011-13 Emergency Boards	-	-	(663,318)	(663,318)	-	-	-	-	-
2011-13 Leg Approved Budget	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	-	-	-	-	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	679,238	679,238	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**679,238**	**679,238**	**-**	**-**	-	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2013-15 Current Service Level	**-**	**-**	**679,238**	**679,238**	**-**	**-**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Capital Improvements **Cross Reference Number: 44300-088-00-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**-**	**-**	**679,238**	**679,238**	**-**	**-**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**-**	**-**	**679,238**	**679,238**	**-**	**-**	-	**-**	**-**
080 - E-Boards									
081 - May 2012 E-Board	-	-	-	-	-	-	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	-	-	-	-	-	-	-
093 - Other PERS Adjustments	-	-	-	-	-	-	-	-	-
094 - December 2012 Rebalance	-	-	-	-	-	-	-	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	-	-	-	-	-	-	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority
Capital Improvements
2013-15 Biennium

Agency GRB Working
Cross Reference Number: 44300-088-00-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**-**	**-**	**679,238**	**679,238**	**-**	**-**	-	**-**	**-**
Percentage Change From 2011-13 Leg Approved Budget	-	-	-	-	-	-	-	-	-
Percentage Change From 2013-15 Current Service Level	-	-	-	-	-	-	-	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
OHA Central Services **Cross Reference Number: 44300-010-40-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	121	118.04	158,327,429	69,199,731	-	18,670,241	66,083,046	-	4,374,411
2011-13 Emergency Boards	-	-	80,912,525	2,139,813	-	(31,170)	78,803,882	-	-
2011-13 Leg Approved Budget	**121**	**118.04**	**239,239,954**	**71,339,544**	**-**	**18,639,071**	144,886,928	**-**	**4,374,411**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	3	1.43	(3,340,953)	1,155,355	-	188,675	(4,684,983)	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(69,215,191)	(54,161,379)	-	(10,679,401)	-	-	(4,374,411)
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**124**	**119.47**	**166,683,810**	**18,333,520**	**-**	**8,148,345**	140,201,945	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,825,766	1,193,711	-	73,034	559,021	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	165,122	78,691	-	(71,789)	158,220	-	-
Subtotal	**-**	**-**	**1,990,888**	**1,272,402**	**-**	**1,245**	717,241	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	10,709,684	-	-	266,554	10,443,130	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(56,988,458)	-	-	(2,271,428)	(54,717,030)	-	-
Subtotal	**-**	**-**	**(46,278,774)**	**-**	**-**	**(2,004,874)**	(44,273,900)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	2,739,782	672,401	-	107,841	1,959,540	-	-
Subtotal	**-**	**-**	**2,739,782**	**672,401**	**-**	**107,841**	1,959,540	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
OHA Central Services **Cross Reference Number: 44300-010-40-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	266,498	(266,498)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	21	21.00	4,078,584	2,789,541	-	258,283	1,030,760	-	-
Subtotal: 2013-15 Current Service Level	**145**	**140.47**	**129,214,290**	**23,067,864**	**-**	**6,777,338**	99,369,088	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
OHA Central Services **Cross Reference Number: 44300-010-40-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**145**	**140.47**	**129,214,290**	**23,067,864**	**-**	**6,777,338**	99,369,088	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**145**	**140.47**	**129,214,290**	**23,067,864**	**-**	**6,777,338**	99,369,088	**-**	**-**
080 - E-Boards									
081 - May 2012 E-Board	-	-	-	-	-	-	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	(2,232,474)	(460,415)	-	(231,075)	(1,540,984)	-	-
091 - Statewide Administrative Savings	-	-	(359,916)	(198,472)	-	(3,913)	(157,531)	-	-
092 - PERS Taxation Policy	-	-	(73,428)	(35,935)	-	(3,528)	(33,965)	-	-
093 - Other PERS Adjustments	-	-	(586,727)	(287,135)	-	(28,192)	(271,400)	-	-
094 - December 2012 Rebalance	-	-	45,000,000	-	-	-	45,000,000	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	2	2.00	4,420,577	2,581,414	-	(294,567)	2,133,730	-	-
403 - OSH Replacement Project Next Phase	1	0.38	66,330	66,330	-	-	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	11	9.42	1,769,927	887,351	-	-	882,576	-	-
Subtotal Policy Packages	**14**	**11.80**	**48,004,289**	**2,553,138**	**-**	**(561,275)**	46,012,426	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority
OHA Central Services
2013-15 Biennium

Agency GRB Working
Cross Reference Number: 44300-010-40-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**159**	**152.27**	**177,218,579**	**25,621,002**	**-**	**6,216,063**	145,381,514	**-**	**-**
Percentage Change From 2011-13 Leg Approved Budget	31.40%	29.00%	-25.90%	-64.10%	-	-66.70%	0.30%	-	-100.00%
Percentage Change From 2013-15 Current Service Level	9.70%	8.40%	37.20%	11.10%	-	-8.30%	46.30%	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Oregon Health Authority **Cross Reference Number: 44300-000-00-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	4,089	4,033.27	12,001,337,489	1,721,639,876	10,779,583	1,989,328,229	4,877,574,818	3,294,911,521	107,103,462
2011-13 Emergency Boards	(53)	(53.00)	146,455,831	(24,581,752)	(390,969)	18,594,801	152,833,751	-	-
2011-13 Leg Approved Budget	**4,036**	**3,980.27**	**12,147,793,320**	**1,697,058,124**	**10,388,614**	**2,007,923,030**	5,030,408,569	**3,294,911,521**	**107,103,462**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(17)	(5.77)	62,847,683	59,206,873	52,545	(679,257)	4,267,522	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			6,198,900	16,860,966	-	(10,662,066)	-	-	-
Base Nonlimited Adjustment			537,387,820	-	-	-	-	537,387,820	-
Capital Construction			(59,900,000)	-	-	(59,900,000)	-	-	-
Subtotal 2013-15 Base Budget	**4,019**	**3,974.50**	**12,694,327,723**	**1,773,125,963**	**10,441,159**	**1,936,681,707**	5,034,676,091	**3,832,299,341**	**107,103,462**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	10,363,925	4,807,191	4,801	4,522,119	1,029,814	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	5,139,022	2,835,798	1,666	1,208,573	1,092,985	-	-
Subtotal	**-**	**-**	**15,502,947**	**7,642,989**	**6,467**	**5,730,692**	2,122,799	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	89	89.00	152,058,257	118,155,629	800,963	(65,988,830)	99,090,495	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(1,123,383,459)	2,142,847	-	(392,337,448)	(733,188,858)	-	-
Subtotal	**89**	**89.00**	**(971,325,202)**	**120,298,476**	**800,963**	**(458,326,278)**	(634,098,363)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	472,563,909	55,186,632	230,863	125,589,504	291,556,910	-	-
State Gov"t & Services Charges Increase/(Decrease)			5,023,110	2,293,087	-	595,506	2,134,517	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal	**-**	**-**	**477,587,019**	**57,479,719**	**230,863**	**126,185,010**	293,691,427	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	99	99.00	2,185,121,898	83,332,723	-	18,319,852	2,083,469,323	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	1	619,538,915	-	(587,226,215)	(32,312,699)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	(6)	(6.00)	282,288	(545,812)	-	983,467	(155,367)	-	-
Subtotal: 2013-15 Current Service Level	**4,201**	**4,156.50**	**14,401,496,674**	**2,660,872,973**	**11,479,452**	**1,042,348,235**	6,747,393,211	**3,832,299,341**	**107,103,462**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Oregon Health Authority **Cross Reference Number: 44300-000-00-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**4,201**	**4,156.50**	**14,401,496,674**	**2,660,872,973**	**11,479,452**	**1,042,348,235**	6,747,393,211	**3,832,299,341**	**107,103,462**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	(1)	(1.00)	(332,811)	-	-	(332,811)	-	-	-
Modified 2013-15 Current Service Level	**4,200**	**4,155.50**	**14,401,163,863**	**2,660,872,973**	**11,479,452**	**1,042,015,424**	6,747,393,211	**3,832,299,341**	**107,103,462**
080 - E-Boards									
081 - May 2012 E-Board	(34)	(33.38)	(6,145,385)	(3,850,697)	-	(810,600)	(1,484,088)	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**(34)**	**(33.38)**	**(6,145,385)**	**(3,850,697)**	**-**	**(810,600)**	(1,484,088)	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	(43)	(43.00)	545,098,848	(674,035,751)	(915,008)	802,312,431	596,322,307	(178,585,131)	-
091 - Statewide Administrative Savings	-	-	(14,988,887)	(2,811,405)	-	(9,943,831)	(2,233,651)	-	-
092 - PERS Taxation Policy	-	-	(1,876,174)	(1,038,964)	(2,589)	(429,125)	(405,496)	-	-
093 - Other PERS Adjustments	-	-	(14,991,522)	(8,301,815)	(20,690)	(3,428,908)	(3,240,109)	-	-
094 - December 2012 Rebalance	22	16.89	878,931,779	(68,077,509)	-	368,671,883	578,337,405	-	-
201 - APD - Program transfer to OHA	-	-	344,381,775	125,761,280	-	-	218,620,495	-	-
401 - PC & Network Infrastructure Investments	12	10.56	3,692,477	666,667	-	2,359,143	666,667	-	-
402 - Health Systems Transformation	2	2.00	4,467,197	2,615,946	-	(311,665)	2,162,916	-	-
403 - OSH Replacement Project Next Phase	286	19.32	89,605,945	2,994,618	-	86,649,890	(38,563)	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	12,625,000	12,625,000	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	11	9.42	2,004,172	1,004,489	-	-	999,683	-	-
Subtotal Policy Packages	**290**	**15.19**	**1,848,950,610**	**(608,597,444)**	**(938,287)**	**1,245,879,818**	1,391,191,654	**(178,585,131)**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

Oregon Health Authority **Cross Reference Number: 44300-000-00-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**4,456**	**4,137.31**	**16,243,969,088**	**2,048,424,832**	**10,541,165**	**2,287,084,642**	8,137,100,777	**3,653,714,210**	**107,103,462**
Percentage Change From 2011-13 Leg Approved Budget	10.40%	3.90%	33.70%	20.70%	1.50%	13.90%	61.80%	10.90%	-
Percentage Change From 2013-15 Current Service Level	6.10%	-0.50%	12.80%	-23.00%	-8.20%	119.40%	20.60%	-4.70%	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Medical Assistance Programs **Cross Reference Number: 44300-020-01-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	450	435.96	6,567,856,187	901,703,540	-	1,571,634,301	4,094,518,346	-	-
2011-13 Emergency Boards	(9)	(9.00)	(36,811,481)	(28,386,064)	-	4,423,184	(12,848,601)	-	-
2011-13 Leg Approved Budget	**441**	**426.96**	**6,531,044,706**	**873,317,476**	**-**	**1,576,057,485**	4,081,669,745	**-**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(36)	(30.23)	3,520,612	3,800,883	-	(1,246,831)	966,560	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**405**	**396.73**	**6,534,565,318**	**877,118,359**	**-**	**1,574,810,654**	4,082,636,305	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,125,547	572,886	-	(13,642)	566,303	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	1,037,018	463,134	-	69,443	504,441	-	-
Subtotal	**-**	**-**	**2,162,565**	**1,036,020**	**-**	**55,801**	1,070,744	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	1	1.00	92,775,248	79,230,698	-	(75,294,327)	88,838,877	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(1,061,549,330)	2,142,847	-	(385,220,349)	(678,471,828)	-	-
Subtotal	**1**	**1.00**	**(968,774,082)**	**81,373,545**	**-**	**(460,514,676)**	(589,632,951)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	425,962,996	40,301,903	-	118,864,976	266,796,117	-	-
Subtotal	**-**	**-**	**425,962,996**	**40,301,903**	**-**	**118,864,976**	266,796,117	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Medical Assistance Programs **Cross Reference Number: 44300-020-01-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	99	99.00	2,104,735,348	36,439,883	-	18,319,852	2,049,975,613	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	1	593,105,626	-	(566,759,993)	(26,345,632)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	(6)	(6.00)	178,570,685	66,218,597	-	(973,307)	113,325,395	-	-
Subtotal: 2013-15 Current Service Level	**499**	**490.73**	**8,277,222,831**	**1,695,593,933**	**-**	**683,803,307**	5,897,825,591	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Medical Assistance Programs **Cross Reference Number: 44300-020-01-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**499**	**490.73**	**8,277,222,831**	**1,695,593,933**	**-**	**683,803,307**	5,897,825,591	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**499**	**490.73**	**8,277,222,831**	**1,695,593,933**	**-**	**683,803,307**	5,897,825,591	**-**	**-**
080 - E-Boards									
081 - May 2012 E-Board	(12)	(11.88)	(1,666,643)	(841,902)	-	(31,839)	(792,902)	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**(12)**	**(11.88)**	**(1,666,643)**	**(841,902)**	**-**	**(31,839)**	(792,902)	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	933,805,175	(616,007,632)	-	835,175,504	714,637,303	-	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	(173,922)	(75,527)	-	(6,299)	(92,096)	-	-
093 - Other PERS Adjustments	-	-	(1,389,717)	(603,496)	-	(50,333)	(735,888)	-	-
094 - December 2012 Rebalance	8	8.00	696,458,645	(58,281,612)	-	368,781,536	385,958,721	-	-
201 - APD - Program transfer to OHA	-	-	344,381,775	125,761,280	-	-	218,620,495	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	-	-	-	-	-	-	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**8**	**8.00**	**1,973,081,956**	**(549,206,987)**	**-**	**1,203,900,408**	1,318,388,535	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

Medical Assistance Programs **Cross Reference Number: 44300-020-01-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**495**	**486.85**	**10,248,638,144**	**1,145,545,044**	**-**	**1,887,671,876**	7,215,421,224	**-**	**-**
Percentage Change From 2011-13 Leg Approved Budget	12.20%	14.00%	56.90%	31.20%	-	19.80%	76.80%	-	-
Percentage Change From 2013-15 Current Service Level	-0.80%	-0.80%	23.80%	-32.40%	-	176.10%	22.30%	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Oregon Educators Benefit Board (OEBB) **Cross Reference Number: 44300-020-03-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	22	22.00	1,448,639,511	-	-	10,639,511	-	1,438,000,000	-
2011-13 Emergency Boards	-	-	-	-	-	-	-	-	-
2011-13 Leg Approved Budget	**22**	**22.00**	**1,448,639,511**	**-**	**-**	**10,639,511**	-	**1,438,000,000**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(1)	(1.00)	(65,634)	-	-	(65,634)	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			190,294,000	-	-	-	-	190,294,000	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**21**	**21.00**	**1,638,867,877**	**-**	**-**	**10,573,877**	-	**1,628,294,000**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	(7,944)	-	-	(7,944)	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	(5,818)	-	-	(5,818)	-	-	-
Subtotal	**-**	**-**	**(13,762)**	**-**	**-**	**(13,762)**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	-	-	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(125,000)	-	-	(125,000)	-	-	-
Subtotal	**-**	**-**	**(125,000)**	**-**	**-**	**(125,000)**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	247,921	-	-	247,921	-	-	-
Subtotal	**-**	**-**	**247,921**	**-**	**-**	**247,921**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

Oregon Educators Benefit Board (OEBB) **Cross Reference Number: 44300-020-03-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	7,323	-	-	7,323	-	-	-
Subtotal: 2013-15 Current Service Level	**21**	**21.00**	**1,638,984,359**	**-**	**-**	**10,690,359**	-	**1,628,294,000**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Oregon Educators Benefit Board (OEBB) **Cross Reference Number: 44300-020-03-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**21**	**21.00**	**1,638,984,359**	**-**	**-**	**10,690,359**	-	**1,628,294,000**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**21**	**21.00**	**1,638,984,359**	**-**	**-**	**10,690,359**	-	**1,628,294,000**	**-**
080 - E-Boards									
081 - May 2012 E-Board	-	-	-	-	-	-	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	(10,412)	-	-	(10,412)	-	-	-
093 - Other PERS Adjustments	-	-	(83,197)	-	-	(83,197)	-	-	-
094 - December 2012 Rebalance	3	3.00	961,224	-	-	961,224	-	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	-	-	-	-	-	-	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**3**	**3.00**	**867,615**	**-**	**-**	**867,615**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority | **Agency GRB Working**
Oregon Educators Benefit Board (OEBB) | **Cross Reference Number: 44300-020-03-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**24**	**24.00**	**1,639,851,974**	**-**	**-**	**11,557,974**	-	**1,628,294,000**	**-**
Percentage Change From 2011-13 Leg Approved Budget	9.10%	9.10%	13.20%	-	-	8.60%	-	13.20%	-
Percentage Change From 2013-15 Current Service Level	14.30%	14.30%	0.10%	-	-	8.10%	-	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Private Health Partnerships **Cross Reference Number: 44300-020-04-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	52	51.36	640,912,692	12,746,819	-	73,210,468	143,285,144	411,670,261	-
2011-13 Emergency Boards	(9)	(9.00)	70,905,743	(5,744,544)	-	(160,498)	76,810,785	-	-
2011-13 Leg Approved Budget	**43**	**42.36**	**711,818,435**	**7,002,275**	**-**	**73,049,970**	220,095,929	**411,670,261**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	26	25.39	5,161,303	449,277	-	1,829,998	2,882,028	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**69**	**67.75**	**716,979,738**	**7,451,552**	**-**	**74,879,968**	222,977,957	**411,670,261**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	(116,088)	13,342	-	(101,004)	(28,426)	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	100,391	(15,471)	-	48,636	67,226	-	-
Subtotal	**-**	**-**	**(15,697)**	**(2,129)**	**-**	**(52,368)**	38,800	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	3,931,200	3,931,200	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**3,931,200**	**3,931,200**	**-**	**-**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	11,749,240	177,575	-	2,862,032	8,709,633	-	-
Subtotal	**-**	**-**	**11,749,240**	**177,575**	**-**	**2,862,032**	8,709,633	**-**	**-**

Oregon Health Authority
Private Health Partnerships
2013-15 Biennium

Agency GRB Working
Cross Reference Number: 44300-020-04-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	5,247,160	1,752,155	-	-	3,495,005	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	25,134,268	-	(25,134,268)	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	(8)	(8.00)	(1,387,814)	(260,768)	-	(493,561)	(633,485)	-	-
Subtotal: 2013-15 Current Service Level	**61**	**59.75**	**736,503,827**	**38,183,853**	**-**	**52,061,803**	234,587,910	**411,670,261**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Private Health Partnerships **Cross Reference Number: 44300-020-04-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**61**	**59.75**	**736,503,827**	**38,183,853**	**-**	**52,061,803**	234,587,910	**411,670,261**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**61**	**59.75**	**736,503,827**	**38,183,853**	**-**	**52,061,803**	234,587,910	**411,670,261**	**-**
080 - E-Boards									
081 - May 2012 E-Board	-	-	-	-	-	-	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	(329,390,392)	(11,619,748)	-	(29,063,664)	(110,121,849)	(178,585,131)	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	(23,149)	(7,137)	-	(5,843)	(10,169)	-	-
093 - Other PERS Adjustments	-	-	(184,973)	(57,029)	-	(46,689)	(81,255)	-	-
094 - December 2012 Rebalance	-	-	54,262,291	-	-	-	54,262,291	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	-	-	-	-	-	-	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**-**	**-**	**(275,336,223)**	**(11,683,914)**	**-**	**(29,116,196)**	(55,950,982)	**(178,585,131)**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority
Private Health Partnerships
2013-15 Biennium

Agency GRB Working
Cross Reference Number: 44300-020-04-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**61**	**59.75**	**461,167,604**	**26,499,939**	**-**	**22,945,607**	178,636,928	**233,085,130**	**-**
Percentage Change From 2011-13 Leg Approved Budget	41.90%	41.10%	-35.20%	278.40%	-	-68.60%	-18.80%	-43.40%	-
Percentage Change From 2013-15 Current Service Level	-	-	-37.40%	-30.60%	-	-55.90%	-23.90%	-43.40%	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Public Employees Benefit Board (PEBB) **Cross Reference Number: 44300-020-02-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	19	18.50	1,413,956,621	-	-	8,715,361	-	1,405,241,260	-
2011-13 Emergency Boards	-	-	-	-	-	-	-	-	-
2011-13 Leg Approved Budget	**19**	**18.50**	**1,413,956,621**	**-**	**-**	**8,715,361**	-	**1,405,241,260**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	1	1.00	535,686	-	-	535,686	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			347,093,820	-	-	-	-	347,093,820	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**20**	**19.50**	**1,761,586,127**	**-**	**-**	**9,251,047**	-	**1,752,335,080**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	(59,864)	-	-	(59,864)	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	23,663	-	-	23,663	-	-	-
Subtotal	**-**	**-**	**(36,201)**	**-**	**-**	**(36,201)**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	-	-	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(125,000)	-	-	(125,000)	-	-	-
Subtotal	**-**	**-**	**(125,000)**	**-**	**-**	**(125,000)**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	158,909	-	-	158,909	-	-	-
Subtotal	**-**	**-**	**158,909**	**-**	**-**	**158,909**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

Public Employees Benefit Board (PEBB) **Cross Reference Number: 44300-020-02-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2013-15 Current Service Level	**20**	**19.50**	**1,761,583,835**	**-**	**-**	**9,248,755**	-	**1,752,335,080**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Public Employees Benefit Board (PEBB) **Cross Reference Number: 44300-020-02-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**20**	**19.50**	**1,761,583,835**	**-**	**-**	**9,248,755**	-	**1,752,335,080**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**20**	**19.50**	**1,761,583,835**	**-**	**-**	**9,248,755**	-	**1,752,335,080**	**-**
080 - E-Boards									
081 - May 2012 E-Board	-	-	-	-	-	-	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	(10,467)	-	-	(10,467)	-	-	-
093 - Other PERS Adjustments	-	-	(83,633)	-	-	(83,633)	-	-	-
094 - December 2012 Rebalance	-	-	-	-	-	-	-	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	-	-	-	-	-	-	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**-**	**-**	**(94,100)**	**-**	**-**	**(94,100)**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

Public Employees Benefit Board (PEBB) **Cross Reference Number: 44300-020-02-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**20**	**19.50**	**1,761,489,735**	**-**	**-**	**9,154,655**	-	**1,752,335,080**	**-**
Percentage Change From 2011-13 Leg Approved Budget	5.30%	5.40%	24.60%	-	-	5.00%	-	24.70%	-
Percentage Change From 2013-15 Current Service Level	-	-	-	-	-	-1.00%	-	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Public Health Program **Cross Reference Number: 44300-020-06-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	695	683.30	492,009,925	32,587,158	-	72,031,541	244,662,175	40,000,000	102,729,051
2011-13 Emergency Boards	-	-	12,641,009	1,823,157	-	5,106,994	5,710,858	-	-
2011-13 Leg Approved Budget	**695**	**683.30**	**504,650,934**	**34,410,315**	**-**	**77,138,535**	250,373,033	**40,000,000**	**102,729,051**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(12)	(13.98)	7,541,373	1,211,334	-	3,083,694	3,246,345	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**683**	**669.32**	**512,192,307**	**35,621,649**	**-**	**80,222,229**	253,619,378	**40,000,000**	**102,729,051**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,793,219	2,068,828	-	(91,208)	(184,401)	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	416,759	(142,901)	-	333,431	226,229	-	-
Subtotal	**-**	**-**	**2,209,978**	**1,925,927**	**-**	**242,223**	41,828	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	17	17.00	2,741,310	-	-	-	2,741,310	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**17**	**17.00**	**2,741,310**	**-**	**-**	**-**	2,741,310	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	6,282,808	818,455	-	1,017,033	4,447,320	-	-
Subtotal	**-**	**-**	**6,282,808**	**818,455**	**-**	**1,017,033**	4,447,320	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Public Health Program **Cross Reference Number: 44300-020-06-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	1,017,100	-	(568,148)	(448,952)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	(1)	(1.00)	865,067	(173,120)	-	1,126,639	(88,452)	-	-
Subtotal: 2013-15 Current Service Level	**699**	**685.32**	**524,291,470**	**39,210,011**	**-**	**82,039,976**	260,312,432	**40,000,000**	**102,729,051**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
Public Health Program **Cross Reference Number: 44300-020-06-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**699**	**685.32**	**524,291,470**	**39,210,011**	**-**	**82,039,976**	260,312,432	**40,000,000**	**102,729,051**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**699**	**685.32**	**524,291,470**	**39,210,011**	**-**	**82,039,976**	260,312,432	**40,000,000**	**102,729,051**
080 - E-Boards									
081 - May 2012 E-Board	(3)	(3.00)	(653,608)	(184,720)	-	(150,348)	(318,540)	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**(3)**	**(3.00)**	**(653,608)**	**(184,720)**	**-**	**(150,348)**	(318,540)	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Administrative Savings	-	-	-	-	-	-	-	-	-
092 - PERS Taxation Policy	-	-	(314,377)	(26,003)	-	(95,545)	(192,829)	-	-
093 - Other PERS Adjustments	-	-	(2,512,026)	(207,777)	-	(763,450)	(1,540,799)	-	-
094 - December 2012 Rebalance	11	5.89	11,058,994	-	-	(42,877)	11,101,871	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	-	-	-	-	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	-	-	-	-	-	-	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**11**	**5.89**	**8,232,591**	**(233,780)**	**-**	**(901,872)**	9,368,243	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority
Public Health Program
2013-15 Biennium

Agency GRB Working
Cross Reference Number: 44300-020-06-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**707**	**688.21**	**531,870,453**	**38,791,511**	**-**	**80,987,756**	269,362,135	**40,000,000**	**102,729,051**
Percentage Change From 2011-13 Leg Approved Budget	1.70%	0.70%	5.40%	12.70%	-	5.00%	7.70%	-	-
Percentage Change From 2013-15 Current Service Level	1.10%	0.40%	1.40%	-1.10%	-	-1.30%	3.50%	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
OHA Shared Services **Cross Reference Number: 44300-010-45-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	361	352.12	121,340,662	-	-	121,340,662	-	-	-
2011-13 Emergency Boards	-	-	3,221,972	-	-	3,221,972	-	-	-
2011-13 Leg Approved Budget	**361**	**352.12**	**124,562,634**	**-**	**-**	**124,562,634**	-	**-**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	14	14.39	(7,418,710)	73,796	-	(7,610,286)	117,780	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**375**	**366.51**	**117,143,924**	**73,796**	**-**	**116,952,348**	117,780	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	4,674,113	-	-	4,674,113	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	728,877	3,064	-	720,923	4,890	-	-
Subtotal	**-**	**-**	**5,402,990**	**3,064**	**-**	**5,395,036**	4,890	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	71	71.00	14,858,574	-	-	14,858,574	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(4,595,671)	-	-	(4,595,671)	-	-	-
Subtotal	**71**	**71.00**	**10,262,903**	**-**	**-**	**10,262,903**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	833,810	-	-	833,810	-	-	-
Subtotal	**-**	**-**	**833,810**	**-**	**-**	**833,810**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
OHA Shared Services **Cross Reference Number: 44300-010-45-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	4	4.00	620,008	(76,860)	-	819,538	(122,670)	-	-
Subtotal: 2013-15 Current Service Level	**450**	**441.51**	**134,263,635**	**-**	**-**	**134,263,635**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**
OHA Shared Services **Cross Reference Number: 44300-010-45-00-00000**
2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**450**	**441.51**	**134,263,635**	**-**	**-**	**134,263,635**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**450**	**441.51**	**134,263,635**	**-**	**-**	**134,263,635**	-	**-**	**-**
080 - E-Boards									
081 - May 2012 E-Board	(2)	(2.00)	(454,553)	-	-	(454,553)	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**(2)**	**(2.00)**	**(454,553)**	**-**	**-**	**(454,553)**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Administrative Savings	-	-	(9,343,303)	-	-	(9,343,303)	-	-	-
092 - PERS Taxation Policy	-	-	(255,271)	-	-	(255,271)	-	-	-
093 - Other PERS Adjustments	-	-	(2,039,733)	-	-	(2,039,733)	-	-	-
094 - December 2012 Rebalance	-	-	(1,028,000)	-	-	(1,028,000)	-	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	12	10.56	2,359,143	-	-	2,359,143	-	-	-
402 - Health Systems Transformation	-	-	-	-	-	-	-	-	-
403 - OSH Replacement Project Next Phase	7	1.77	244,331	-	-	244,331	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**19**	**12.33**	**(10,062,833)**	**-**	**-**	**(10,062,833)**	-	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority
OHA Shared Services
2013-15 Biennium

Agency GRB Working
Cross Reference Number: 44300-010-45-00-00000

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**467**	**451.84**	**123,746,249**	**-**	**-**	**123,746,249**	-	**-**	**-**
Percentage Change From 2011-13 Leg Approved Budget	29.40%	28.30%	-0.70%	-	-	-0.70%	-	-	-
Percentage Change From 2013-15 Current Service Level	3.80%	2.30%	-7.80%	-	-	-7.80%	-	-	-

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

State Assessments and Enterprise-wide Costs **Cross Reference Number: 44300-010-50-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2011-13 Leg Adopted Budget	-	-	138,286,308	59,580,538	-	11,089,720	67,616,050	-	-
2011-13 Emergency Boards	-	-	4,448,768	2,951,220	-	307,733	1,189,815	-	-
2011-13 Leg Approved Budget	**-**	**-**	**142,735,076**	**62,531,758**	**-**	**11,397,453**	68,805,865	**-**	**-**
2013-15 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	-	-	-	-	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			75,414,091	71,022,345	-	17,335	-	-	4,374,411
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2013-15 Base Budget	**-**	**-**	**218,149,167**	**133,554,103**	**-**	**11,414,788**	68,805,865	**-**	**4,374,411**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase-in	-	-	1,660,025	695,115	-	41,180	923,730	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**1,660,025**	**695,115**	**-**	**41,180**	923,730	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	7,327,269	3,173,727	-	614,296	3,539,246	-	-
State Gov"t & Services Charges Increase/(Decrease)			5,023,110	2,293,087	-	595,506	2,134,517	-	-
Subtotal	**-**	**-**	**12,350,379**	**5,466,814**	**-**	**1,209,802**	5,673,763	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	4,969,696	(4,969,696)	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	6,241,564	4,247,805	-	258,690	1,735,069	-	-
Subtotal: 2013-15 Current Service Level	**-**	**-**	**238,401,135**	**143,963,837**	**-**	**17,894,156**	72,168,731	**-**	**4,374,411**

Summary of 2013-15 Biennium Budget

Oregon Health Authority **Agency GRB Working**

State Assessments and Enterprise-wide Costs **Cross Reference Number: 44300-010-50-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2013-15 Current Service Level	**-**	**-**	**238,401,135**	**143,963,837**	**-**	**17,894,156**	72,168,731	**-**	**4,374,411**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2013-15 Current Service Level	**-**	**-**	**238,401,135**	**143,963,837**	**-**	**17,894,156**	72,168,731	**-**	**4,374,411**
080 - E-Boards									
081 - May 2012 E-Board	-	-	-	-	-	-	-	-	-
082 - September 2012 E-Board	-	-	-	-	-	-	-	-	-
083 - December 2012 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Administrative Savings	-	-	(5,285,668)	(2,612,933)	-	(596,615)	(2,076,120)	-	-
092 - PERS Taxation Policy	-	-	-	-	-	-	-	-	-
093 - Other PERS Adjustments	-	-	-	-	-	-	-	-	-
094 - December 2012 Rebalance	-	-	(26,763,399)	(8,570,075)	-	-	(18,193,324)	-	-
201 - APD - Program transfer to OHA	-	-	-	-	-	-	-	-	-
401 - PC & Network Infrastructure Investments	-	-	1,333,334	666,667	-	-	666,667	-	-
402 - Health Systems Transformation	-	-	46,620	34,532	-	(17,098)	29,186	-	-
403 - OSH Replacement Project Next Phase	-	-	7,458,470	-	-	7,458,470	-	-	-
404 - Strengthen Comm'ty Mental Health Svcs & ITRS	-	-	-	-	-	-	-	-	-
405 - Ofc of Equity & Inclusion - Health Equity	-	-	-	-	-	-	-	-	-
406 - Health Information Technology	-	-	234,245	117,138	-	-	117,107	-	-
Subtotal Policy Packages	**-**	**-**	**(22,976,398)**	**(10,364,671)**	**-**	**6,844,757**	(19,456,484)	**-**	**-**

Summary of 2013-15 Biennium Budget

Oregon Health Authority | **Agency GRB Working**

State Assessments and Enterprise-wide Costs | **Cross Reference Number: 44300-010-50-00-00000**

2013-15 Biennium

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Total 2013-15 Agency GRB Working	**-**	**-**	**215,424,737**	**133,599,166**	**-**	**24,738,913**	52,712,247	**-**	**4,374,411**
Percentage Change From 2011-13 Leg Approved Budget	-	-	50.90%	113.70%	-	117.10%	-23.40%	-	-
Percentage Change From 2013-15 Current Service Level	-	-	-9.60%	-7.20%	-	38.30%	-27.00%	-	-

FALL 2012 DHS|OHA CASELOAD FORECAST

Budget, Planning and Analysis
Office of Forecasting, Research and Analysis

DHS Oregon Department of Human Services

Oregon Health Authority

DHS
Oregon Department
of Human Services

Oregon Health Authority

FALL 2012 DHS|OHA CASELOAD FORECAST

November 2012

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The **Supplemental Nutrition Assistance Program (SNAP)** Biennial Average Forecast for 2011–13 is 440,182 households, 1.1 percent higher than the Spring 2012 Forecast. The forecast average for the 2013–15 biennium is 435,230 households, 2.7 percent higher than the Spring 2012 Forecast and 1.1 percent lower than the Fall 2012 Forecast average for 2011–13.

The **Temporary Assistance to Needy Families (TANF)** Biennial Average Forecast for 2011–13 is 34,934 families, 0.9 percent higher than the Spring 2012 Forecast. The forecast average for the 2013–15 biennium is 32,986 families, 1.5 percent higher than the Spring 2012 Forecast and 5.6 percent lower than the Fall 2012 Forecast average for 2011–13.

The **Employment Related Day Care (ERDC)** caseload is funded to an average of 8,500 families for the remainder of the current biennium. The forecast assumes that the program will accommodate all qualified families during the 2013–15 biennium. As a result, the forecast average for the 2013–15 biennium is 10,040 families, 2.6 percent lower than the Spring 2012 Forecast and 18.7 percent higher than the Fall 2012 Forecast average for 2011–13.

The **Vocational Rehabilitation** Biennial Average Forecast for 2011–13 is 8,500 clients, 0.5 percent higher than the Spring 2012 Forecast. The forecast average for the 2013–15 biennium is 9,225 clients, 2.5 percent higher than the Spring 2012 Forecast and 8.5 percent higher than the Fall 2012 Forecast for the 2011–13 biennial average.

The total **Long–Term Care (LTC)** Biennial Average Forecast for Aging and People with Disabilities in 2011–13 is 28,011 clients, 0.3 percent lower than the Spring 2012 Forecast. The forecast average for the 2013–15 biennium of 28,676 clients is nearly identical to the Spring 2012 Forecast and 2.4 percent higher than the Fall 2012 Forecast for the 2011–13 biennial average.

The **Developmental Disabilities** Case Management Enrollment Biennial Average Forecast is 20,212 clients for 2011–13, and 21,498 clients for 2013–15 forecast periods. The forecast average for the 2013–15 biennium is essentially unchanged from the Spring 2012 Forecast and 6.4 percent higher than the Fall 2012 Forecast for the 2011–13 biennial average.

The total **Medical Assistance Programs** Biennial Average Forecast is expected to reach 663,339 clients by June 2013 and 706,152 clients by June 2015. The caseload expectation for June 2013 represents a 3.4 percent increase over the same month in 2011 while the June 2015 estimate represents a 6.5 percent increase over June 2013.[1]

The total **Mandated Mental Health** Biennial Average Forecast for the 2011–13 biennium is 5,147 clients, 15.1 percent lower than the Spring 2012 Forecast. This change is due to a change in the data's definition. A level shift is presented in the historical data. The Fall 2012 forecast average for the 2013–15 biennium is 5,387 clients, 17.0 percent lower than the Spring 2012 Forecast and 4.7 percent higher than the Fall 2012 Forecast for 2011–13.

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1. *These estimates do not include the potential effect of the Affordable Care Act beginning in January 2014. See page 26 for discussion of these estimated effects.*

Introduction

This document summarizes the Fall 2012 forecasts of client caseloads for the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA). The Office of Forecasting, Research and Analysis (OFRA) issues these forecasts semiannually in the spring and fall. DHS caseload forecasts cover the major program areas administered by the department: Self Sufficiency, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Medical Assistance Programs and Addictions and Mental Health. Forecasts are developed using a combination of time-series techniques, input-output deterministic models and expert consensus. Forecast accuracy is tracked using monthly reports that compare forecast caseloads with actual caseload counts. Forecasts are used for planning and budgeting and usually extend through the end of the next biennium.

Forecast environment and risks

Oregon's economy was severely affected by the global recession of 2008–09, and it has yet to fully recover. Oregon lost nearly 150,000 jobs between December 2007 and December 2009, more than half of which disappeared during the six months ending in March 2009. The sudden and significant loss of jobs resulted in sudden and dramatic increases in many DHS and OHA caseloads. This period is easily identified in many of the caseload graphs that follow. Post-recession job gains have been steady but slow. As of August 2012, Oregon's nonfarm employment stood at 1,643,200, an increase of 40,300 over August 2009. Clearly, the state has a long way to go to reach pre-recession employment levels. Growth has started to slow in recession-sensitive caseloads, and recently small caseload declines have registered. Oregon's Office of Economic Analysis (OEA) predicts a gradual employment recovery but, given expected population growth, the ratio of employment to working-age population is not expected to approach its pre-recession level until well after the end of the DHS and OHA forecast horizon of June 2015. Some DHS and OHA clients face additional barriers to employment such as limited education and work experience. They often work in industries that depend on discretionary spending such as leisure and hospitality or retail trade. These factors combine to cause the most economically sensitive DHS caseloads to increase rapidly at the onset of recession and decline slowly during economic recovery. This recovery dynamic has been incorporated into economically sensitive DHS and OHA forecasts.

Forecasts are based on specific assumptions about the future, and an important part of forecasting is identifying the major risks to those assumptions. Caseload dynamics are influenced by demographics, the economy and policy choices. Demographic changes have a long-term and predictable influence on caseloads. Economic factors can have a dramatic effect on some caseloads, especially during recessions. The most immediate and dramatic effects on caseloads result from policy changes that alter the pool of eligible clients or the duration of their program eligibility. Sometimes economic factors influence policy changes. For example, a poor economy will cause tax receipts to decline, which can in turn force spending cuts that limit eligibility for some programs. The Employment Related Day Care (ERDC) and Vocational Rehabilitation (OVRS) programs are examples of this situation.

The Office of Economic Analysis (OEA) identifies major risks to Oregon's economy in its quarterly economic forecasts. Three are listed in the third quarter 2012 edition. They are 1) a euro zone recession or currency crisis; 2) continued economic slowdown in China; and 3) the unsettled state of the federal government's fiscal policy (also known as the fiscal cliff). Forecasts are based on current practices and policies applied to the expected state of external factors such as demographics and the economy. We do not attempt to anticipate future policy changes. Moreover, the effects of policy changes that have been adopted but not implemented sometimes cannot be quantified to the degree needed to accurately forecast outcomes. Future policy changes or uncertainty about the implementation of recent policy changes represent a major risk to the caseload forecasts.

Department of Human Services

Total Department of Human Services Biennial Average Forecast comparison

	2011-2013 biennium			Fall 2012 Forecast		
	Spring 12 Forecast 2011-13	Fall 12 Forecast 2011-13	% diff. Spring 12 to Fall 12 2011-13	Fall 12 Forecast 2011-13	Fall 12 Forecast 2013-15	% diff. Fall 12 2011-13 to 2013-15
Self Sufficiency						
Supplemental Nutrition Assistance Program (households)	435,327	440,182	1.1%	440,182	435,230	-1.1%
Temporary Assistance for Needy Families - Basic and UN (families: cash assistance)	34,636	34,934	0.9%	34,934	32,986	-5.6%
Employment Related Day Care (families)	8,449	8,459	0.1%	8,459	10,040	18.7%
Child Welfare (children served)[1]						
Adoption Assistance	11,025	11,025	0.0%	11,025	11,315	2.6%
Guardianship Assistance	1,153	1,153	0.0%	1,153	1,263	9.5%
Out of Home Care	8,247	8,247	0.0%	8,247	8,185	-0.8%
Child In-Home	2,926	2,926	0.0%	2,926	2,993	2.3%
Vocational Rehabilitation Services	8,461	8,500	0.5%	8,500	9,225	2.5%
Aging and People with Disabilities						
Long-Term Care: In-Home	10,935	10,834	-0.9%	10,834	10,802	-0.3%
Long-Term Care: Community-Based	12,630	12,687	0.5%	12,687	13,365	5.3%
Long-Term Care: Nursing Facilities[2]	4,529	4,490	-0.9%	4,490	4,509	0.4%
Developmental Disabilities						
Total DD Services[3]	14,721	14,619	-0.7%	14,619	15,548	6.4%
Total Case Management Enrollment	20,213	20,212	0.0%	20,212	21,498	6.4%

1. *The Child Welfare forecast is unchanged from the fall 2011 edition. DHS implemented a new child welfare computer system (OR-KIDS) in August 2011. A forecasting data warehouse based on OR-KIDS data is currently being developed.*
2. *Nursing Facility services have been separated based on whether they are long-term care or post-acute NF.*
3. *Total DD Services and DD ancillary services do not add up to Total Case Management Enrollment.*

Self Sufficiency Programs (SSP)

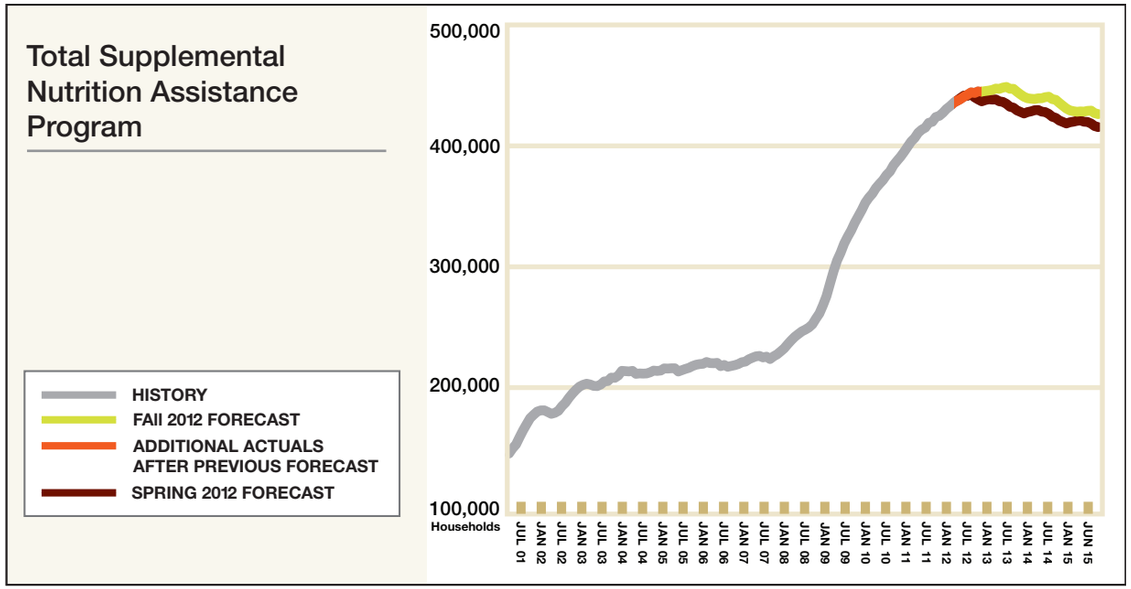
Supplemental Nutrition Assistance Program (SNAP) — There were 442,980 households (807,900 persons) receiving SNAP benefits in September 2012, about one-fifth of all Oregonians. The SSP portion of SNAP rose rapidly at the onset of 2009 and continued to grow at a steadily decreasing rate until leveling off in the spring and summer of 2012. The caseload decreased in July and September 2012 — the first declines since 2007. The APD SNAP caseload has been increasing for several years, but the rate of increase accelerated starting in 2009. The combined SNAP Biennial Average Forecast for 2011–13 is 440,182 households, 1.1 percent higher than the Spring 2012 Forecast. The Fall 2012 Forecast average for the 2013–15 biennium is 435,230 households, 2.7 percent higher than the Spring 2012 Forecast. The increase is due to a slight change in the expected rate of decline in the SSP caseload. The risks to the SNAP Forecast include those stated in the "Forecast environment and risks" section, above. In addition, at the time of this writing, Congress had not yet reauthorized the farm bill that enables the SNAP program. There is a risk that the law in its final form could affect the caseload. Finally, the implementation of the Medicaid expansion portion of the Affordable Care Act will likely add additional households to SNAP as part of the Medicaid enrollment process.

Temporary Assistance for Needy Families (TANF) — There were 35,290 families receiving TANF benefits in September 2012. The TANF caseload underwent nearly uninterrupted growth starting in January 2008 until leveling off in the spring and summer of 2012. The caseload has declined in three of the past four months, a promising sign. The TANF caseload is expected to stay near its current level until January 2013 when several hundred families are expected to turn to TANF after losing their Emergency Unemployment Compensation (EUC). Thereafter the caseload is expected to decline during the spring and summer months of the next several years as Oregon's job market continues to gain strength. The TANF Biennial Average Forecast for 2011–13 is 34,934 families, 0.9 percent higher than the Spring 2012 Forecast. The Fall 2012 Forecast average for the 2013–15 biennium is 32,986 families, 1.5 percent higher than the Spring 2012 Forecast. The difference is mostly due to the EUC exhaustion effect, which could not be estimated for the Spring 2012 Forecast, but was considered a risk. The risks to the TANF Forecast include those stated in the "Forecast environment and risks" section, above. Other risks include the magnitude of the EUC exhaustion effect and unforeseen policy changes to the TANF program including work participation requirements (JOBS program).

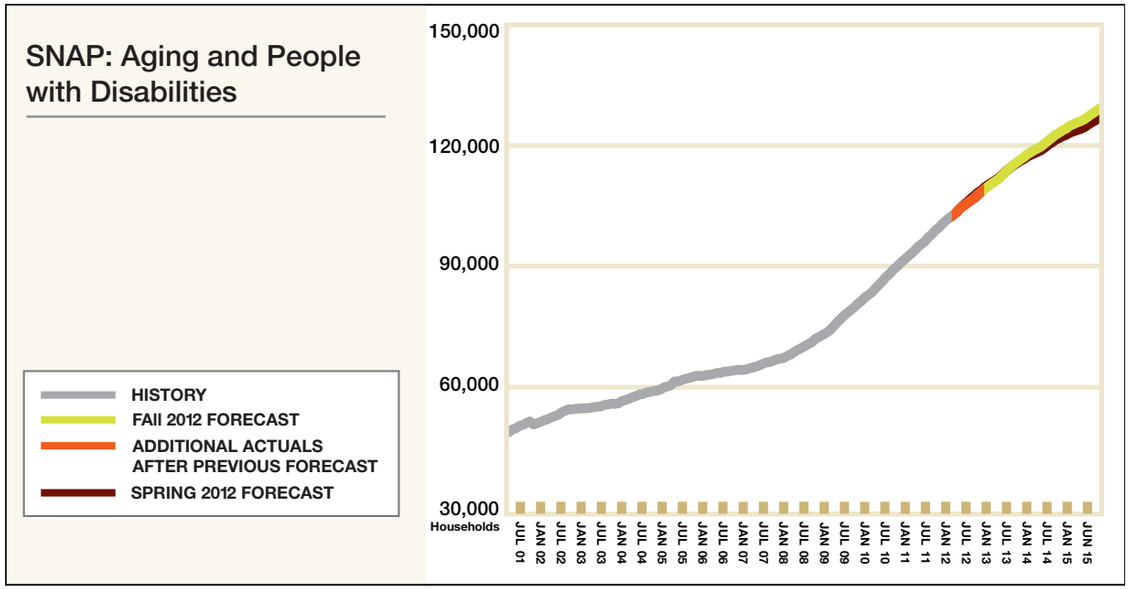
Employment Related Day Care (ERDC) — This program has undergone a series of budget reductions due to declining tax revenue in Oregon's depressed economy. The caseload averaged nearly 11,000 families during fiscal year 2010. Since then the program has been limited to families with a recent history of receiving TANF, and the number of eligible families is supplemented by drawing names from a reservation list. As a result, the caseload has averaged 9,100 families since fiscal year 2011. The caseload is funded to an average of 8,500 families for the remainder of the current biennium. The forecast assumes that the program will accommodate all qualified families during the 2013–15 biennium. As a result, the current caseload of 9,300 families is expected to increase by 22 percent to 11,380 families by June 2015. Continued budget reductions or unforeseen policy changes pose the major risk to the ERDC Forecast.

Temporary Assistance for Domestic Violence Survivors (TA-DVS) — This is a relatively small caseload that experiences regular seasonal fluctuations. The Fall 2012 Forecast for the 2011–13 biennium is 501 families, 5.8 percent lower than the Spring 2012 Forecast. The caseload is expected to average 505 families during the 2013–15 biennium, about the same as in 2011–13.

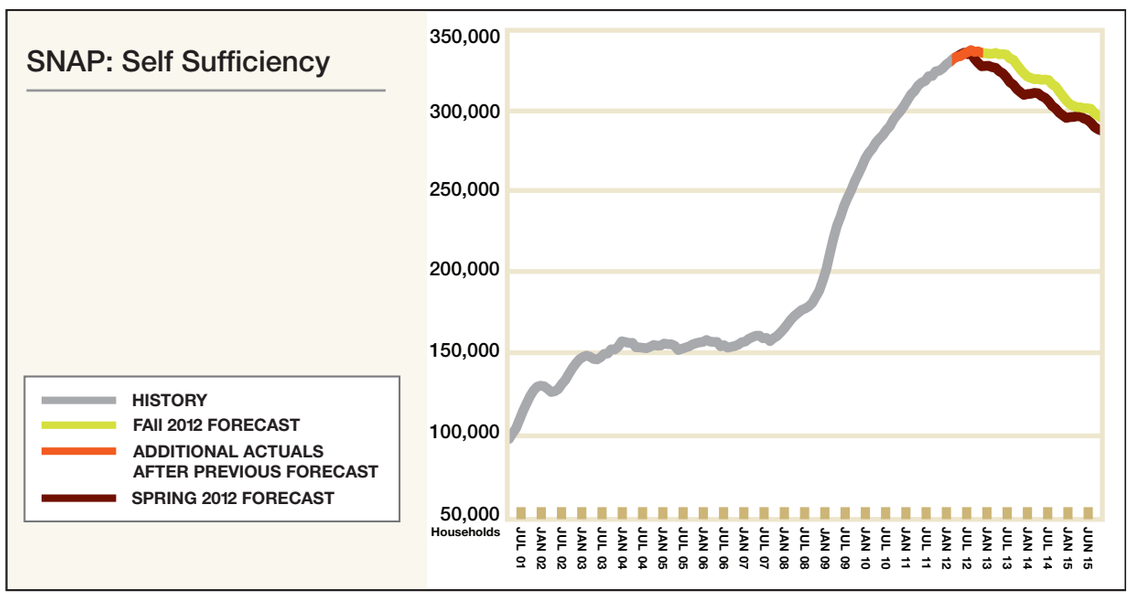
Total Supplemental Nutrition Assistance Program



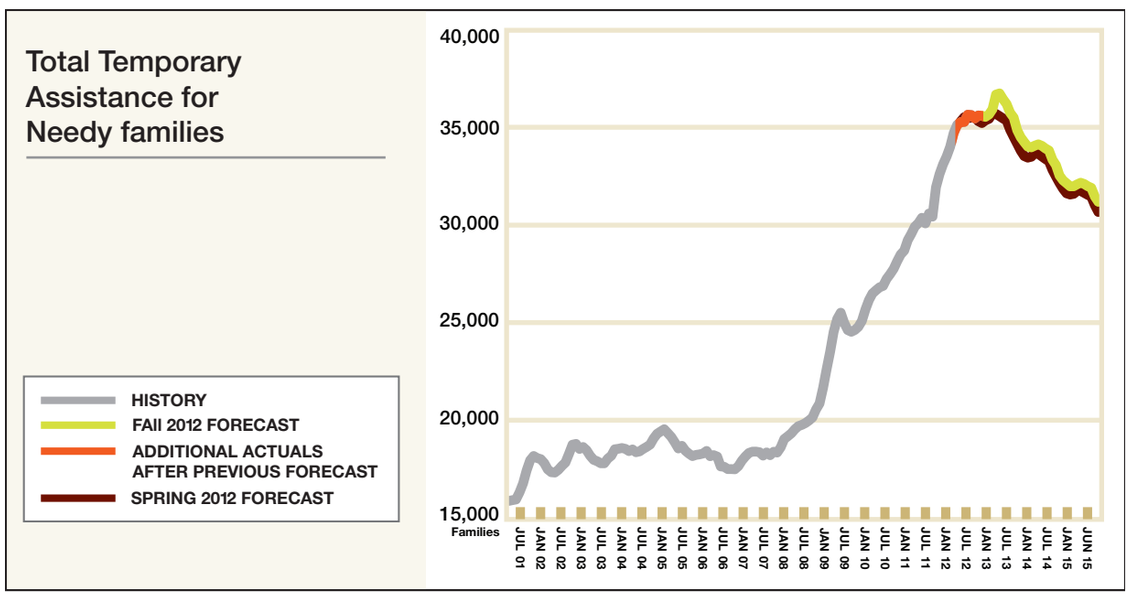
SNAP: Aging and People with Disabilities



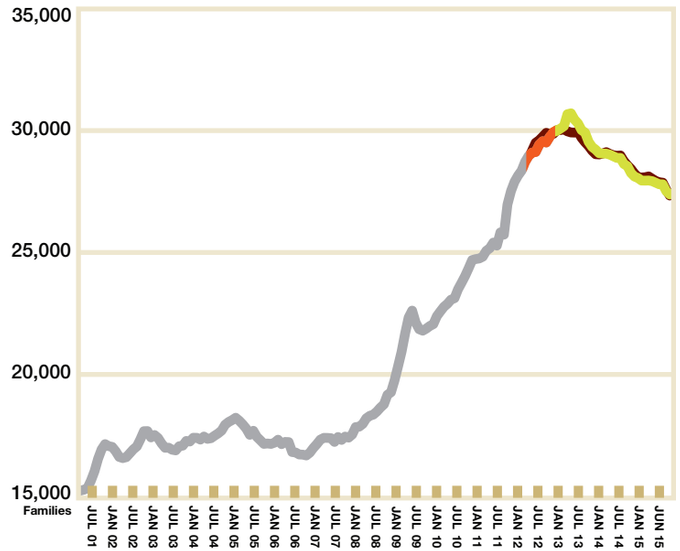
SNAP: Self Sufficiency



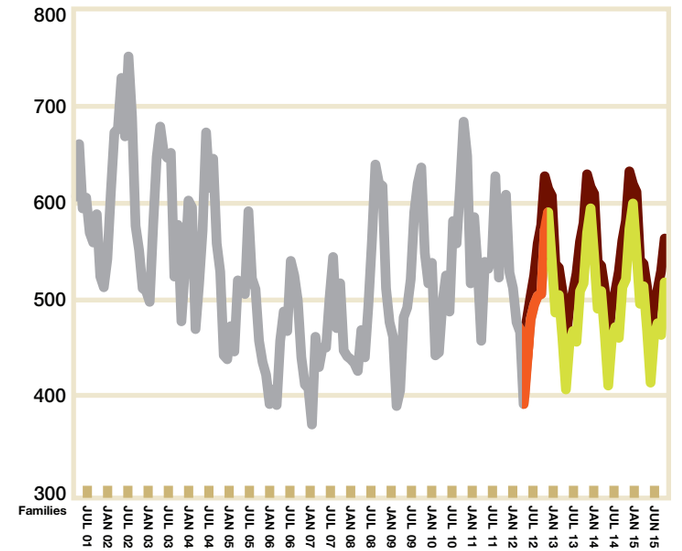
Total Temporary Assistance for Needy families



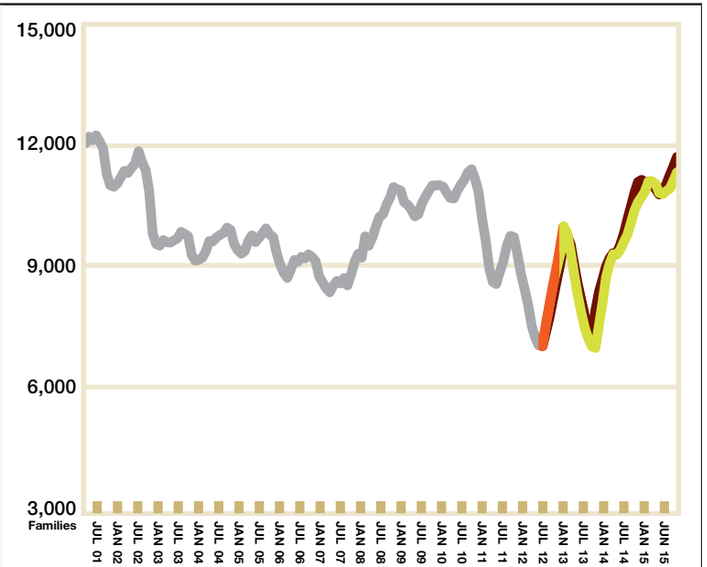
TANF: Basic



Temporary Assistance for Domestic Violence Survivors



Employment Related Day Care

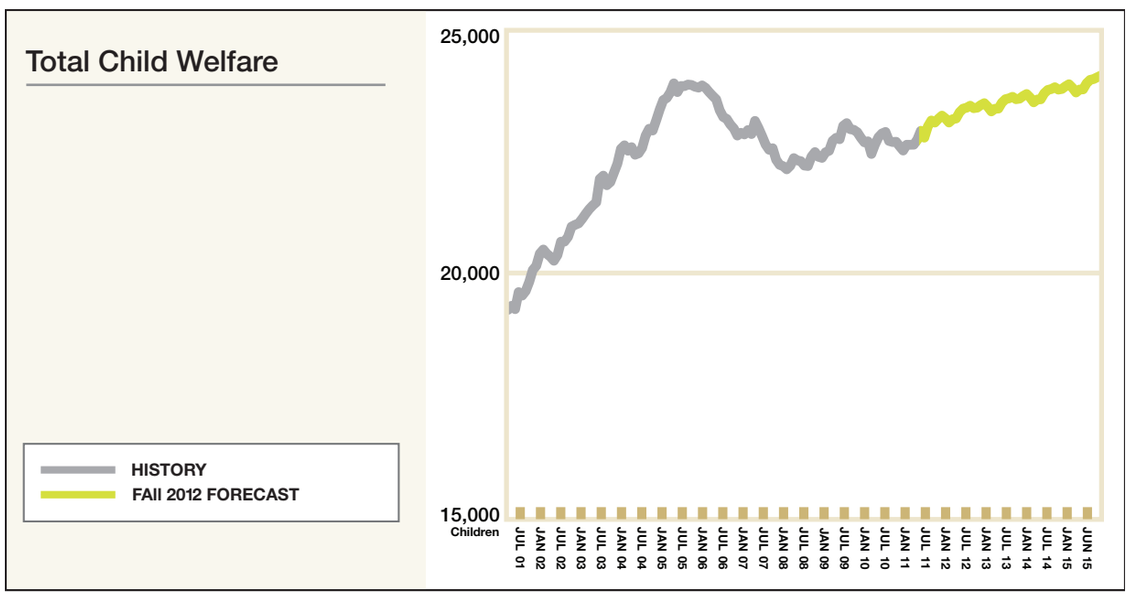


Self Sufficiency Biennial Average Forecast comparison

	2011-2013 biennium			Fall 2012 Forecast		
Supplemental Nutrition Assistance Program (households)	**Spring 12 Forecast 2011-13**	**Fall 12 Forecast 2011-13**	**% diff. Spring 12 to Fall 12 2011-13**	**Fall 12 Forecast 2011-13**	**Fall 12 Forecast 2013-15**	**% diff. Fall 12 2011-13 to 2013-15**
Self Sufficiency	328,068	333,083	1.5%	333,083	312,380	-6.2%
Aging and People with Disabilities	107,259	107,099	-0.1%	107,099	122,850	14.7%
SNAP total	**435,327**	**440,182**	**1.1%**	**440,182**	**435,230**	**-1.1%**
Temporary Assistance for Needy Families (families: cash/grants)						
Basic	29,152	29,234	0.3%	29,234	28,469	-2.6%
UN	5,484	5,700	3.9%	5,700	4,517	-20.8%
TANF total	**34,636**	**34,934**	**0.9%**	**34,934**	**32,986**	**-5.6%**
Pre-SSI	671	600	-10.6%	600	501	-16.4%
Employment Related Day Care (families)	8,449	8,459	0.1%	8,459	10,040	18.7%
Temporary Assistance for Domestic Violence Survivors (families)	532	501	-5.8%	501	505	0.7%

Child Welfare

DHS implemented a new Child Welfare computer system (OR-KIDS) in August 2011. A data warehouse based on OR-KIDS information is currently being developed. As a result, there is no Fall 2012 Forecast. The information in the charts and table is based on the Fall 2011 Forecast.



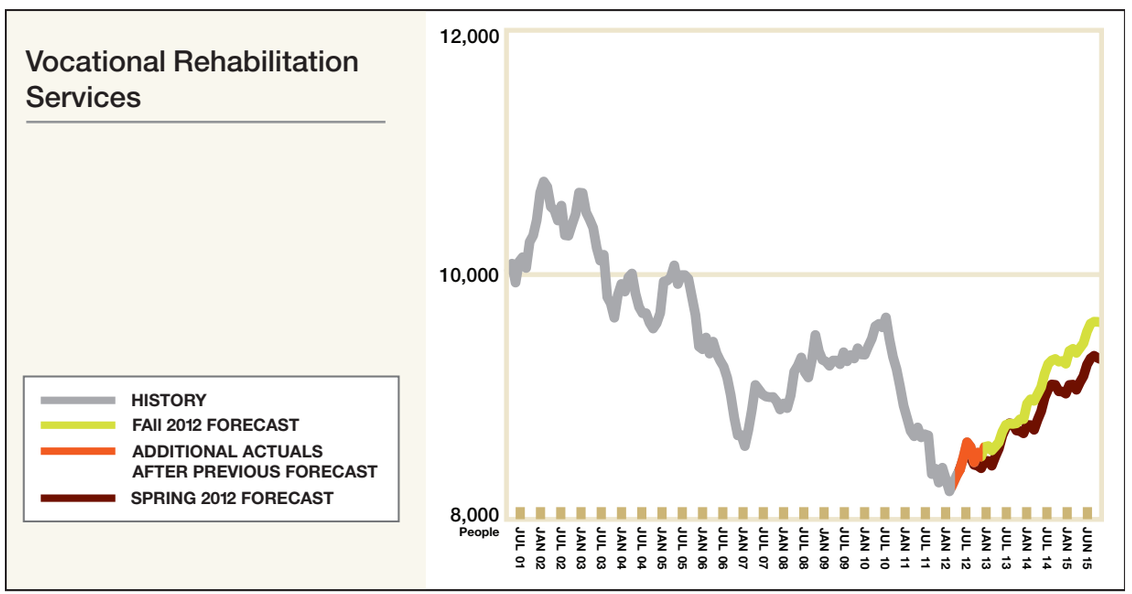
Child Welfare Biennial Average Forecast comparison

Child Welfare (children)[1]	2011-2013 biennium			Fall 2012 Forecast		
	Spring 12 Forecast 2011-13	Fall 12 Forecast 2011-13	% diff. Spring 12 to Fall 12 2011-13	Fall 12 Forecast 2011-13	Fall 12 Forecast 2013-15	% diff. Fall 12 2011-13 to 2013-15
Adoption Assistance	11,025	11,025	0.0%	11,025	11,315	2.6%
Guardianship Assistance	1,153	1,153	0.0%	1,153	1,263	9.5%
Out of Home Care	8,247	8,247	0.0%	8,247	8,185	-0.8%
Child In-Home	2,926	2,926	0.0%	2,926	2,993	2.3%
Child Welfare[2] total	**23,351**	**23,351**	**0.0%**	**23,351**	**23,756**	**1.7%**

1. *The Child Welfare forecast is unchanged from the fall 2011 edition. DHS implemented a new child welfare computer system (OR-KIDS) in August 2011. A forecasting data warehouse based on OR-KIDS data is currently being developed.*
2. *Excludes Child Protective Services Assessments, Recovering Family Mutual Homes, Independent Youth, Title IV-E Tribal Foster Care, Psychiatric Residential Treatment, and Developmentally Disabled Foster Care.*

Vocational Rehabilitation (OVRS)

From 2006 through 2008 the OVRS caseload averaged 9,100 clients. In 2009 budget reductions caused the program to operate under an order of selection, a means of prioritizing clients when demand for services exceeds program capacity. As a result, the caseload averaged 6,000 clients during 2009. Since 2010 OVRS has avoided placing clients on the waiting list and the caseload has averaged 8,400 clients. The Fall 2012 Forecast for the 2011–13 biennium is 8,500 clients, 0.5 percent higher than the Spring 2012 Forecast. The caseload is expected to average 9,225 clients during the 2013–15 biennium, 8.5 percent higher than in 2011–13. Major risks include a renewed activation of the order of selection and the eventual outcome of Lane v. Kitzhaber, a federal class-action lawsuit that could require OVRS to expand its capacity to accommodate more clients.



Vocational Rehabilitation Services Biennial Average Forecast comparison

Vocational Rehabilitation Services	2011-2013 biennium			Fall 2012 Forecast		
	Spring 12 Forecast 2011-13	Fall 12 Forecast 2011-13	% diff. Spring 12 to Fall 12 2011-13	Fall 12 Forecast 2011-13	Fall 12 Forecast 2013-15	% diff. Fall 12 2011-13 to 2013-15
Total clients receiving service	8,461	8,500	0.5%	8,999	9,225	2.5%

Aging and People with Disabilities — Long-Term Care (LTC)

The Long-Term Care Forecast is divided into three categories: In-Home, Community-Based Care, and Nursing Facilities (NFC). Starting with the Fall 2011 Forecast, two NFC caseload categories (Medicare Extended Care and Post-Hospital Benefit) were re-classified as short-term medically related services, and thus were no longer included in the NFC Long-Term Care caseload. NFC LTC now includes only Basic, Complex Medical Add-On, Enhanced Care, and Pediatric Care.

After five years of steady decline, the LTC caseload began to increase in 2008 due to the economic downturn as well as demographic and program changes. Since the latter part of 2010, the caseload has grown very slowly, with 2011 growth coming in slightly slower than anticipated a year ago in the Fall 2011 Forecast. The Fall 2012 Forecast reflects the slower growth trends in all three LTC program areas in spite of significant natural growth in Oregon's over-65 population.

The **Total Long-Term Care** Biennial Average Forecast for 2011–13 is 28,011 clients, 0.3 percent lower than the Spring 2012 Forecast. The Fall 2012 Forecast average for the 2013–15 biennium is 28,676 clients, a 2.4 percent increase from 2011–13.

The **In-Home Care** Biennial Average Forecast for 2011–13 is 10,834 clients, 0.9 percent lower than the Spring 2012 Forecast. The Fall 2012 Forecast average for the 2013–15 biennium is 10,802 clients, 0.3 percent lower than the 2011–13 biennial average. In-Home Services (In-Home Agency and Independent Choices) are not included in this forecast.

The **Community-Based Care** Biennial Average Forecast for 2011–13 is 12,687 clients, which is 0.5 percent higher than the Spring 2012 Forecast. The Fall 2012 Forecast average for the 2013–15 biennium is 13,365 clients, a 5.3 percent increase from 2011–13.

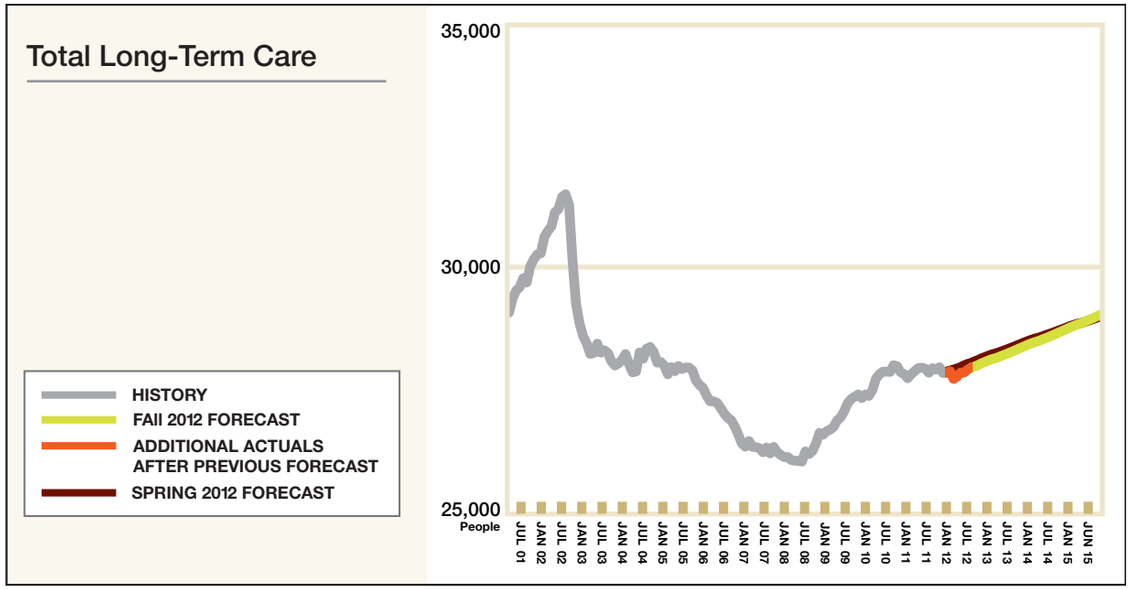
The **Nursing Facility Care** Biennial Average Forecast for 2011–13 is 4,490 clients, 0.9 percent lower than the Spring 2012 Forecast. The Fall 2012 Forecast average for the 2013–15 biennium is 4,509 clients, a 0.4 percent increase from 2011–13.

Slow growth in the Fall 2012 Forecast can be attributed to a variety of factors, several of which are also driving clients to Community-Based Care settings.

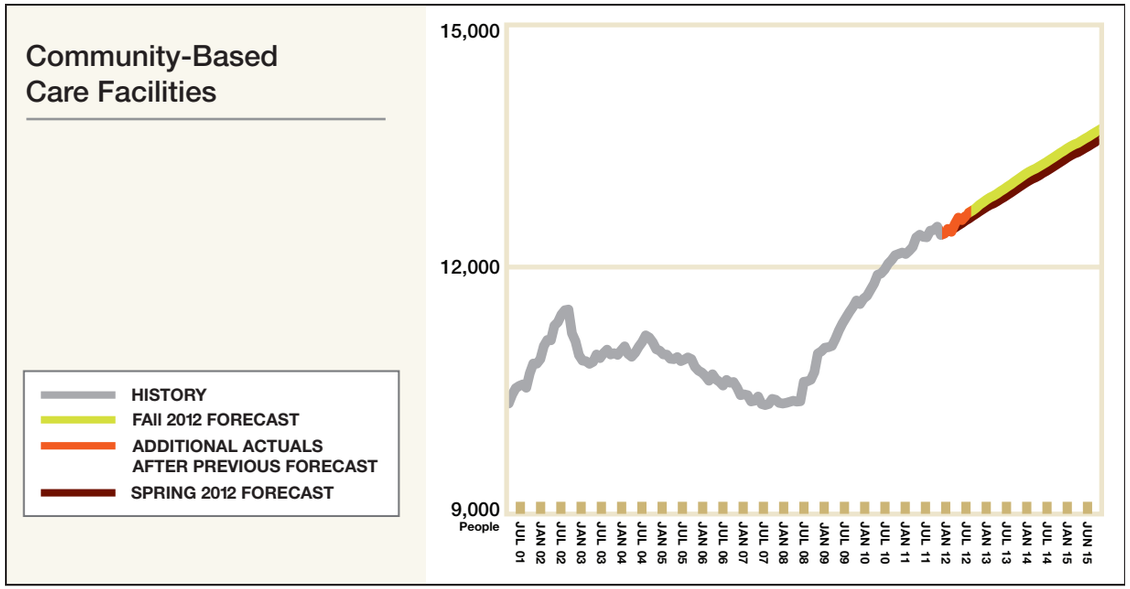
In-Home caseloads have been affected by reduced funding for home modifications, limitations on staff time available to plan and coordinate clients' successful return home following medical emergencies and, frequently, the loss of housing (or affordable housing) while the client is temporarily away from home. With the weak economy, low/slow housing prices and increase in multigenerational households, clients may be deferring applications for assistance until a medical emergency occurs. Clients who cannot afford to pay rent while they are out of their homes for medical care may ultimately lose their homes. Due to the current weak economy, the wait for subsidized housing can be up to two years.

Nursing Facility caseloads have been decreasing for several years, primarily due to agency initiatives focused on shifting clients to lower levels of care whenever possible. The current forecast assumes these initiatives have achieved their full potential and that caseload will grow slightly through 2013–15 and resume growth sometime beyond the current forecast horizon.

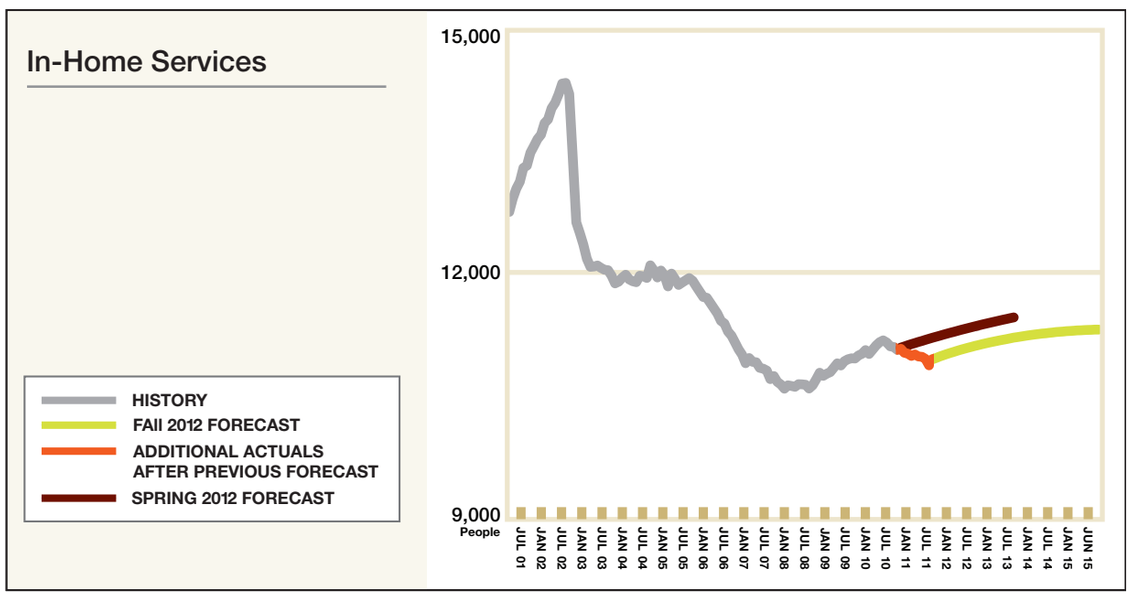
Total Long-Term Care



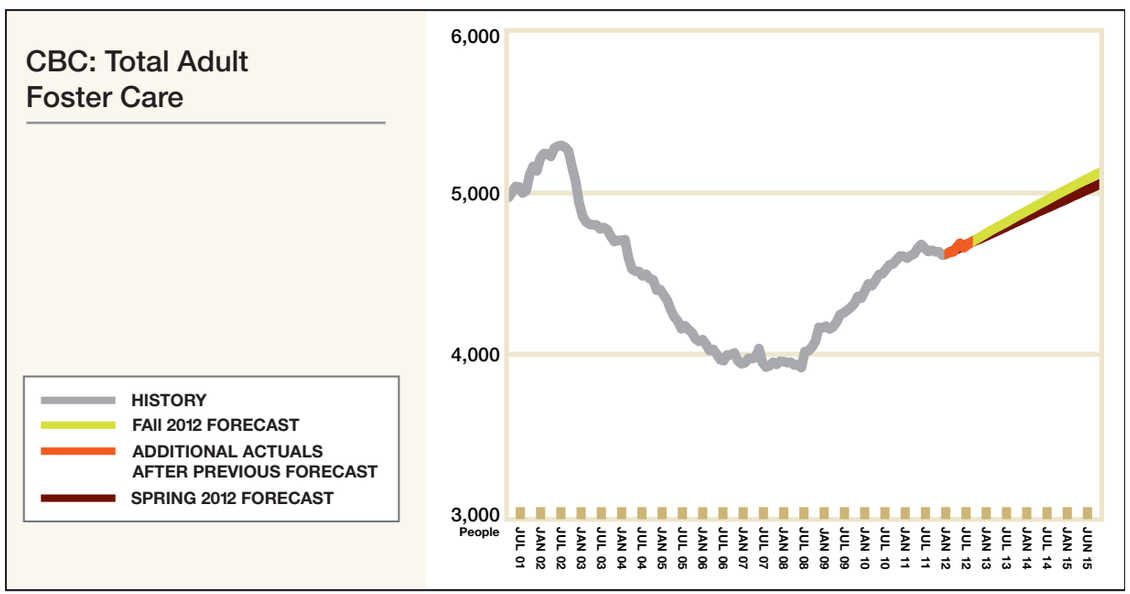
Community-Based Care Facilities



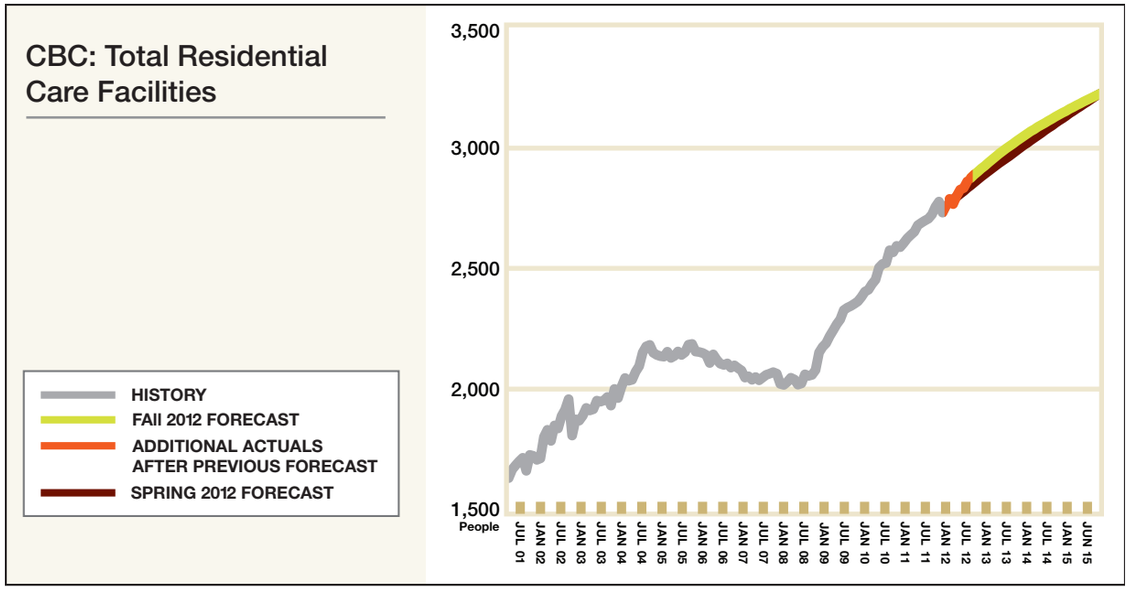
In-Home Services



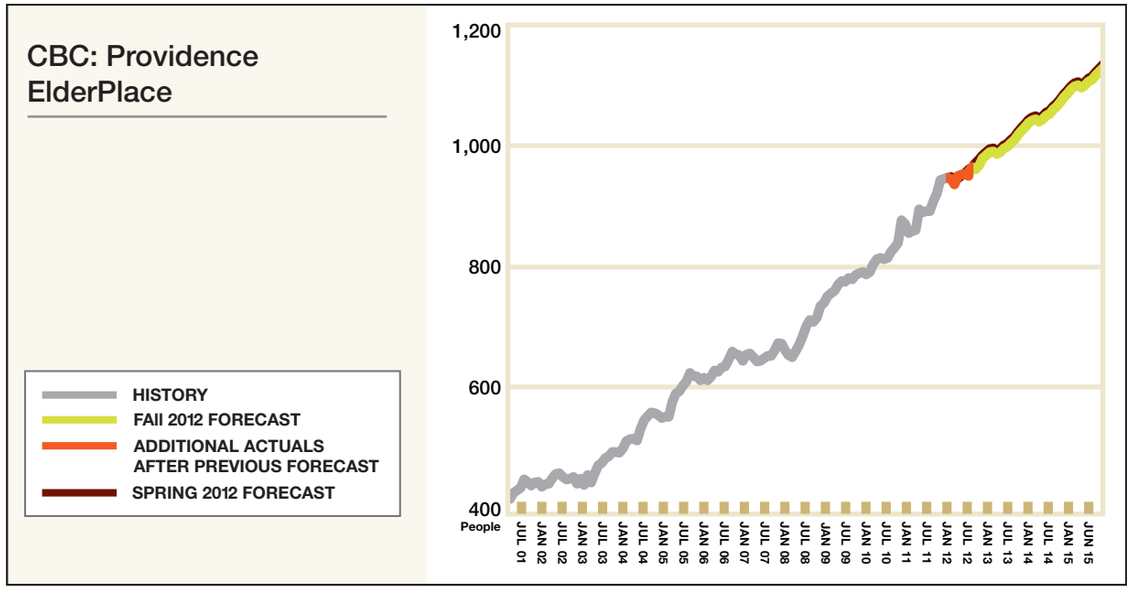
CBC: Total Adult Foster Care



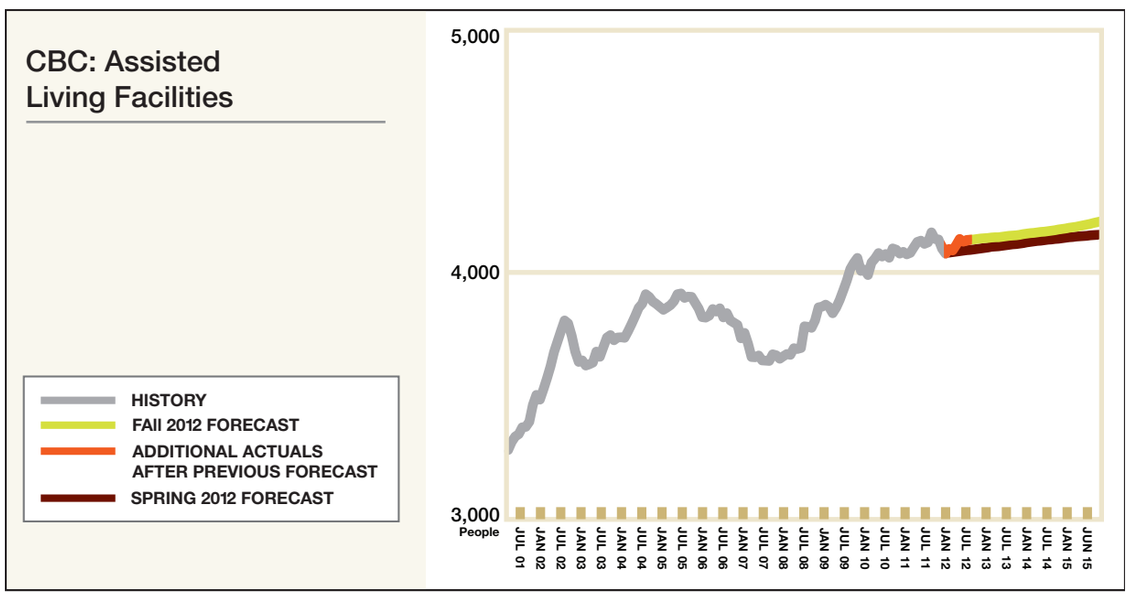
CBC: Total Residential Care Facilities



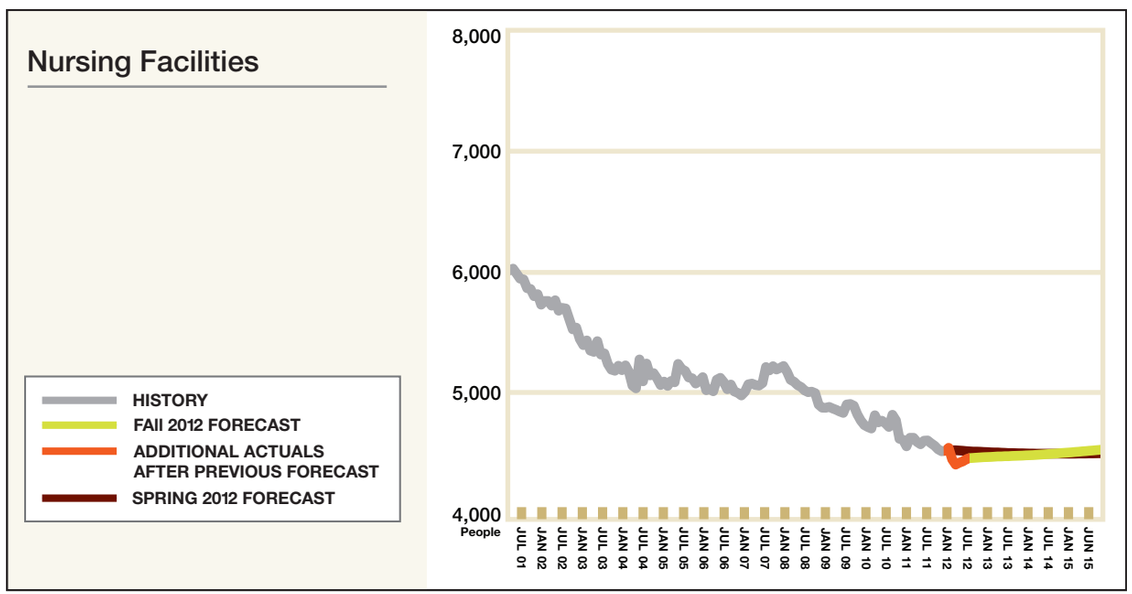
CBC: Providence ElderPlace



CBC: Assisted Living Facilities



Nursing Facilities



Aging and People with Disabilities Biennial Average Forecast comparison

Aging and People with Disabilities	2011-2013 biennium			Fall 2012 Forecast		
	Spring 12 Forecast 2011-13	Fall 12 Forecast 2011-13	% diff. Spring 12 to Fall 12 2011-13	Fall 12 Forecast 2011-13	Fall 12 Forecast 2013-15	% diff. Fall 12 2011-13 to 2013-15
In-Home Hourly	8,669	8,524	-1.7%	8,524	8,494	-0.4%
In-Home Live-In	1,062	1,084	2.1%	1,084	1,108	2.2%
In-Home Spousal Pay	138	112	-18.8%	112	91	-18.8%
Specialized Living	149	149	0.0%	149	150	0.7%
State Plan Personal Care	917	965	5.2%	965	959	-0.6%
In-Home subtotal	**10,935**	**10,834**	**-0.9%**	**10,834**	**10,802**	**-0.3%**
Commercial Adult Foster Care	3,237	3,251	0.4%	3,251	3,569	9.8%
Relative Adult Foster Care	1,463	1,460	-0.2%	1,460	1,417	-2.9%
Regular Residential Care	998	1,011	1.3%	1,011	1,030	1.9%
Contract Residential Care	1,851	1,859	0.4%	1,859	2,095	12.7%
Assisted Living	4,110	4,139	0.7%	4,139	4,183	1.1%
ElderPlace (PACE)	971	967	-0.4%	967	1,071	10.8%
Community-Based Care subtotal	**12,630**	**12,687**	**0.5%**	**12,687**	**13,365**	**5.3%**
Basic Nursing Facility Care	3,885	3,806	-2.0%	3,806	3,810	0.1%
Complex Medical Add-On	531	572	7.7%	572	587	2.6%
Enhanced Care	62	62	0.0%	62	60	-3.2%
Pediatric Care	51	50	-2.0%	50	52	4.0%
Nursing Facilities subtotal	**4,529**	**4,490**	**-0.9%**	**4,490**	**4,509**	**0.4%**
Long-Term Care total	**28,094**	**28,011**	**-0.3%**	**28,011**	**28,676**	**2.4%**
Medicare Extended Care	117	138	17.9%	138	146	5.8%
Post-Hospital Benefit	10	10	0.0%	10	10	0.0%
Total Post-Acute NFC[1]	**127**	**148**	**16.5%**	**148**	**156**	**5.4%**

1. *Nursing Facility services have been separated based on whether they are long-term care or medical related post-acute care.*

Developmental Disabilities (DD)

Case management enrollment is an entry-level eligibility, evaluation and coordination service delivered to all individuals with developmental disabilities. The Biennial Average Forecast for 2011–13 is 20,212 clients, which is nearly identical to the Spring 2012 Forecast. The Fall 2012 Forecast average for the 2013–15 biennium is 21,498 clients, a 6.4 percent increase from 2011–13.

The other caseload categories are grouped into three distinct areas: adult DD services, children DD services, and other DD services.

Adult services include Brokerage Enrollment, 24-Hour Residential Care, Supported Living, Comprehensive In-Home Support Services, and State Operated Community Programs. Non-Residential Foster Care serves both adults and children, with approximately 19 percent of clients under the age of 18.

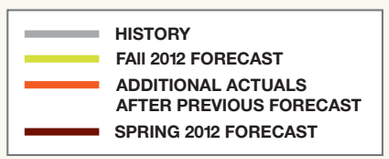
Brokerage Enrollment caseload the Fall 2012 Biennial Average Forecast for 2011–13 is 7,323 clients, 0.7 percent lower than the Spring 2012 Forecast; and 7,908 clients for the 2013–15 biennium, a 8.0 percent increase from 2011–13. The Brokerage forecast is lower due to new Medicaid eligibility requirements that went into effect in October 2011. For 24-Hour Residential Care the Fall 2012 Forecast is 0.7 percent higher than the Spring 2012 Forecast with a biennial average of 2,596 clients in 2011–13, and 2,689 clients in 2013–15. For Supported Living the Fall 2012 Biennial Average Forecast for 2011–13 is 700 clients and 685 clients for the 2013–15 biennium, which is 2.1 percent lower for the 2013–15 biennium.

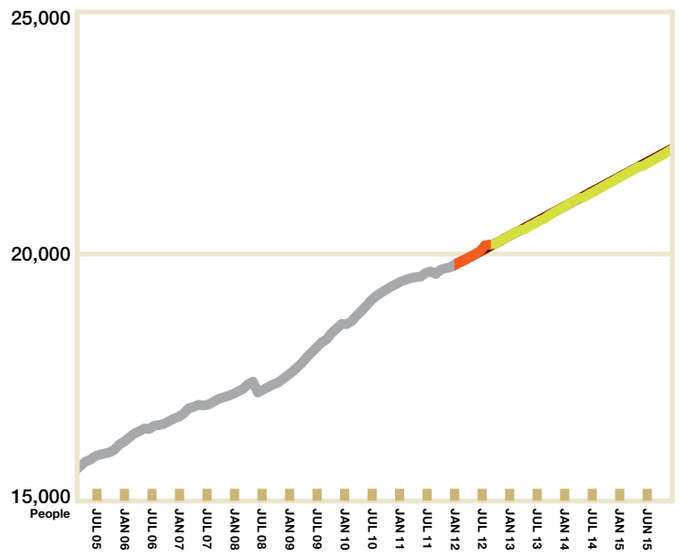
The Comprehensive In-Home Support Services Spring 2012 Biennial Average Forecast for 2011–13 is 276 clients, which is 5.7 percent higher than the Spring 2012 Forecast; and 305 clients for the 2013–15 biennium, a 10.5 percent increase from 2011–13. For Non-Residential Foster Care the Fall 2012 Biennial Average Forecast for 2011–13 is 2,888 clients, 2.6 percent lower than the Spring 2012 Forecast; and 3,049 clients for the 2013–15 biennium, a 5.6 percent increase from 2011–13. In this forecast period, some of the existing Non-Relative Foster Care facilities are converting to 24-Hour Residential Care. Consequently, this will introduce some fluctuation in caseload counts in these two caseload categories.

Developmentally disabled children services include Children Intensive In-Home Support (composed of Medically Fragile Children Services, Intensive Behavior Program, and Medically Involved Program), Children Residential Care, Children Proctor Care, and Long-Term Diversion. All children's services are expected to maintain the spring 2012 caseload levels during the 2011–13 and 2013–15 biennia. All DD children services caseloads are likely to be reorganized under a new DD Children waiver in this forecast period. Such changes will have various risks including eligibility and the redefinition of some of these caseload categories.

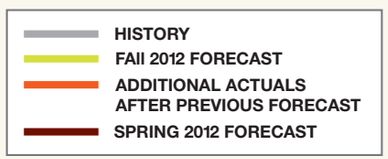
Other DD services include Crisis Services, Employment and Community Inclusion, and Transportation. Crisis Services caseload significantly declined in 2009–11 due to program management action and is expected to remain stable at or below the current forecast level of 55 through 2013–15. For Employment and Community Inclusion, the forecast for 2011–13 is 4,150 clients, 0.8 percent lower than the Spring 2012 Forecast; and 4,265 clients for the 2013–15 biennium, a 2.8 percent increase from 2011-13. For Transportation, the forecast for 2011–13 shows a big decline (23.4 percent) from the 2009–11 forecast cycle; however, the change reflects how data is reported rather than an actual change in services provided. The new Transportation caseload forecast is based on data from the eXPRS system that does not include clients receiving services funded by local match — approximately one-fourth of clients. The forecast for Transportation services in 2011–13 is 2,081 clients, 2.9 percent lower than the Spring 2012 Forecast, and 2,162 clients in the 2013–15 biennium, an increase of 3.9 percent from 2011-13.

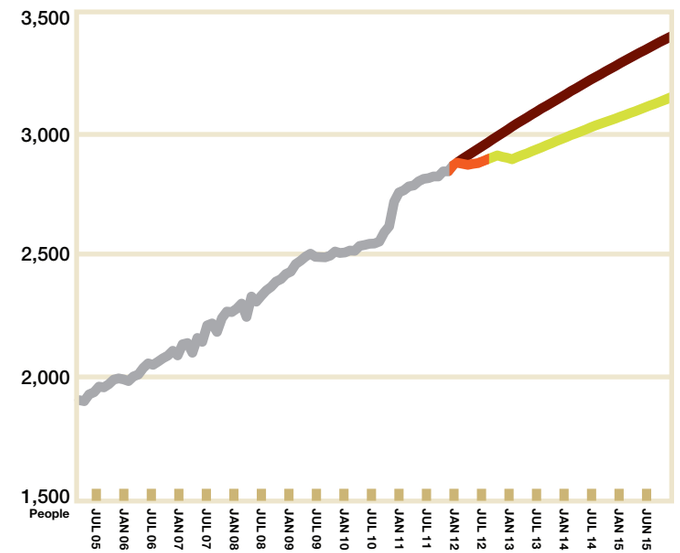
Case Management



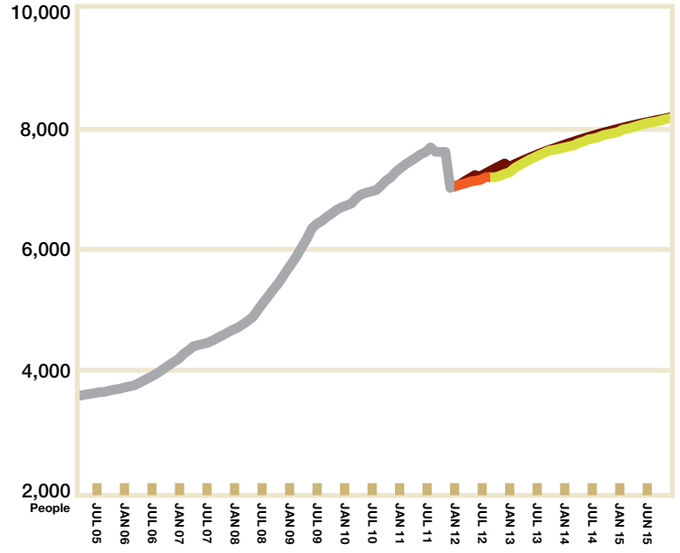


Adult Non-Related Foster Care

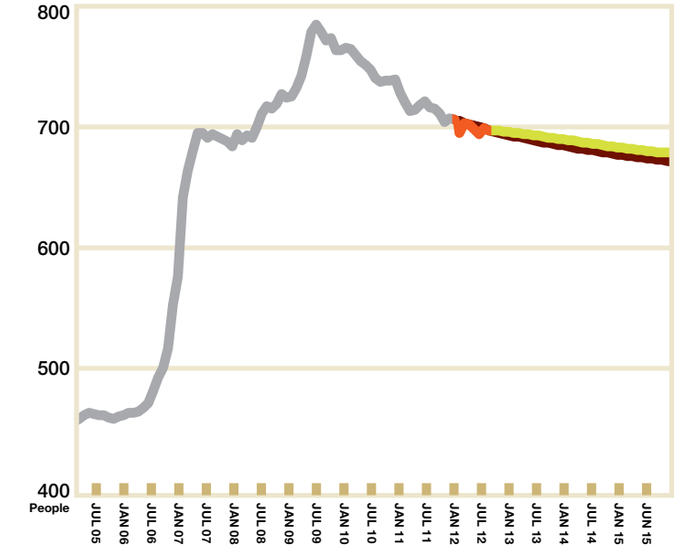




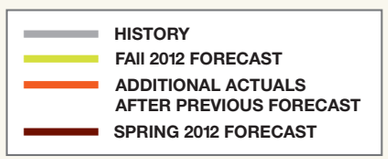
Adult Brokerage Enrollment

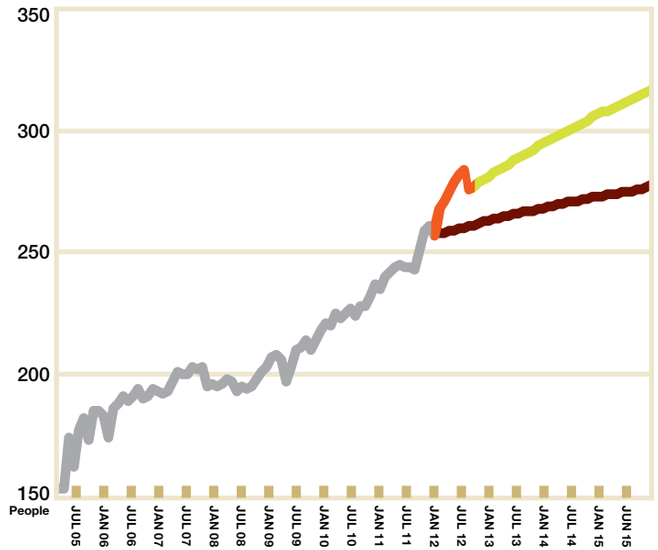


Adult Supported Living

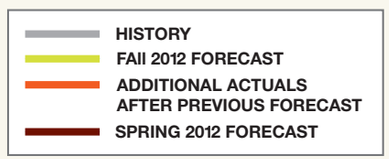


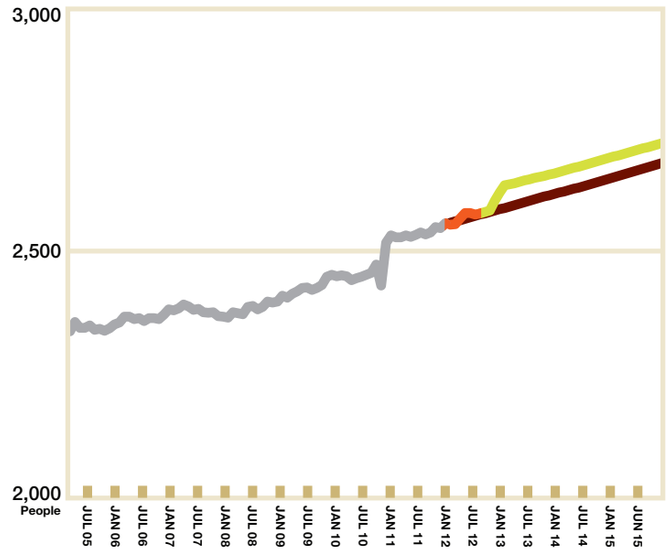
Adult Comprehensive In-Home Services



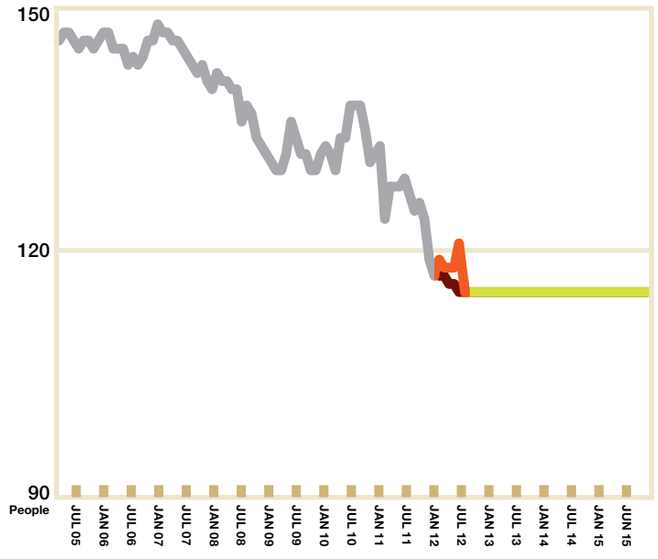


Adult and Children 24-Hour Residential

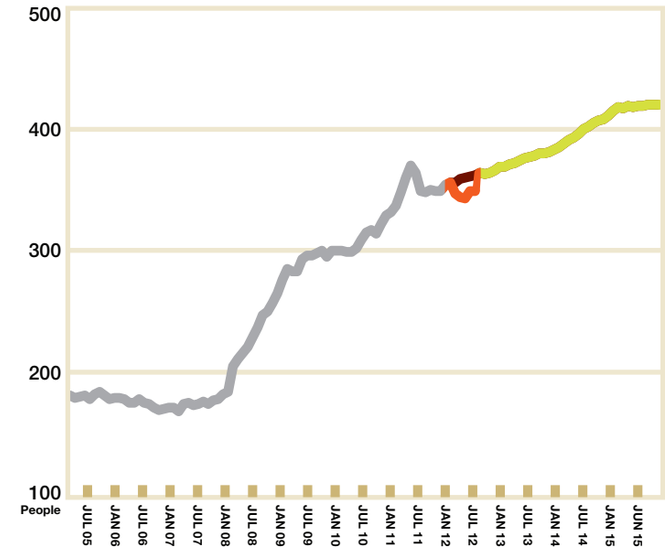




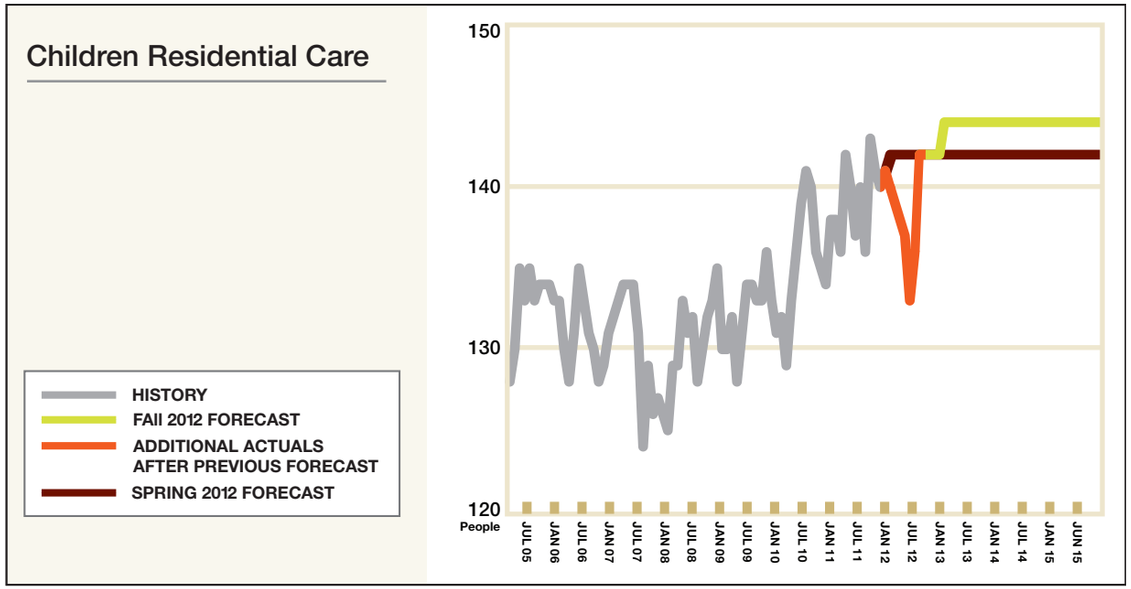
Adult State Operated Community Programs



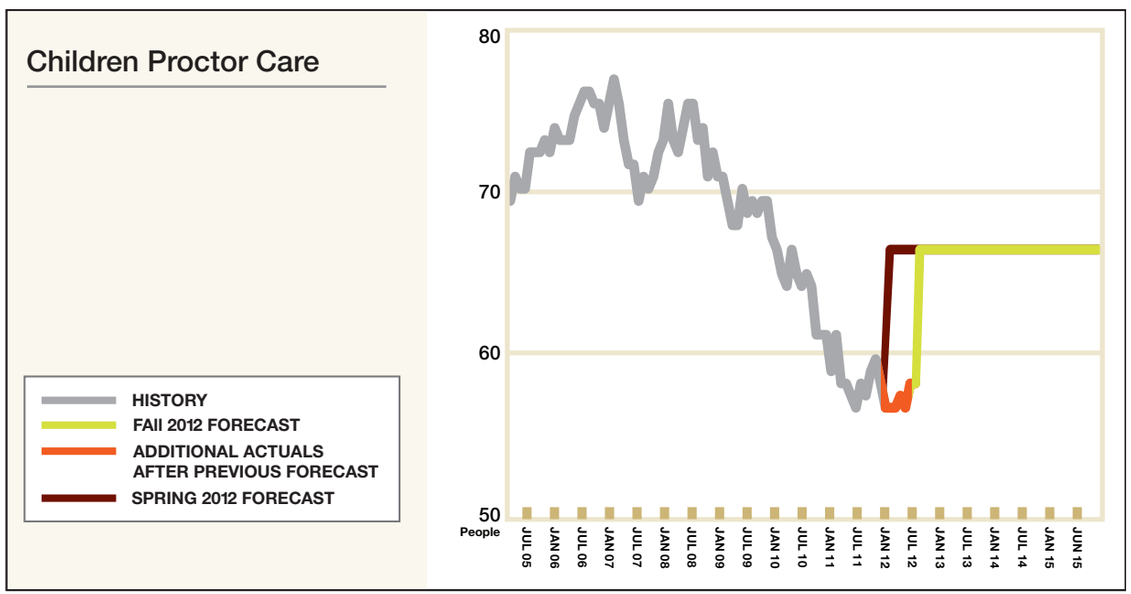
Children Intensive In-Home Services



Children Residential Care



Children Proctor Care



Developmental Disabilities Biennial Average Forecast comparison

	2011-2013 biennium			Fall 2012 Forecast		
	Spring 12 Forecast 2011-13	Fall 12 Forecast 2011-13	% diff. Spring 12 to Fall 12 2011-13	Fall 12 Forecast 2011-13	Fall 12 Forecast 2013-15	% diff. Fall 12 2011-13 to 2013-15
Case Management Enrollment total	**20,213**	**20,212**	**0.0%**	**20,212**	**21,498**	**6.4%**
Adult						
Comprehensive In-Home Services	261	276	5.7%	276	305	10.5%
Brokerage Enrollment	7,376	7,323	-0.7%	7,323	7,908	8.0%
Non-Related Foster Care	2,966	2,888	-2.6%	2,888	3,049	5.6%
24-Hour Residential	2,578	2,596	0.7%	2,596	2,689	3.6%
Supported Living	699	700	0.1%	700	685	-2.1%
State-Operated Community Programs	117	117	0.0%	117	115	-1.7%
Children						
Children Intensive In-Home Support	365	362	-0.8%	362	406	12.2%
Children Residential Care	142	141	-0.7%	141	144	2.1%
Children Proctor Care	60	57	-5.0%	57	62	8.8%
Long-Term Diversion	157	159	1.3%	159	185	16.4%
DD Services total	**14,721**	**14,619**	**-0.7%**	**14,619**	**15,548**	**6.4%**
Other DD Services						
Crisis Services	51	48	-5.9%	48	55	14.6%
Transportation	2,144	2,081	-2.9%	2,081	2,162	3.9%
Employment and Community Inclusion	4,183	4,150	-0.8%	4,150	4,265	2.8%

Note: Total DD Services and DD ancillary services do not add up to Total Case Management Enrollment.

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast comparison

	2011-2013 biennium			Fall 2012 Forecast		
Medical Assistance Programs[1]	**Spring 12 Forecast 2011-13**	**Fall 12 Forecast 2011-13**	**% diff. Spring 12 to Fall 12 2011-13**	**Fall 12 Forecast 2011-13**	**Fall 12 Forecast 2013-15**	**% diff. Fall 12 2011-13 to 2013-15**
OHP Plus: Temporary Assistance to Needy Families (Medical)	184,499	184,603	0.1%	184,603	192,628	4.3%
OHP Plus: Children (PLM-C & CHIP)	222,196	220,381	-0.8%	220,381	226,484	2.8%
OHP Plus: Aging and People with Disabilities (ABAD & OAA)	116,088	115,505	-0.5%	115,505	124,130	7.5%
OHP Plus: Poverty Level Medical Women	13,047	13,012	-0.3%	13,012	13,314	2.3%
OHP Plus: Substitute Care & Adoption Services	18,492	18,748	1.4%	18,748	19,208	2.5%
OHP Plus total	**554,322**	**552,250**	**-0.4%**	**552,250**	**575,765**	**4.3%**
Other Medical Assistance Programs	47,099	46,947	-0.3%	46,947	51,906	10.6%
OHP Standard	61,433	64,070	4.3%	64,070	59,042	-7.8%
KidsConnect	7,597	6,914	-9.0%	6,914	11,268	63.0%
Addictions and Mental Health[2]						
Total Criminal Commitment	811	851	4.9%	851	837	-1.6%
Total Civil Commitment[3]	5,299	4,324	-18.4%	4,324	4,657	7.7%
Mandated Care total	**6,059**	**5,147**	**-15.1%**	**5,147**	**5,387**	**4.7%**

1. *These estimates do not reflect additional clients anticipated as the result of the Federal Patient Protection and Affordable Care Act's implementation beginning in January 2014. If the current estimated addition of 224,000 clients by June 2015 holds true, the 2013–2015 biennium could experience an average of 807,706 clients.*
2. *All groups and subgroups are forecast independently using unduplicated client counts. Since one individual can be counted in more than one group due to overlapping service episodes, totals are usually less than the sum of the lower level categories.*
3. *The difference between the spring 2012 and fall 2012 forecasts is almost entirely due to how client data are captured and counted, not a difference in the number of people served. In mid-2012, the DHS|OHA Integrated Client Services Data Warehouse was adjusted to correct two errors. First, there was a correction in service episode end dates for clients in 24-hour and/or community services, which reduced civil commit caseload counts by more than 1,000 people. Second, a service category that had been inadvertently omitted from forensic services was added back in, increasing the total forensic caseload by approximately 50 people.*

Medical Assistance Programs (MAP)

The primary drivers of caseload growth for Medical Assistance Programs since 2008 were the longest recessionary period since WWII (December 2007 through an official ending date of June 2009) and implementation of the Oregon Healthy Kids Initiative in July 2009. Taken together, these two influencing factors drove the total MAP caseloads from 407,000 clients in December 2007 to 669,680 clients in April 2012 (the most recent month for which actual caseload data were available at time of writing). This represents a total MAP caseload increase of 64.5 percent.

Although the recent recession officially ended in June 2009, upward pressure on MAP caseloads continued through February 2011, at which point total caseload growth began to slow. Between February 2010 and February 2011, total MAP caseloads grew by an average rate of 1.6 percent per month. Beginning in March 2011, growth slowed to an average of 0.4 percent per month. This rate has persisted through April 2012 and is expected to slow further through the end of the current biennium, providing a slight decline in total caseloads.

Four of the measured groups accounted for greater than 80 percent of the caseload: Total TANF (TANF Related Medical and TANF Extended) at 30.8 percent, Poverty Level Medical Children at 24.9 percent, Aid to the Blind and Disabled at 13.4 percent, and CHIP at 11.9 percent.

TANF Related Medical and TANF Extended are often combined since they are programmatically tied. These two groups are relatively sensitive to external economic shocks with caseload effects continuing well after other measures of economic shock have abated. The primary forecast risk for these groups lies in estimating the timing of when growth will slow. Preliminary measures for recent months indicate a leveling of this total population with greater numbers of clients shifting from TANF Related Medical to TANF Extended as their economic condition improves.

Poverty Level Medical Children is the second largest MAP group. This group has grown substantially since the inception of the Oregon Healthy Kids Initiative in July 2009. As expected, this group leveled out at around 150,000 clients due to saturation of the eligible population pool.

Aid to the Blind and Disabled caseloads have grown consistently across 10 years of historical observation, varying from 0.25 to 0.5 percent per month. This group is expected to continue this growth rate into the foreseeable future.

CHIP caseloads are sensitive to both economic conditions and the effects of the Healthy Kids Initiative as outreach into communities and schools has increased exposure to medical insurance availability. This group, despite leveling off in the past 12 months, is expected to resume a pattern of slow growth as economic conditions improve and children currently counted in the Poverty Level Medical Children shift to this group.

The remaining 20 percent of the total MAP caseload is made up of clients in Old Age Assistance at 5.9 percent, total Citizen Alien Waived Emergent Medical (CAWEM) at 4.4 percent, Qualified Medical Beneficiary at 3.3 percent, Foster/Substitute Care at 3.1 percent, Poverty Level Medical Women at 2.2 percent, and Breast and Cervical Cancer Program at 0.1 percent

Old Age Assistance caseloads have grown relatively consistently since January 2009. Prior to that time, this caseload held constant at approximately 31,000 clients. Program changes, including elimination of a special General Assistance eligibility group, were the single greatest contributing factor to observed program growth. This group is also sensitive to general demographic changes as the population aged 65 and greater increases within the state. Expectation is for this group to continue in a growth pattern through the forecast horizon as those demographic shifts continue.

The total **CAWEM** caseloads are comprised of CAWEM General and a relatively new CAWEM Pre-Natal program. Clients in these caseloads are documented non-citizens who are eligible for special reduced benefits generally consisting only of emergency medical coverage. Clients in the Pre-Natal portion of the program would be, except for pregnancy, eligible for the normal CAWEM program. The Pre-Natal program is only available in participating counties and is not currently available statewide. Forecasting these program groups has proven to be difficult as the population of documented non-citizens varies with external influences including both economic shocks and immigration policies. Current expectation is for this total group to hover around the 20,000 mark through the forecast horizon.

Like Old Age Assistance, **Qualified Medical Beneficiary** caseloads have exhibited a consistent pattern of slow growth. Clients are Medicare-eligible and generally aged. Expectations are for this group to continue growing at approximately 1 percent per month through the forecast horizon.

Foster/Substitute Care caseloads have increased significantly since a new Child Welfare computer system was implemented in August 2011. Prior to that time, the caseload had been dropping for a period of 12 months. At this time, there is reason to believe that the data have been compromised. This represents a substantial risk in forecasting future caseloads for this category as observable history is suspect. As of this writing, the potential for inaccurate historical data is being explored. The current forecast is for a very slow pattern of growth in this group through the 2013–2015 biennium.

Poverty Level Medical Women caseloads have grown at a steady, but variable, rate since January 2009. This group exhibits substantial seasonality with observable upward level shifts in caseload totals across the years. This group is expected to continue observed patterns of growth through the remainder of the forecast horizon.

The **Breast and Cervical Cancer Program** has shown consistent slow growth since at least January 2005. Recent legislation expanded the program statewide. In fall 2011, caseloads began to increase at a rate far above that experienced prior to legislative implementation. Current expectation is for this group to grow at a rate of approximately 2 percent to 4 percent per month, compared to 1 percent to 2 percent growth prior to legislative expansion.

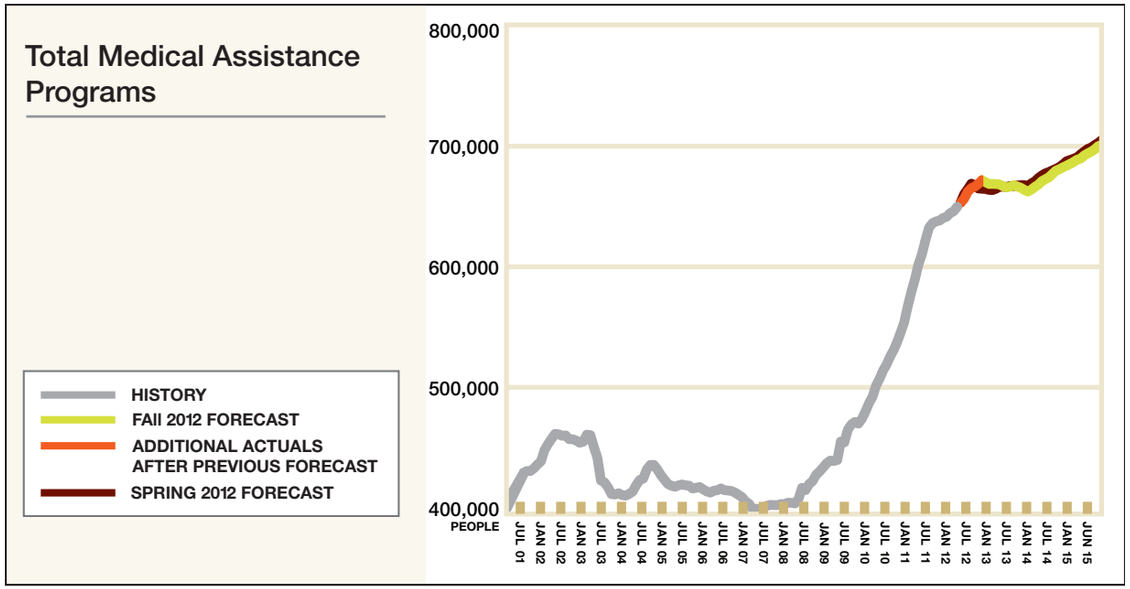
The **Standard** program is comprised of two distinct eligibility groups: Families, and Adults and Couples. The Families portion of the Standard program typically represents about 35 percent of the caseload with the remaining 65 percent falling into Adults and Couples. The Standard caseload is subject to a program cap based on a unique hospital tax program funding stream. Clients in this caseload enter via one of two routes. New clients are admitted as the result of a lottery from a continuous self-selected eligibility list. Clients who are currently on other MAP caseloads, but lose eligibility for participation in those caseloads, are also allowed to transition into one of the Standard groups upon eligibility review. Because of program capacity limitations, total caseloads for Standard are ”managed” on a monthly basis to achieve a biennial average of 60,000 clients.

The federal **Affordable Care Act (2010)** will substantially affect Oregon MAP caseloads beginning in 2014. One result of this act is that adult Oregonians between 100 percent and 138 percent of federal poverty level will now be eligible for Medicaid. Currently, estimates are being developed of the act’s effect on Oregon’s Medicaid caseloads. The State Health Access Data Assistance Center, funded by the Robert Wood Johnson Foundation and housed at the University of Minnesota, is providing assistance and modeling. As of this writing, it is estimated that somewhere between 200,000 and 225,000 clients will be added to MAP caseloads between January 2014 and June 2015. These estimates continue to be tentative. The high-end estimate of 225,000 additional clients would result in an estimated 2013–2015 biennial average total caseload of approximately 822,000, compared to a biennial average of 687,000 expected without the influence of the Affordable Care Act. This represents a biennial average increase of approximately 19.8 percent. However, the total number of clients added would exceed the biennial average. Assuming the high-end of the estimated range would increase the total caseload in June 2015 to 931,000 active clients, an increase of 31.9 percent over the 706,000 clients is expected without ACA influence.

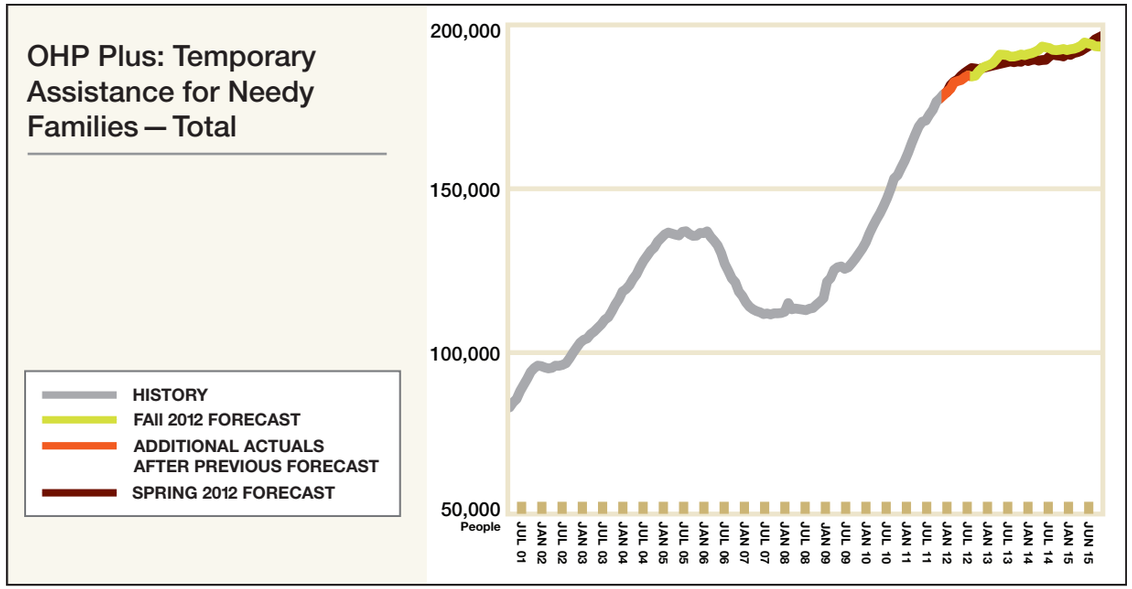
The **KidsConnect** program represents an alternative state-sponsored children's health insurance option for children of families who fall between 200 and 300 percent of the federal poverty level and are not eligible for Medicaid. This program was developed as part of the Oregon Healthy Kids Initiative. Since the start of the KidsConnect program in February 2010, caseloads have grown steadily to 7,075 clients in August 2012. Assuming a continuation of the current growth rate, this program is expected to reach 13,367 clients by June 2015. This program also will be affected by the advent of the Affordable Care Act. It is currently assumed that the KidsConnect program will transition to the Oregon Health Exchange in concert with the implementation of the Affordable Care Act in January 2014. Based on current American Community Survey data in combination with the Oregon Health Survey of 2011, approximately 15,900 Oregon children are estimated to be eligible for the KidsConnect program. The insurance mandates associated with the ACA coupled with proactive changes in marketing strategies via the Oregon Health Exchange are expected to put upward pressure on growth in the KidsConnect program. Under these assumptions, the KidsConnect caseload is expected to reach demand saturation by July 2014 when it will stabilize at approximately 16,000 clients.

Continuing work on refining the modeling effort for this group may result in changes to this forecast.

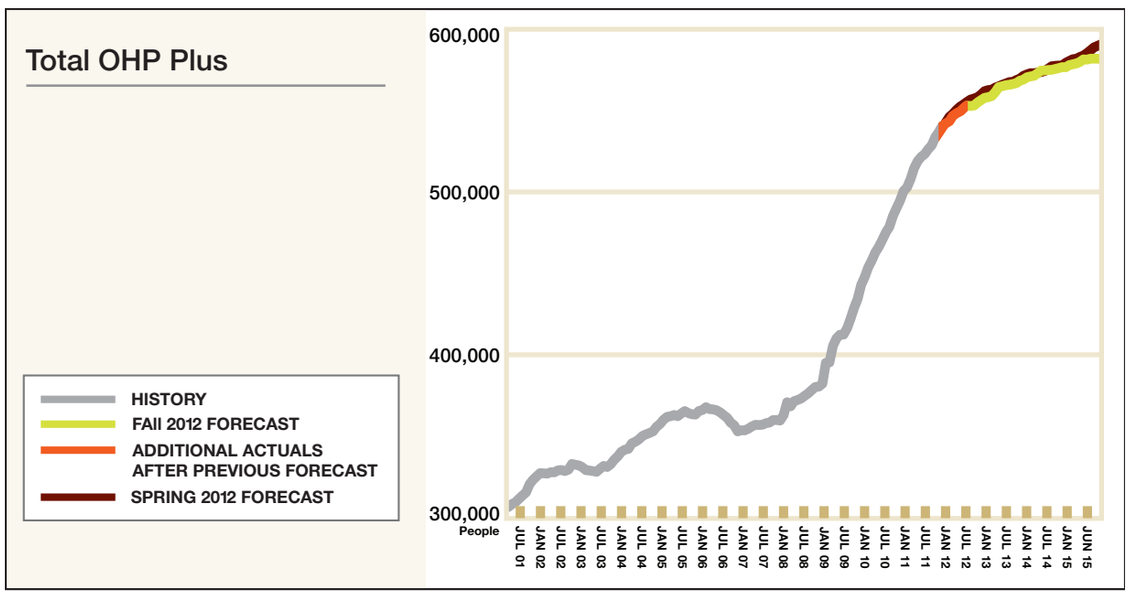
Total Medical Assistance Programs



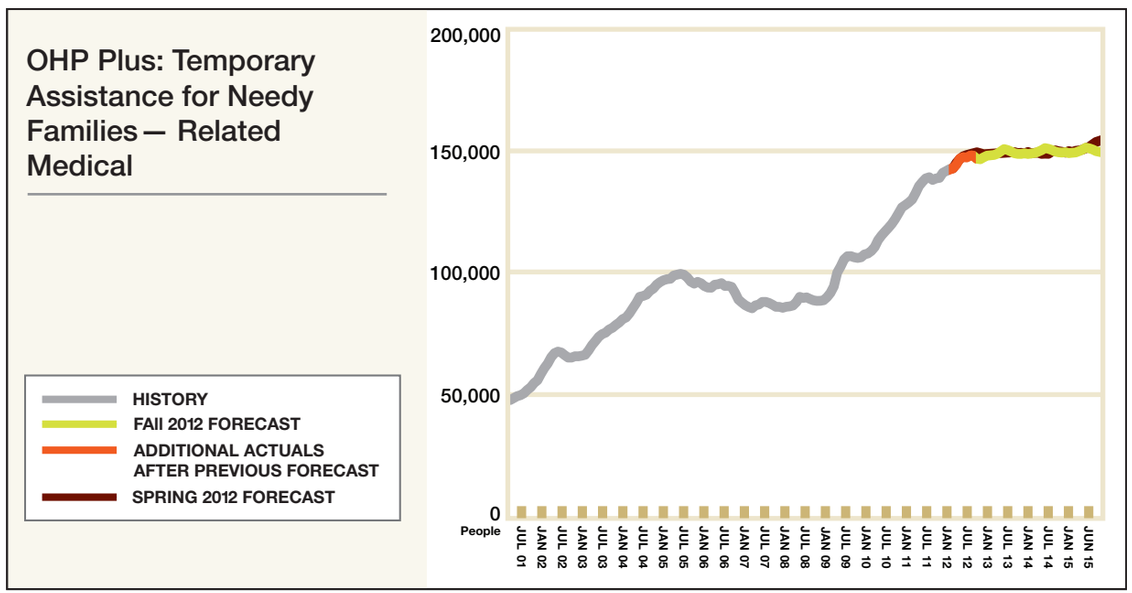
OHP Plus: Temporary Assistance for Needy Families — Total



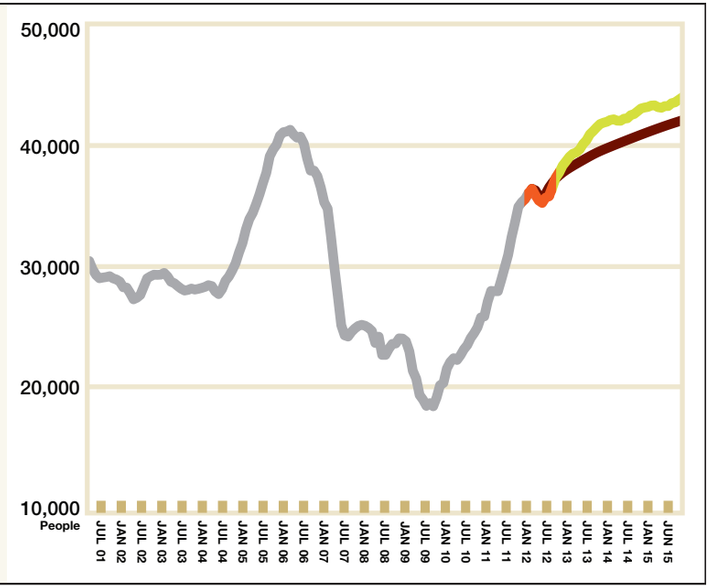
Total OHP Plus



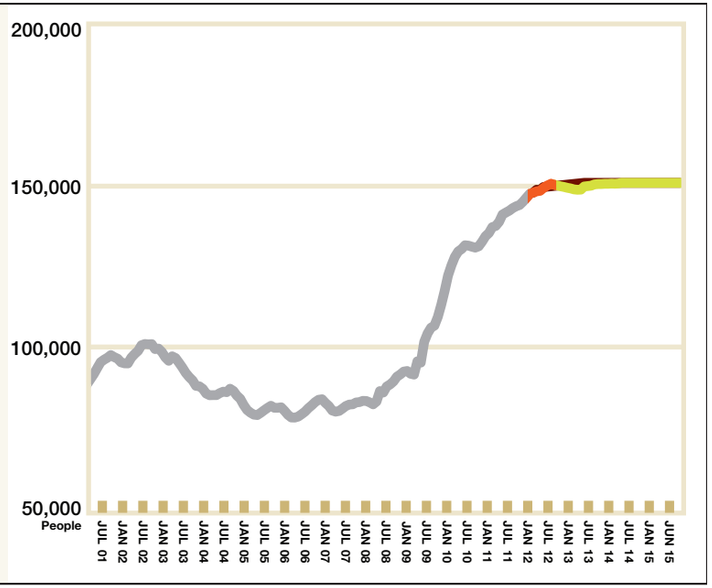
OHP Plus: Temporary Assistance for Needy Families — Related Medical



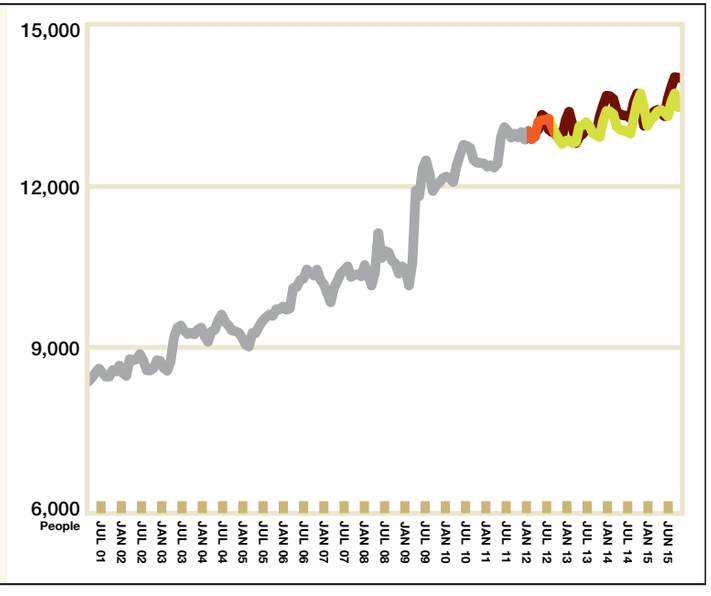
OHP Plus: Temporary Assistance for Needy Families — Extended



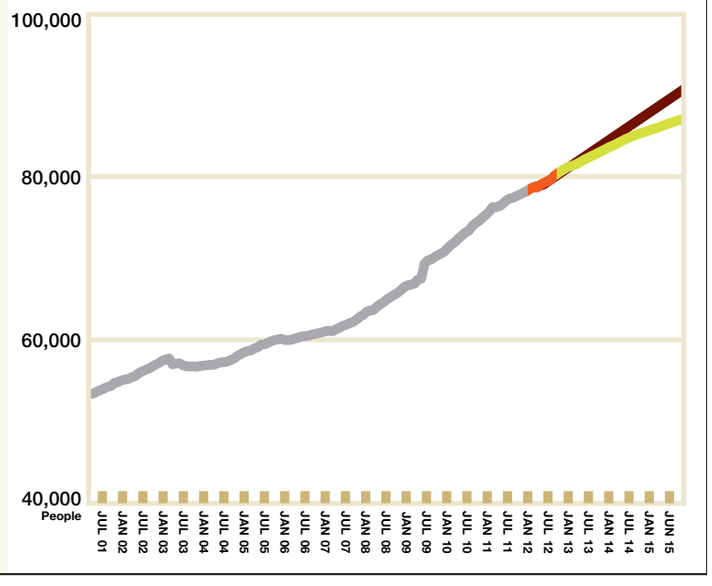
OHP Plus: Poverty Level Medical Children



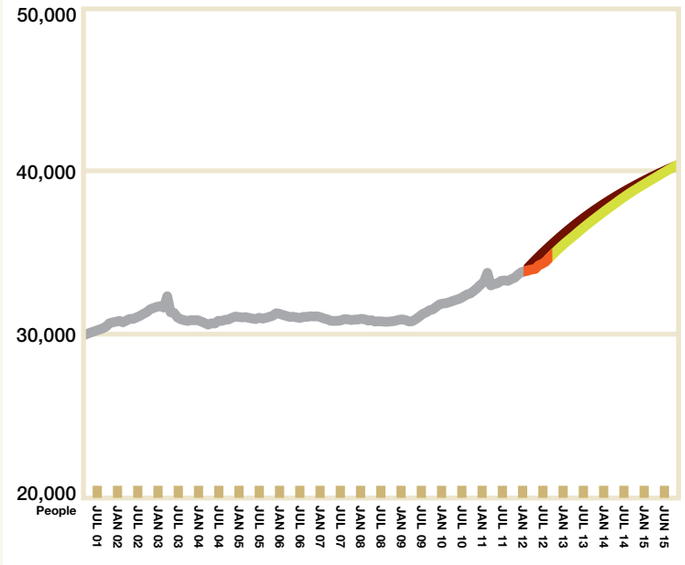
OHP Plus: Poverty Level Medical Women



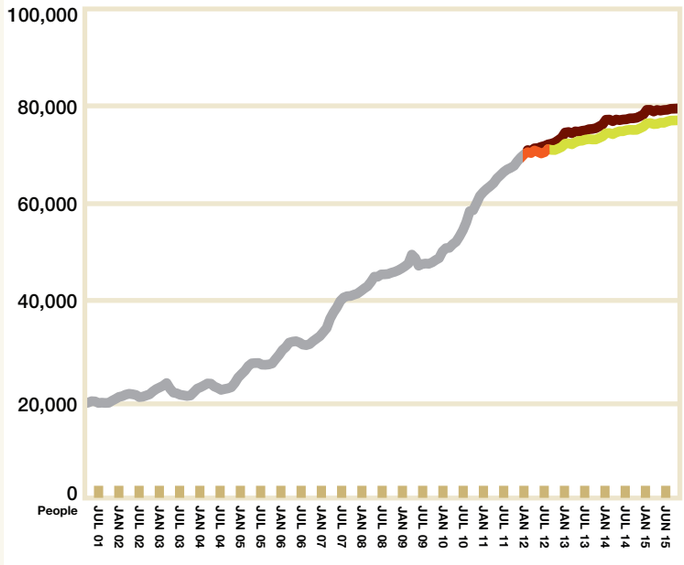
OHP Plus: Aid to the Blind and Disabled



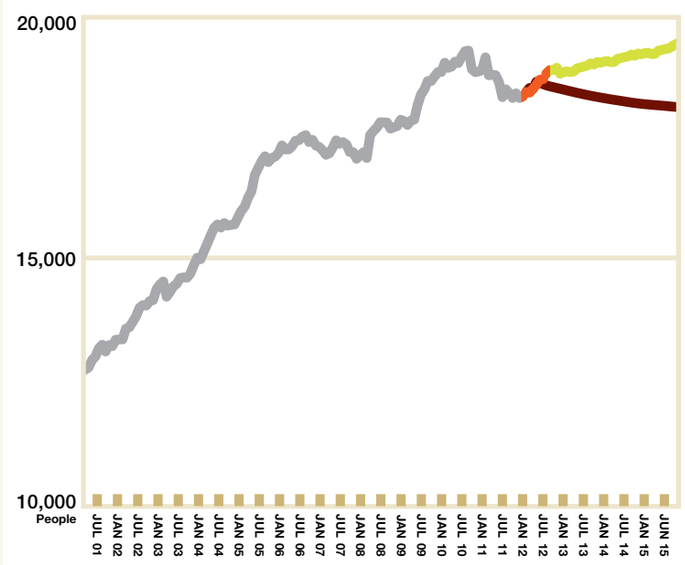
OHP Plus: Old Age Assistance



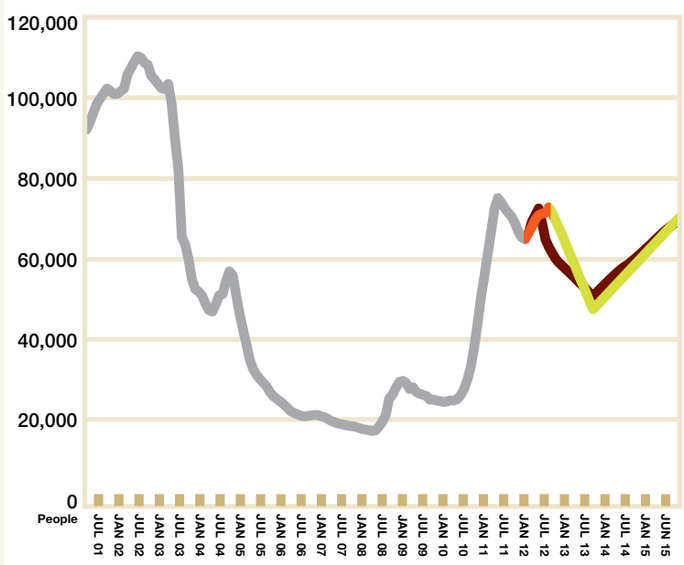
OHP Plus: Children's Health Insurance Program



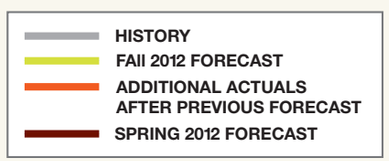
OHP Plus: Substitute Care and Adoption Services

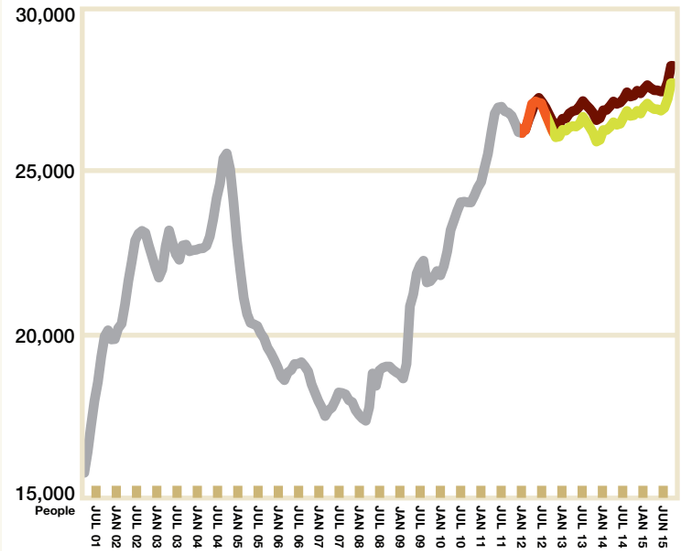


OHP Standard

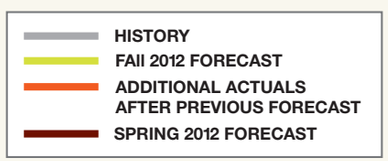


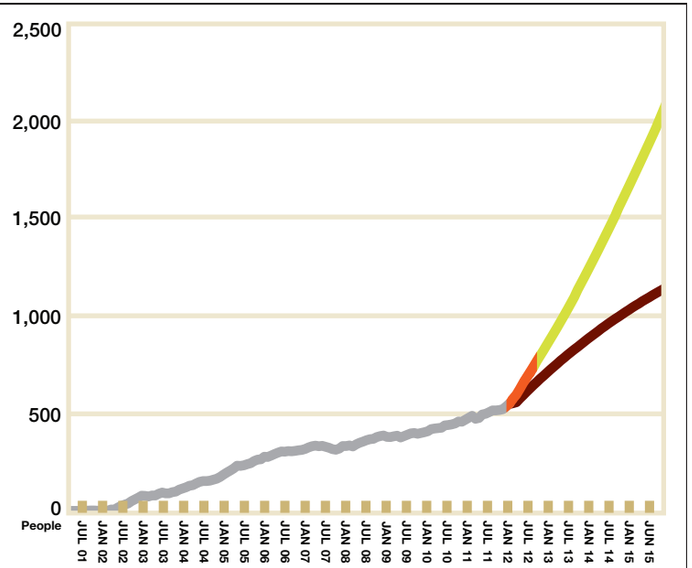
Other: Citizen/Alien Waived Emergency Medical



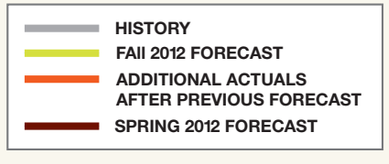


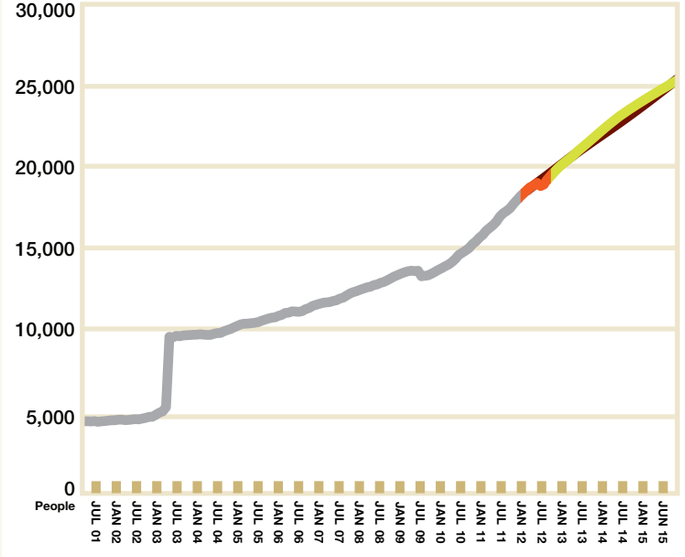
Other: Breast and Cervical Cancer



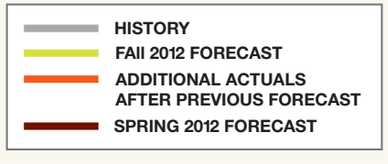


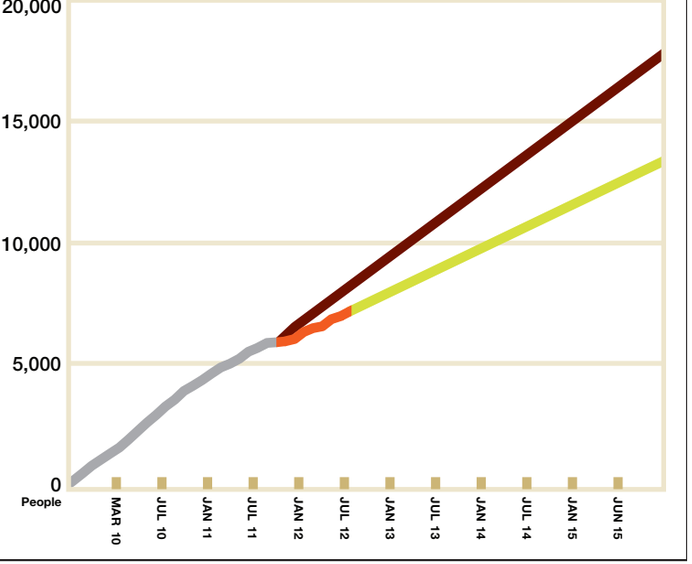
Other: Qualified Medicare Beneficiary





KidsConnect





Medical Assistance and KidsConnect Biennial Average Forecast comparison

	2011-2013 biennium			Fall 2012 Forecast		
OHP Plus	**Spring 12 Forecast 2011-13**	**Fall 12 Forecast 2011-13**	**% diff. Spring 12 to Fall 12 2011-13**	**Fall 12 Forecast 2011-13**	**Fall 12 Forecast 2013-15**	**% diff. Fall 12 2011-13 to 2013-15**
TANF-Related Medical	147,164	146,781	-0.3%	146,781	149,861	2.1%
TANF-Extended	37,335	37,822	1.3%	37,822	42,767	9.4%
TANF Medical subtotal	**184,499**	**184,603**	**0.1%**	**184,603**	**192,628**	**3.6%**
Poverty Level Medical Women	13,047	13,012	-0.3%	13,012	13,314	3.5%
Poverty Level Medical Children	149,535	149,026	-0.3%	149,026	150,990	1.0%
Aid to the Blind and Disabled	80,524	80,425	-0.1%	80,425	85,284	8.3%
Old Age Assistance	35,564	35,080	-1.4%	35,080	38,846	10.0%
Substitute Care and Adoption Services	18,492	18,748	1.4%	18,748	19,208	-1.3%
Children's Health Insurance Program	72,661	71,355	-1.8%	71,355	75,494	7.4%
OHP Plus subtotal	**554,322**	**552,250**	**-0.4%**	**552,250**	**575,765**	**4.3%**
Other Medical Assistance Programs						
Citizen/Alien Waived Emergency Medical	26,737	26,504	-0.9%	26,504	26,686	2.1%
Qualified Medicare Beneficiary	19,691	19,651	-0.2%	19,651	23,643	18.7%
Breast and Cervical Cancer Program	671	792	18.0%	792	1,578	48.9%
Other Medical Assistance subtotal	**47,099**	**46,947**	**-0.3%**	**46,947**	**51,906**	**9.7%**
OHP Standard	61,433	64,070	4.3%	64,070	59,042	-1.2%
Total Medical Assistance Programs[1]	**662,854**	**663,267**	**0.1%**	**663,267**	**686,714**	**4.2%**
KidsConnect	7,597	6,914	-9.0%	6,914	11,268	87.9%

1. *These estimates do not reflect additional clients anticipated as the result of the Federal Patient Protection and Affordable Care Act's implementation beginning in January 2014. If the current estimated addition of 224,000 clients by June 2015 holds true, the 2013–2015 biennium could experience an average of 807,706 clients.*

Addictions and Mental Health (AMH)

This forecast is for clients receiving mental health services from Oregon Health Authority through Addictions and Mental Health (AMH). Services primarily fall into two categories: Community Services, including Residential Care, and the Oregon State Hospital system. Community programs provide outpatient services including intervention, therapy, case management, child and adolescent day treatment, crisis, and pre-commitment services. The state hospitals – located in Salem, Portland and Pendleton – provide 24-hour supervised care to people with the most severe mental health disorders, including people who have been found guilty except for insanity.

For budgeting purposes, the Mental Health caseload is divided into two client groups: Mandated and Non-Mandated. Oregon law requires Mandated populations, including criminally and civilly committed patients, to receive mental health services. These services occur both in the community, including residential care settings,,and in the state hospitals. Non-Mandated services are primarily provided in community outpatient settings. Only Mandated caseloads are forecast.

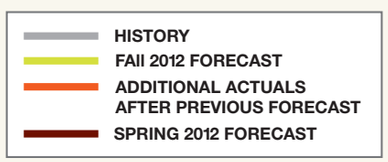
Total Mandated: The Fall 2012 biennial average forecast for the 2011–13 biennium is 15.1 percent lower than in the Spring 2012 Forecast. This drop in the biennial average does not represent fewer people; it portrays a difference in the way the data are defined. Between the Spring 2012 Forecast and the Fall 2012 Forecast, a number of data system changes were implemented. Caseload category definition changes to 24-Hour and Community Services resulted in level shifts for these subgroups and aggregate groups. Based on the new definitions, the mandated caseload is expected to increase to 5,208 clients by June 2013. The 2013–15 biennial average is estimated to be 4.7 percent more clients than the 2011–13 biennial average.

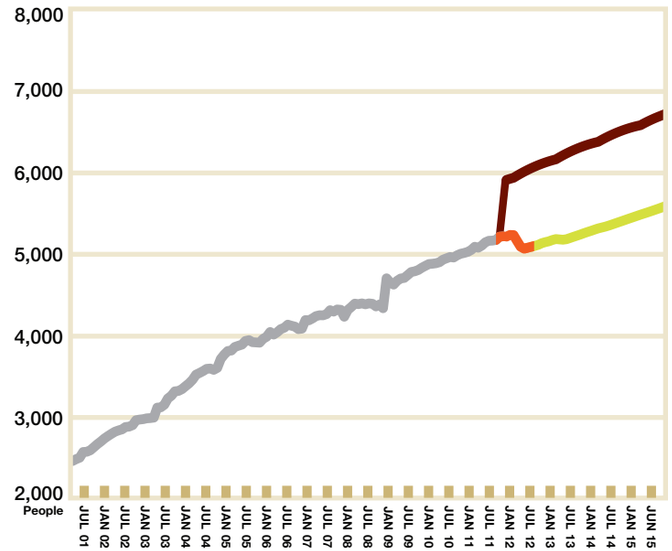
Total Forensic: The Total Forensic (or Criminal Commitment) caseload is an unduplicated count of State Hospital Aid and Assist clients and clients under the jurisdiction of the Psychiatric Security Review Board. Because the Aid and Assist caseload fluctuates widely, so too does the Total Forensic caseload. The fall 2012 average for the 2011–13 biennium, 851 clients, is forecast to be slightly higher than the numbers anticipated by the Spring 2012 Forecast. Recent data from 2012 illustrate a decrease from 2011, and due to these data, the Total Forensic caseload is expected to decrease 1.6 percent from 2011–13 to 2013–15.

Total Psychiatric Security Review Board (PSRB): During the 2011 legislative session, HB 3100 and SB 420 passed through the legislature and became law. HB 3100 created a certification process for forensic evaluators, and SB 420 shifted jurisdiction from the PSRB to the Oregon Health Authority for persons committed to the State Hospital when guilty except for insanity for non-Measure 11 crimes. The passage of these bills may cause a shift between PSRB categories as clients are moved to settings that most appropriately meet their mental health needs. The Total PSRB caseload has been stable for the last several years. The Fall 2012 Forecast anticipates that the average caseload for the 2013–15 biennium will be 738 clients, a decrease of 0.3 percent from the 2011–13 biennium.

Total Civil Commitment: The Total Civil Commitment population has been increasing in line with Oregon's population. It is expected that the Civilly Committed caseload will increase through the end of the 2013–15 biennium. Monthly counts are expected to increase 4.2 percent from January 2012 to June 2013. The Fall 2012 Forecast anticipates that the average caseload for the 2013–15 biennium will be 4,657 clients, an increase of 7.7 percent over the 2011–13 biennium.

Total Mandated Mental Health





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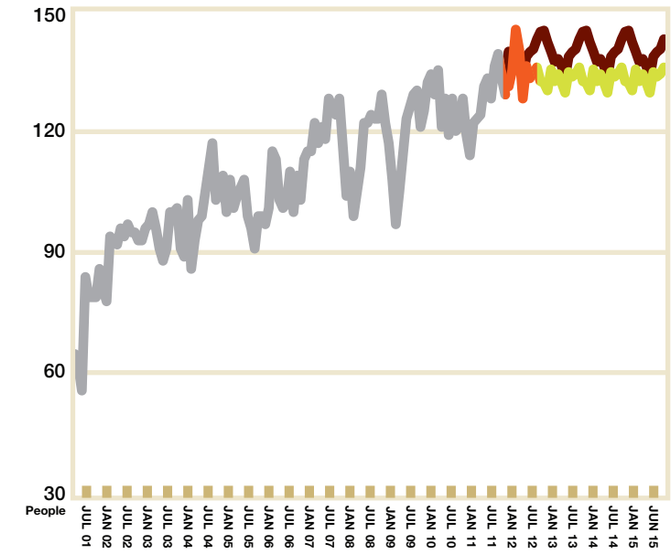
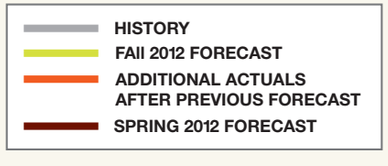
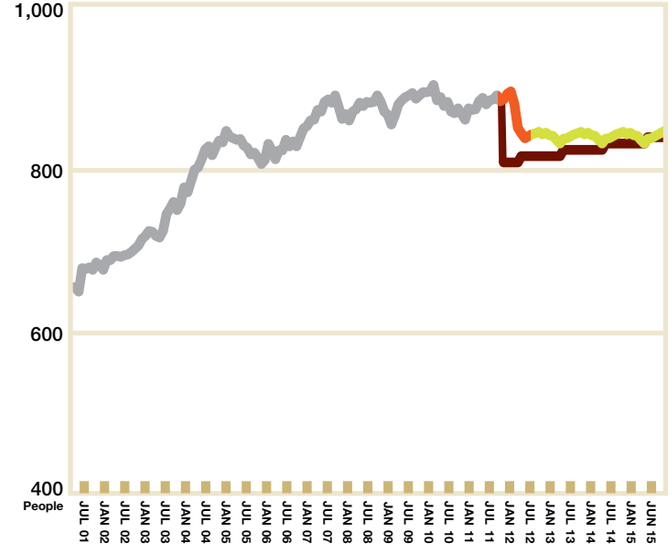
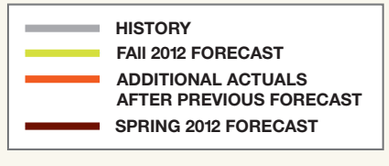


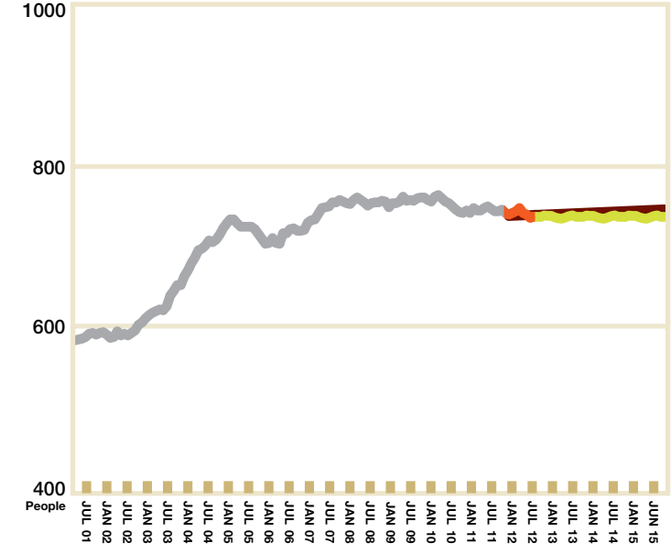
Total Criminal Commitment





Criminal: Psychiatric Security Review Board





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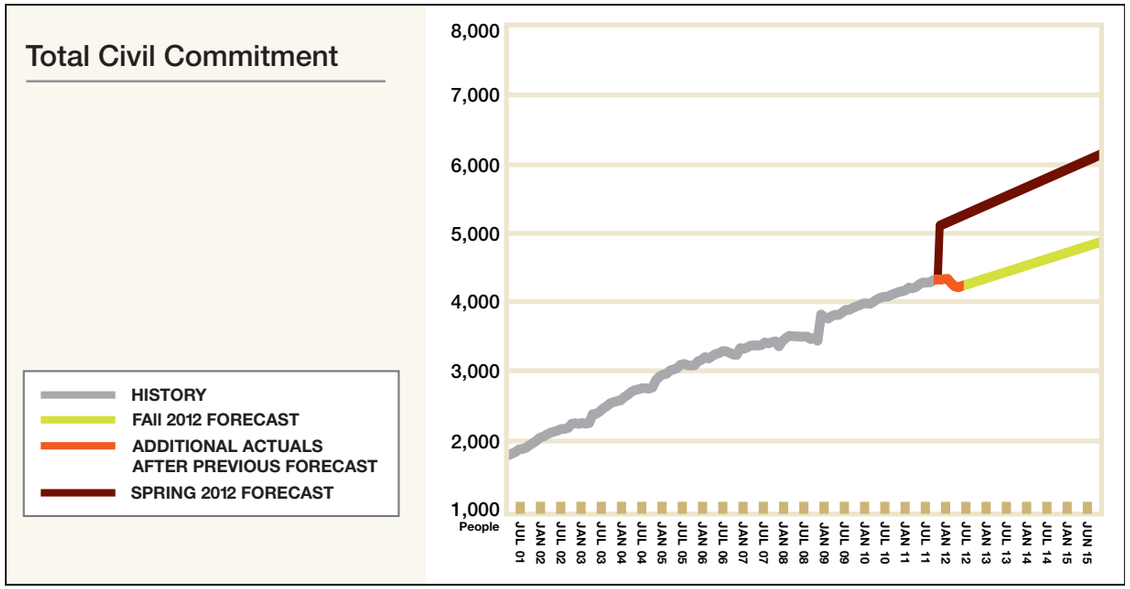
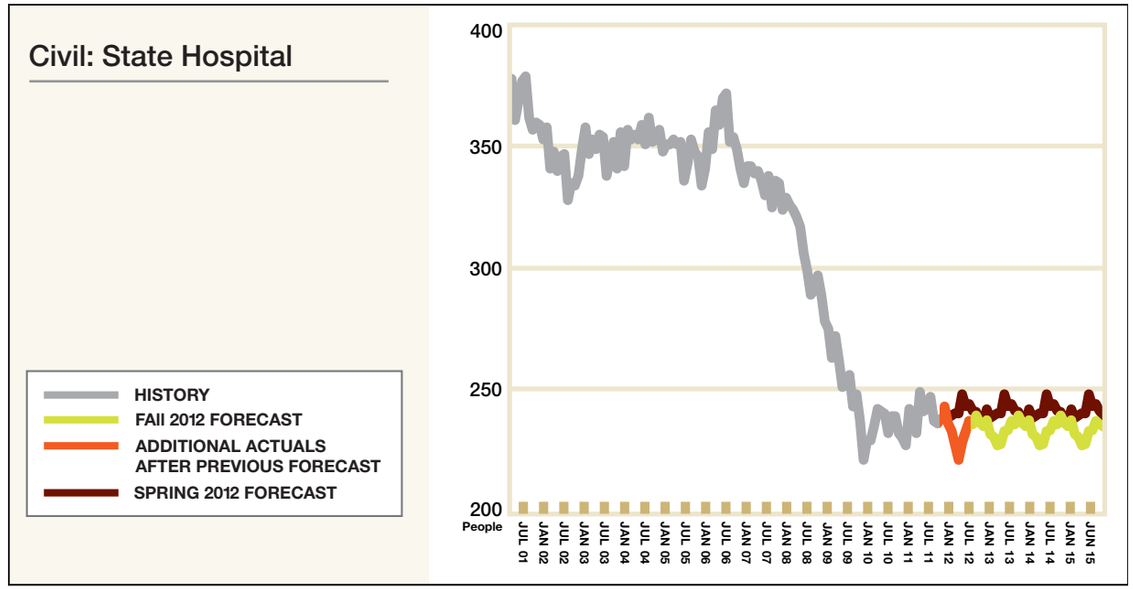
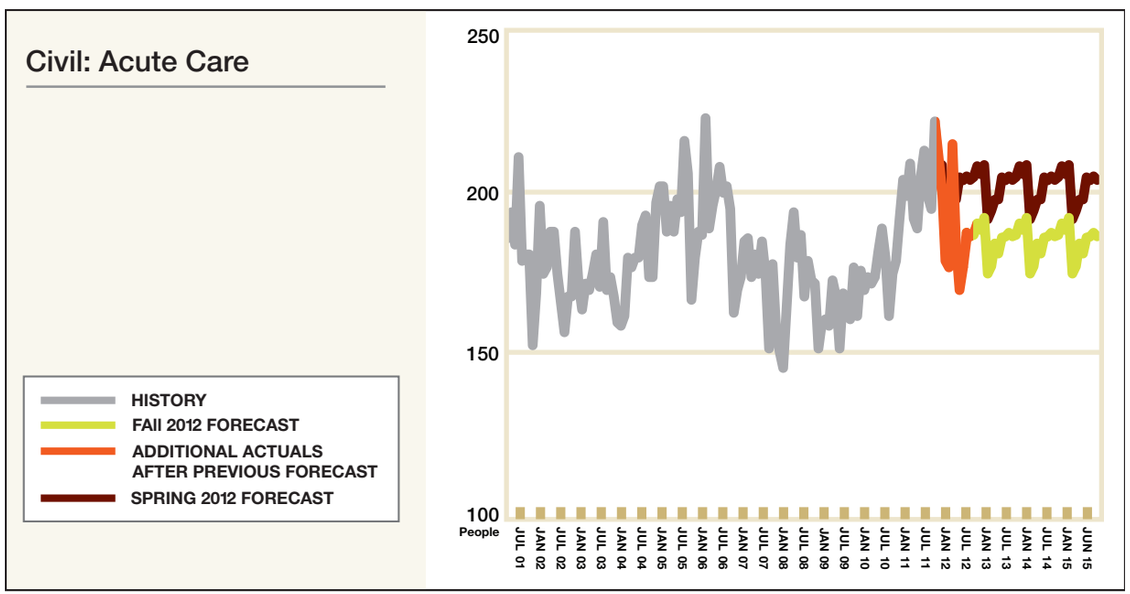


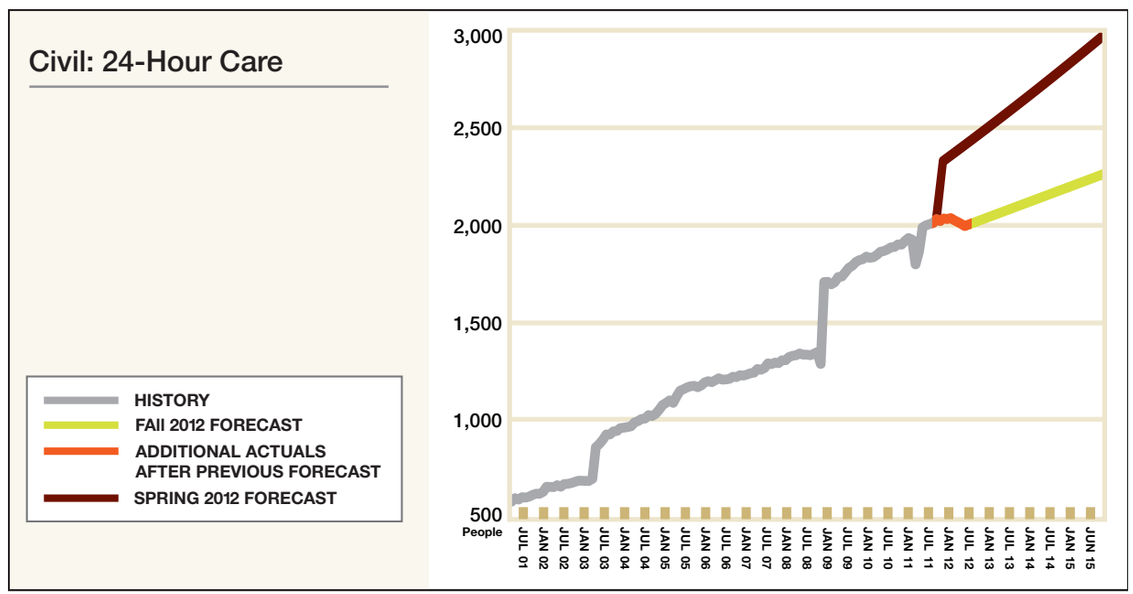
Civil: State Hospital



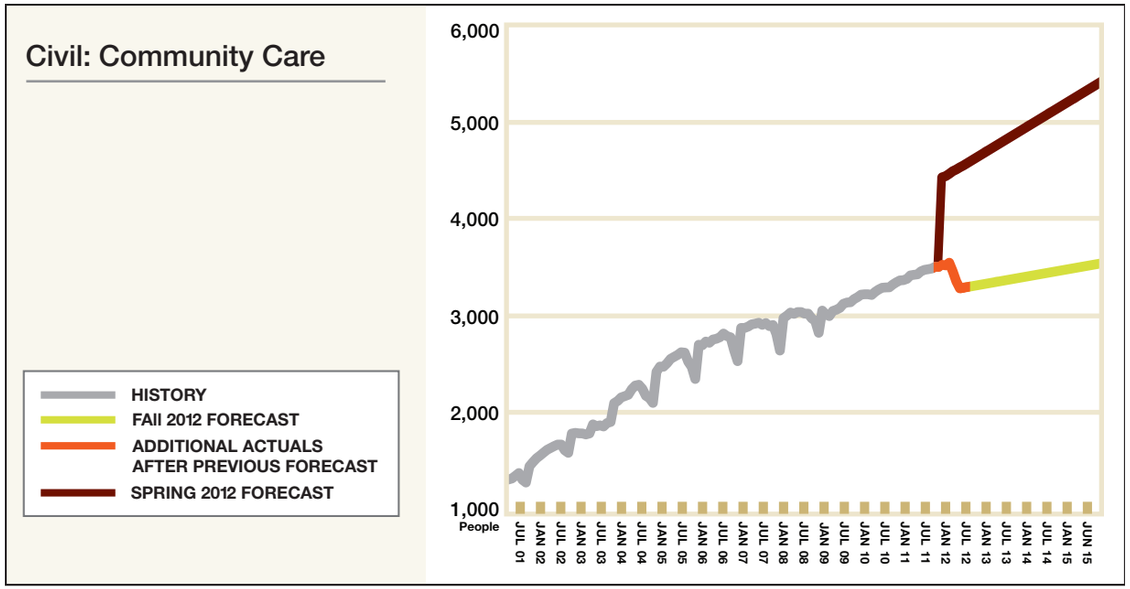
Civil: Acute Care



Civil: 24-Hour Care



Civil: Community Care



Addictions and Mental Health[1] Biennial Average Forecast comparison

	2011-2013 biennium			Fall 2012 Forecast		
	Spring 12 Forecast 2011-13	Fall 12 Forecast 2011-13	% diff. Spring 12 to Fall 12 2011-13	Fall 12 Forecast 2011-13	Fall 12 Forecast 2013-15	% diff. Fall 12 2011-13 to 2013-15
Criminal Commitment						
Aid and Assist	140	134	-4.3%	134	133	-0.7%
Psychiatric Security Review Board	741	740	-0.1%	740	738	-0.3%
Criminal Commitment total	**811**	**851**	**4.9%**	**851**	**837**	**-1.6%**
Civil Commitment[2]						
24-Hour Care	2,445	2,031	-16.9%	2,031	2,171	6.9%
Acute Care	202	189	-6.4%	189	185	-2.1%
State Hospital	240	234	-2.5%	234	234	0.0%
Non-Residential Community Care	4,651	3,395	-27.0%	3,395	3,471	2.2%
Civil Commitment total	**5,299**	**4,324**	**-18.4%**	**4,324**	**4,657**	**7.7%**
Mandated Care total	**6,059**	**5,147**	**-15.1%**	**5,147**	**5,387**	**4.7%**

1. *All groups and subgroups are forecast independently using unduplicated client counts. Since one individual can be counted in more than one group due to overlapping service episodes, totals are usually less than the sum of the lower level categories.*
2. *The difference between the spring 2012 and fall 2012 forecasts is almost entirely due to how client data are captured and counted, not a difference in the number of people served. In mid-2012, the DHS|OHA Integrated Client Services Data Warehouse was adjusted to correct two errors. First, there was a correction in service episode end dates for clients in 24-hour and/or community services, which reduced civil commit caseload counts by more than 1,000 people. Second, a service category that had been inadvertently omitted from forensic services was added back in, increasing the total forensic caseload by approximately 50 people.*

Department of Human Services
Caseload definitions

AGING AND PEOPLE WITH DISABILITIES (APD)

Aging and People with Disabilities programs provide Long-Term Care (LTC) services to qualifying people who, due to their age or disabilities, need help with their activities of daily living (ADL), including eating, dressing/ grooming, bathing/ personal hygiene, mobility, bowel and bladder management, and cognition.

Area Agencies on Aging (AAA) and DHS staff help clients find the appropriate care settings to meet their needs and determine financial eligibility. Clients in the Long-Term Care caseload must meet the Medicaid waiver financial eligibility requirements including monthly income not exceeding 300 percent of SSI ($2,094) and $2,000 resource limit, and non-financial requirements including a service priority level (SPL) assessment consistent with the amount and skill of care needed.

The LTC forecast is divided into three categories: In-Home, Community-Based Care, and Nursing Facilities (NF).

LTC IN-HOME PROGRAMS

In-Home programs provide personal assistance services that help people stay in their homes when they need assistance with activities of daily living (ADL).

- **In-Home Hourly**

  In-Home Hourly caseload includes clients who hire hourly workers to assist them in meeting their ADL needs and other common household tasks. A small percentage of the In-Home Hourly caseload includes Personal Care services. Personal Care services are available to people who are Medicaid-eligible but not eligible for waivered services. Services are limited to no more than 20 hours a month.

- **Live-In Provider**

  Live-In Provider caseload includes clients who hire a live-in home care worker to provide 24-hour care.

- **Spousal Pay**

  Spousal Pay caseload includes those clients who choose to have their care provided by their spouse. Spouses are paid for services that they provide.

- **Specialized Living**

  Specialized Living provides care in a home-like environment for clients with specialized needs (such as quadriplegics or clients with acquired brain injuries). These clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or are served in other Community-Based Care facilities.

- **State Plan Personal Care**

  State Plan Personal Care includes essential supportive services that enable clients to move into and/or remain in their own homes, such as basic personal hygiene, toileting, mobility, transfer, nutrition and meal preparation, and medication management. These In-home care services are limited to no more than 20 hours per month.

LTC COMMUNITY-BASED CARE (CBC)

Community-Based Care caseload includes clients receiving services in licensed Community-Based Care settings. Services include assistance with ADL, medication oversight and social activities; services can also include nursing and behavioral supports to meet complex needs.

- **Adult Foster Care (AFC)**

  Adult Foster Care provides long-term care in home-like settings licensed for five or fewer unrelated people.

  - **Relative AFC** clients receive services at their relative caretaker's home.
  - **Commercial AFC** is open to clients who are not related to the care provider.

- **Residential Care Facilities (RCF)**

  Residential Care Facilities are licensed 24-hour care settings serving six or more residents. Facilities range in size from six beds to over 100.

  - **Regular RCF** is a sub-program of RCF.
  - **Contract RCF** is licensed to provide specialized Alzheimer care.

- **Assisted Living Facilities (ALF)**

  Assisted Living Facilities are licensed 24-hour care settings for six or more residents that include private apartments and focus on resident independence and choice.

- **Elder Place (PACE)**

  Elder Place is a capitated Medicare/Medicaid program of All-Inclusive Care for the Elderly (PACE). Seniors served in this program live in a variety of care settings. PACE is responsible for coordinating their clients' acute health and long-term care needs.

NURSING FACILITIES (NF)

Nursing Facilities provide institutional services for seniors and people with disabilities in nursing facilities licensed and regulated by DHS. Nursing facilities provide individuals with skilled nursing services, housing, related services and ongoing assistance with activities of daily living.

Starting with the Fall 2011 Forecast, NF LTC includes only Basic, Complex Medical Add-On, Enhanced Care, and Pediatric Care. Two NF caseload categories (Medicare Extended Care and Post-Hospital Benefit) were re-classified as short-term medically related services, not Long-Term Care. Starting with the 2013–15 biennium, medically related Nursing Facility Care will be moved from DHS (APD) to OHA (MAP).

- **Long-Term Care**
  - **LTC NF: Basic Care**

    Basic Care clients need 24-hour comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care due to either age or physical disability.

  - **LTC NF: Complex Medical Add-On**

    Complex Medical Add-On clients have medical conditions that require additional nursing services and staff assistance beyond basic care.

  - **LTC NF: Enhanced Care**

    Enhanced Care clients have demonstrated behavior that makes it difficult to provide care in regular community-based care settings. Examples of such client behavior may include self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms or problematic medication needs.

  - **LTC NF: Pediatric Care**

    Children under 21 receive nursing care in the state's pediatric nursing facility units.

- **Medically Related Care**
  - **Medicare Extended Care**

    Medicare Extended Care (or extended skilled nursing care) clients are

both Medicare- and Medicaid-eligible. They are placed in a nursing facility after a Medicare-qualifying hospital stay. Medicare controls these clients' extended care stays.

- **OHP Post-Hospital Benefit**

  OHP Post-Hospital Benefit is an Oregon Health Plan (OHP) extended skilled nursing care service. The OHP benefit pays for a maximum of 20 days of post-hospital extended skilled nursing care for clients who are not Medicare-eligible and meet state program criteria.

CHILD WELFARE

Child Welfare programs oversee the safety of children who have been abused or neglected. The Child Protective Services (CPS) program investigates reports of child abuse or neglect. If abuse or neglect is founded, caseworkers prepare an action plan and provide case management to ensure safety for the child using the strengths of the family.

The Child Welfare caseload is an unduplicated count of children served in the various programs listed below. A child can be counted only once during a month, and if there is participation in more than one of the programs listed below, they are counted in only one group. The groups are listed below in order of this counting priority.

- **Adoption Assistance**

  Adoption Assistance coordinates and supervises adoption for children previously in foster care who can not return safely to the care of their biological parents. Adoption Assistance services can include financial and/or medical help with the costs associated with the adoptive child's needs.

- **Guardianship Assistance**

  Guardianship Assistance helps remove financial barriers for individuals who provide a permanent home for children who would otherwise be in foster care. Guardianship allows an alternative plan to adoption. Guardianship Assistance services can include financial support for costs associated with the needs of the child (similar to a foster care payment).

- **Out of Home Care**

  Out of Home Care programs provide a safe, temporary home for abused or neglected children who cannot remain safely in their homes. Children in the program are placed with relatives, foster families, or in residential treatment care settings. The program aims to reunite children with their parents. Out of Home Care services can include financial support and/or medical help for costs associated with the child's needs.

- **Child In-Home**

  In-Home Services provide support and safety monitoring services to prevent placement of children in foster care and to support reunification with the parents after foster care. Caseworkers oversee services and monitor in-home safety plans for children. In-Home Services can include financial support for costs associated with the safety, permanence and well-being of children, and outside resources to help meet those needs.

  This caseload is split into two categories: Protected Child in Home, where the child has not been in foster care since the case was opened and Reunited Child in Home, where the child was in foster care during an earlier stage of the current case but has since been reunited with his or her family.

DEVELOPMENTAL DISABILITIES SERVICES

Developmental Disabilities Services programs provide support to qualified adults and children with developmental disabilities through a combination of case management and services. Developmental disabilities include mental retardation, cerebral palsy, Down's syndrome, autism and other impairments of the brain that occur during childhood. Some people with developmental disabilities also have significant medical or mental health needs.

Adults with developmental disabilities may be eligible for services ranging from supports to help individuals live in their own homes to 24-hour comprehensive services. Twenty-four-hour services are provided in a variety of settings including group homes and foster homes. Children with developmental disabilities may be eligible for services ranging from family support to out-of-home placements. Placements can be to proctor care, foster homes or residential settings.

The forecasted Developmental Disabilities Services programs are counts of individual clients receiving a program's services within the month. Clients can receive services from more than one program in one month (for example, from both a residential and a support program).

- **Case Management**

  Case Management provides entry-level eligibility, evaluation and coordination services to individuals with developmental disabilities.

  All other DD caseload categories are grouped into three distinct areas: adult services, children services, and other services.

- **Adult services include:**

  - **Brokerage Support Services**

    Brokerage Support Services provide entry-level eligibility, evaluation and coordination services to individual adults with developmental disabilities and allows them to live in their own homes or in their family homes.

  - **24-Hour Residential Care**

    24-Hour Residential Care provides 24-hour supervised care, training and support services delivered in neighborhood homes to individuals with developmental disabilities.

  - **Supported Living**

    Support Living provides individualized support services to individuals with developmental disabilities in their home based on their Individual Support Plan.

  - **Comprehensive In-Home Support Services**

    Comprehensive In-Home Support Services help individuals aged 18 years or older with developmental disabilities to continue to live in their homes.

  - **State Operated Community Programs (SOCP)**

    State Operated Community Programs offer 24-hour care and supervision to individuals with developmental disabilities who represent the most risk to the public.

  - **Non-Relative Foster Care**

    Non-Relative Foster Care provides 24-hour foster home care, supervision, the provision of room and board, and assistance with the activities of daily

living. Non-Residential Foster Care serves both adults and children, with approximately 19 percent of clients under the age of 18.

- **Children's services include**
  - **Children Intensive In-Home Services (CIIS)**

    Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their homes. This caseload is composed of three distinct groups: Medically Fragile Children Services, Intensive Behavior Program and Medically Involved Programs.
  - **Children Residential Care**

    Children Residential Care provides 24-hour care, supervision, training and support services to individuals under the age of 18 years in neighborhood homes other than family home or foster care.
  - **Children Proctor Care**

    Children Proctor Care provides individualized services to children through contracted proctor care agencies. A proctor care provider manages, directs and supports services for individuals who reside in homes that meet the state's requirements for child foster homes.
  - **Long-Term Support for Children**

    Long-Term Support for Children provides services to individuals under the age of 18 years with developmental disabilities that are at imminent risk of out-of-home placement resulting from a crisis.
- **Other DD services include:**
  - **Crisis Services**

    Crisis Services offer temporary out-of-home placement services to adults and children.
  - **Employment and Community Inclusion**

    Employment and Community Inclusion services are out-of-home employment or community training services and related supports, delivered to individuals aged 18 or older with developmental disabilities, to improve the individuals' productivity, independence and integration in the community.
  - **Transportation**

    Transportation services are public or private transportation provided to individuals with developmental disabilities.

SELF SUFFICIENCY PROGRAMS (SSP)

Self Sufficiency programs provide assistance for low-income families to help them become healthy, safe, and economically independent. With the exception of SNAP, Self Sufficiency program caseloads count the number of families receiving program benefits within the month. In the SNAP program, caseloads count the number of households receiving the benefit within the month.

- **Supplemental Nutrition Assistance Program (SNAP)**

  As of Oct. 1, 2008, the federal Food Stamp Program became the Supplemental Nutrition Assistance Program (SNAP). Oregon began using this new name on Jan. 1, 2010.

  SNAP benefits improve the health and well-being of low-income individuals by providing them a means to meet their nutritional needs. Recipients use SNAP benefits to buy food.

  To be eligible for SNAP benefits, applicants provide proof of household composition (living in same dwelling, purchase food and prepare meals together) and have assets and income within program limits. The maximum income limit is 185 percent of Federal Poverty Level (FPL) ($40,793 for a household of four); most recipients qualify between 100 and 130 percent of FPL.

  The SNAP forecast includes two caseloads — APD and SSP. Households entering the program through the Self Sufficiency Programs (SSP) are classified as SSP households, while those entering the program through Aging and People with Disabilities (APD) are classified as APD households. The two caseloads share eligibility guidelines and benefit amounts.

- **Temporary Assistance to Needy Families (TANF)**

  The Temporary Assistance for Needy Families (TANF) program provides case management and cash assistance to very poor families with minor children. The goal of the program is to reduce the number of families living in poverty through employment services and community resources.

  Recipients must meet basic TANF asset requirements (including a $2,500–$10,000 resource limit and income less than 46 percent of FPL) to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children on the case, Oregon residence, citizenship status, pursuing assets, deprivation (death, absence, incapacity, or unemployment of a parent) and pursuing treatment for drug abuse or mental health as needed.

  The TANF Basic program includes one-parent families and two-parent families where at least one parent is unable to care for children, or families headed by an adult relative who is not considered financially needy.

  The TANF UN program includes families where both parents are able to care for their children, but both are unemployed or underemployed.

- **Pre-SSI**

  The State Family Pre-SSI/SSDI (SFPSS) program provides cash assistance, case management, and professional level support to TANF-eligible adults and their families in pursuing Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI). To be eligible for Pre-SSI, the adult must be found eligible for a TANF grant and must have severe physical or mental impairment(s) that has

been assessed and determined to meet the program impairment criteria by the program's disability analyst.

- **Employment Related Day Care (ERDC)**

  The Employment Related Day Care (ERDC) program helps low-income families achieve self-sufficiency by providing child care assistance necessary for employment. Payments are made directly to the provider on behalf of the parents. ERDC recipients pay a share of the child care cost based on a sliding fee scale.

  To qualify for ERDC, families must have income not exceeding 185 percent of FPL and meet non-financial eligibility requirements including residency, age and citizenship status of the child(ren). The ERDC program is currently ‘capped’ to an average caseload of 8,500 families. Occasionally a reservation list is opened in order to meet the caseload cap.

- **Temporary Assistance to Domestic Violence Survivors (TA-DVS)**

  The TA-DVS program supports domestic violence survivors by providing temporary financial assistance to flee domestic violence. TA-DVS payments can be issued to meet the family's needs for shelter, food, medical care, relocation, stabilization, or to promote safety or independence from the abuser.

  To be eligible for TA-DVS, a survivor must have a current or future risk of domestic violence; be a pregnant woman or a parent or relative caring for a minor child; and must have income not exceeding TANF limits (46 percent of FPL; TA-DVS only considers income on hand that is available to meet emergency needs).

VOCATIONAL REHABILITATION

The Office of Vocational Rehabilitation Services (OVRS) assesses plans and coordinates vocational rehabilitation services for people who have physical or mental disabilities and need assistance to get and retain employment that matches their skills, potential and interest. Services are provided through local OVRS offices across the state. The program provides counseling, training, job placement, assistive technology, and extended services and supports.

Oregon Health Authority
Caseload definitions

MEDICAL ASSISTANCE PROGRAMS (MAP)

The Medical Assistance Programs Division coordinates the Medicaid portion of the Oregon Health Plan (OHP) and directly administers OHP physical and dental health coverage.

MAP programs are divided into three major categories based on benefit packages:

- Oregon Health Plan Plus (OHP Plus) – a basic benefit package.
- Oregon Health Plan Standard (OHP Standard) – a reduced set of benefits with additional premiums and co-payments for coverage.
- Other Medical Assistance Programs – programs that provide medical benefits but are not considered part of OHP.

Each program is represented by an unduplicated count of individuals on caseload as of the last day of the month.

- **OHP Plus Benefit Package**

  The OHP Plus package offers comprehensive health care services to children and adults who are eligible under traditional, federal Medicaid rules or the CHIP program.

  - **TANF Related Medical (TANF-RM)**

    TANF Related Medical offers OHP Plus medical coverage to families with children who have incomes not exceeding 42 percent of federal poverty level (FPL).

  - **TANF Extended (TANF-EX)**

    TANF Extended is made up of clients who have left the TANF-RM group due to a change in income resulting in a loss of eligibility. Maximum duration of continuing Medicaid coverage is 12 months.

  - **Poverty Level Medical Women (PLMW)**

    Poverty Level Medical Women provides medical insurance coverage to pregnant women with income levels up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth. The income eligibility limit was increased from 170 percent to 185 percent of FPL in February 2003.

  - **Poverty Level Medical Children (PLMC)**

    Poverty Level Medical Children provides medical insurance coverage for children ages 0 through 5 in households with incomes up to 133 percent of the FPL, and for children ages 6 through 18 in households with incomes up to 100 percent of the FPL.

  - **Aid to the Blind and Disabled Program (AB/AD)**

    Aid to the Blind and Disabled provides medical coverage through Medicaid to individuals who are blind or disabled and eligible for federal Supplemental Security Income (SSI). Aged, blind and disabled populations meeting long-term care criteria are eligible up to 300 percent of the SSI level (which is equivalent to approximately 225 percent of the FPL); otherwise, these populations are eligible up to 100 percent of the SSI level.

  - **Old Age Assistance (OAA)**

    Old Age Assistance provides medical insurance coverage through Medicaid for individuals who are age 65 or over and eligible for federal SSI.

  - **Foster/Substitute Care and Adoption Services**

    Foster/Substitute Care and Adoption Services provides medical insurance coverage through Medicaid for children in foster care and children whose

adoptive families are receiving adoption assistance services. These clients are served up to age 21 with potential to age 26 depending on client eligibility.

- **Children's Health Insurance Program (CHIP)**

  The Children's Health Insurance Program covers uninsured children from birth through age 18 living in households with income up to 200 percent of the federal poverty level.

- **OHP Standard Benefit Package**

  The OHP Standard program provides a reduced package of covered medical services compared to the OHP Plus program. The OHP Standard program also requires that participants share some of the costs of their medical coverage through premiums and co-payments. The clients in OHP Standard are not eligible for traditional Medicaid programs under Federal rules and represent an expansion under the Oregon Health Plan.

  - **Adults and Couples**

    The Adults and Couples benefit group includes adults with income up to 100 percent of the FPL who do not have children, and do not qualify for traditional Medicaid programs.

  - **Families**

    The Families benefit group includes adults with incomes up to 100 percent of the FPL who have children, but do not qualify for traditional Medicaid programs.

- **Other Medical Assistance Programs (Non-OHP Benefit Packages)**

  Qualified Medicare Beneficiary (QMB)

  Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. The clients included in this caseload have incomes below 100 percent FPL, but above 100 percent of SSI, which is approximately 67 percent FPL. In addition, they do not meet the criteria for medical covered long-term care services. DHS pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductibles not exceeding the department's fee schedule.

  - **Citizen/Alien Waived Emergency Medical (CAWEM)**

    Citizen/Alien Waived Emergency Medical is a federally mandated program that covers emergency care and childbirth services for non-citizens otherwise eligible for Medicaid services.

  - **Breast and Cervical Cancer Program (BCCP)**

    The Breast and Cervical Cancer provides medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection program administered by Public Health through county health departments and tribal health clinics. After determining eligibility, the client receives OHP Plus benefits including mental and dental health services. A client is eligible until reaching the age of 65, obtaining coverage or ending treatment.

- KidsConnect

  KidsConnect is the private market insurance component of Healthy Kids, Oregon's new health care program for children. Administered by the Office of Private Health Partnerships, KidsConnect is for families that earn too much to qualify for the Oregon Health Plan, but can't afford private health insurance.

ADDICTIONS AND MENTAL HEALTH (AMH)

The Addictions and Mental Health program provides prevention and treatment options for clients with addictions or mental illnesses.

- **Total Mandated Population**

  AMH provides both Mandated and Non-Mandated services. Only mandated caseloads are forecast, including both criminal commitment and civil commitment caseloads. Mandated populations are required to receive mental health services by Oregon law through community settings and state hospitals.

  The state hospitals – located in Salem, Portland and Pendleton – provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed because they are a danger to themselves or others, including people who have been found guilty except for insanity.

  The AMH Mandated Caseload Forecast is the total number of individual clients receiving a mental health service or residing in a facility per month. There may be overlaps between some services, specifically between Residential and Community services. The forecast is calculated using two methods: a monthly count of individuals, and average daily population (ADP). ADP is calculated by summing the total days of service used for a particular program and then dividing by the number of days in a month.

- **Total Criminal Commitment**

  Total Criminal Commitment (Forensics) caseload is composed of two categories: Aid and Assist, and Psychiatric Security Review Board (PSRB). Each category is forecast separately. The total Criminal Commitment caseload forecast adjusts for overlaps.

  - **Criminal: Aid and Assist — State Hospital**

    Criminal Aid and Assist (or "Fitness to Proceed") caseload serves clients who have been charged with a crime and are placed in the Oregon State Hospital until they are fit to stand trial. “Fitness to Proceed” means that the client is able to understand and assist the attorney. Clients in the Aid and Assist caseload receive psychiatric assessment and treatment until they are able to assist their attorney and stand trial.

  - **Criminal: Psychiatric Security Review Board (PSRB)**

    The PSRB caseload includes clients who are under the jurisdiction of the Psychiatric Security Review Board. Clients in PSRB caseloads have been found “guilty except for insanity” of a crime by a court. AMH is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital. Clients in this caseload receive a full range of counseling, medication, skills training and supports to assist their progress toward recovery.

- **Total Civil Commitment**

  The Civilly Committed caseload includes people who are found through a civil court process to be dangerous to themselves and/or others or are unable to care for themselves as a result of mental illness, with the court mandating treatment for the individual. The total Civil Commitment caseload is forecast after adjusting for overlaps in the following four categories:

  - **Civil: Acute Care**

    Civil Acute Care includes clients who, having previously been civilly committed,

undergo a “crisis” and are briefly placed into a hospital with beds specified for mental health clients.

- **Civil: 24-Hour Care**

  Civil 24-Hour Care includes clients who, having been civilly committed, are placed into a residential 24-hour setting.

- **Civil: State Hospital**

  Civil State Hospital Care includes clients who, having been civilly committed, are placed into one of the Oregon State Hospitals.

- **Civil: Community Non-Residential**

  Civil Community Non-Residential Care includes clients who, after having been civilly committed, receive services in a community setting.

DHS Oregon Department of Human Services

Oregon Health Authority

This document can be provided upon request in alternate formats for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact Office of Forecasting Research and Analysis at 503-945-5944 or 503-378-2897 for TTY.

FALL 2012 DHS|OHA REGIONAL FORECASTS BY DISTRICT

Budget, Planning and Analysis
Office of Forecasting, Research and Analysis

DHS Oregon Department of Human Services

Oregon Health Authority

DHS
Oregon Department
of Human Services

Oregon Health Authority

FALL 2012 DHS|OHA REGIONAL FORECAST BY DISTRICT

November 2012

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Regional forecasts by district

Fall 2012 DHS|OHA Regional Caseload Forecast

Budget, Planning and Analysis, Office of Forecasting, Research and Analysis

The Regional Forecast is designed to increase the Statewide Caseload Forecast's use as a tool for regional and local policy decisions by breaking down the Statewide Caseload Forecast into smaller geographic units. By developing a regional focus on caseloads and causal factors, the department hopes to support a wide range of local and community partners as they, in turn, support the diverse needs of Oregonians.

This forecast presents county biennial averages for each district, as well as district totals. The result is a forecast for all 36 Oregon counties for 14 different programs within the Oregon Department of Human Services and the Oregon Health Authority.

Care must be taken in interpreting some of this forecast's results. Because county-by-county values are presented, small numerical values are forecast and published. As the number of cases in a caseload shrinks, the possibility of forecasting error grows. In general, the forecasts presented here are designed to illustrate the general magnitude of caseloads and trends for each county. They are not presented to conform to a highly specific numerical target for caseloads through 2015, especially for small caseloads in counties with small populations where a modest increase in caseload represents a major percentage increase.

In addition to the forecast, Fall 2012 Stakeholder Survey results are included. DHS, OHA, and partner agency staff and managers were surveyed in October 2012 about recent and expected changes in the social services caseload in comparison to fall 2011. This replaces the Delphi Panel survey method used in fall 2011, which provided a qualitative perspective but lacked a broad sampling of respondents across different geographic areas.

Finally, the DHS and OHA statewide biennial forecasts are included in this document in order to provide a contrast to the county and district forecast values. For more information, see the *Fall 2012 DHS/OHA Caseload Forecast.*

Stakeholder survey general results

Human services and medical assistance providers across Oregon received the Fall 2012 Stakeholder Survey. Respondents provide services in cash for food and housing, physical and mental health, abuse and neglect, employment, education, aging services, and advocacy. Thirty-seven responses were received.

Most respondents (81%) endorsed the statement that general demand for services has increased over the last year, while 16% said demand for services is about the same. The majority of respondents (65%) stated that social service agencies are not currently able to meet all client needs.

Respondents were asked whether changes that influence caseload had occurred in the past 12 months in six theme areas — public policy, the economy, funding/resources issues, client beliefs and behaviors, efficiencies, and community resources.

Public policy

Fifty-nine percent of respondents stated that changes to public policy have influenced caseloads. Most indicate that policy changes either have increased caseloads, required more time on individual cases, or increased barriers to people receiving services.

Aging and People with Disabilities workers noted caseloads have been affected by increased requirements for home care workers, loss of exemptions for HMO enrollment and changes in Medicare Part D. They also indicated that workloads have increased due to the mandatory use of risk assessment for all clients.

Many respondents across all disciplines indicated that early work with the new Coordinated Care Organizations (CCOs) adds to their workload.

When it came to barriers to receiving services, direct assistance workers said changes in the TANF JOBS program have resulted in significantly fewer referrals, and a cap on the ERDC program has reduced access to child care. They also considered new requirements to prove citizenship a barrier, including partner agencies restricting services to only those clients with Social Security numbers. On the other hand, assistance workers indicated that policy changes have resulted in decreased client barriers and reduced workload in awarding SNAP.

The economy

Seventy-three percent of respondents stated that the economy has changed caseloads over the past 12 months. The most common responses were that caseloads have increased due to the economy, or that more time is required on individual cases.

Stakeholders believe the aftermath of the Great Recession still has a rippling effect on caseloads, although opinions are now more varied than in the past. While in the past all stakeholders agreed that poor economic performance increased caseloads, now a more subtle influence is occurring - many respondents say caseloads are not expected to increase, or that economic issues are leading to more time on individual cases. Still, very few respondents stated that the economy is reducing caseloads, pointing to a continued belief that economic recovery is slow.

According to respondents, the pattern of consolidating households — with adult children moving back in with their parents — continues around Oregon. In addition, some older Oregonians may be applying for disability payments because they cannot find employment — a phenomenon that may accelerate as the long-term unemployed lose access to extended unemployment benefits.

Funding issues

The majority of respondents believe that funding issues have influenced how cases were managed over the past year. The most commonly cited change is increased barriers to programs due to budget constraints that lead to increased wait-times for services or reduced community supports.

Respondents also indicated that hiring freezes have led to increased caseloads, causing reductions in time spent on each case.

Stakeholders who work with Aging and People with Disabilities' clients predict a possible increase in the nursing home caseload because fewer less-restrictive facilities will accept the reduced provider reimbursement rates.

Respondents stated that a lack of state and county community mental health funding is leading to unnecessary hospitalizations and long waits to finish intakes.

Changes to client beliefs and behaviors

Respondents were evenly split on whether clients' beliefs and behaviors have significantly changed. Of those endorsing the idea that client beliefs and behaviors have changed, most said that these changes increase caseloads or require more time on individual cases.

Illustrating these changes, respondents stated that the increased number of people on social services is reducing the stigma of government benefits among Oregonians increasing demand for services. Others stated that the decrease in available staffing and services has eroded client goodwill, leading to more negative attitudes. Social assistance workers continue to see applicants who have never sought assistance before, and who need more time to understand the system.

Many stakeholders cited confusion in the general public about the coming full implementation of the Affordable Care Act and the creation of Community Care Organizations.

Efficiencies in case processing

Respondents were split on whether incorporating new efficiencies has influenced how cases are managed. Of those who said efficiencies have changed case management, about half said that efficiencies led to more time on individual cases, and half said efficiencies led to less time on individual cases. Respondents stated that DHS modernization efforts have resulted in increased work for staff, and have no real effect on client services. There is a concern that increasing the number of data entry systems will require more case processing time and duplicating effort.

Some respondents stated that individual offices are increasing efficiencies out of necessity, given staffing shortfalls. Fewer workers handling the same number of cases is leading to only the highest priority work being done.

Changes to community resources

The majority of respondents (73%) said community resources have changed over the past 12 months. The most common effects of these changes are increased client barriers to programs and more time on individual cases with people who have lost community supports but are not eligible for DHS services.

Fluctuating funding and the constant threat of reductions have made it difficult to keep good staff as people look for work in a more stable environment.

Respondents indicated that a lack of funding for law enforcement and the courts is leading to longer resolution times for child welfare cases.

Regional Forecast methodology

Each forecast was developed using time series models; however, different methods were used for different programs based on goodness-of-fit. For the current forecast, several programs used the Statewide Forecast as an independent variable. This controlled for the inability of local time series models to detect the variation caused by the recession and recovery. However, it also means that, in the future, counties that do not comport to the statewide trend will be distorted to match the expected statewide pattern. As patterns at the county level are better understood, forecasts will be more accurate.

Goodness-of-fit was determined for each program's forecast by combining the total county values and comparing the result to the official Statewide Forecast. Generally, if the Regional Forecast was within 5 percent of the Statewide Forecast, it was accepted as valid. There will be some inherent error because regional values used for the analysis will never total the exact amount of the statewide historic values. In addition, statewide forecasts use forecast methods not available to the regional forecasts.

To avoid internal discrepancies, each forecast is apportioned to the official Statewide Forecast. Thus, the critical information from the regional forecast becomes the forecast direction of caseload change and the magnitude of change in comparison to the state as a whole.

Data from multiple sources were used in order to interpret the forecast for each county and provide basic demographic and economic information. Information was included from:

- The U.S. Census Bureau, "USA Counties" data (U.S. Census Bureau, Small Area Estimates Branch, release date April 1, 2010) and "2010 Census Data, 2010 Census Briefs";
- The Oregon Employment Department's "Oregon Labor Market Information System," "Current Employment Statistics" and "Labor Force and Unemployment by Area" data, September 2012;
- The Portland State University Population Research Center, "Estimates of Population Age Groups for Oregon and Its Counties," July 1, 2011; and
- Oregon Economic and Revenue Forecast, September 2012 Volume XXXII, No. 3.

A variety of sources were used to estimate the number of insured Oregonians by county. Depending upon the county, data were used from the U.S. Census Bureau American Community Survey 1-year estimate (2011), 3-year estimate (2009-2011) or 5-year estimate (2006-2010). Where no American Community Survey estimate was available at the county level, the Oregon Health Insurance Survey Regional Results (2011) were used.

Total Department of Human Services Biennial Average Forecast comparison

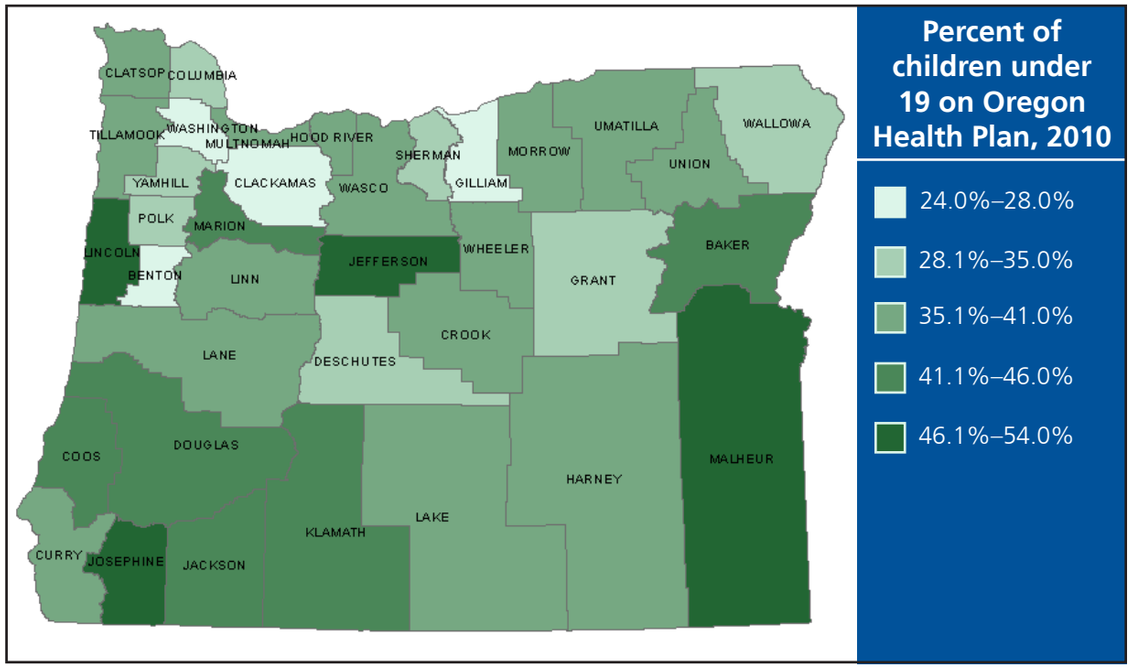
	2011-2013 biennium			Fall 2012 Forecast		
Self Sufficiency	**Spring 12 Forecast 2011-13**	**Fall 12 Forecast 2011-13**	**% diff. Spring 12 to Fall 12 2011-13**	**Fall 12 Forecast 2011-13**	**Fall 12 Forecast 2013-15**	**% diff. Fall 12 2011-13 to 2013-15**
Supplemental Nutrition Assistance Program (households)	435,327	440,182	1.1%	440,182	435,230	-1.1%
Temporary Assistance for Needy Families - Basic and UN (families: cash assistance)	34,636	34,934	0.9%	34,934	32,986	-5.6%
Employment Related Day Care (families)	8,449	8,459	0.1%	8,459	10,040	18.7%
Aging and People with Disabilities						
Long-Term Care: In-Home	10,935	10,834	-0.9%	10,834	10,802	-0.3%
Long-Term Care: Community-Based	12,630	12,687	0.5%	12,687	13,365	5.3%
Long-Term Care: Nursing Facilities	4,529	4,490	-0.9%	4,490	4,509	0.4%
Child In-Home	2,926	2,926	0.0%	2,926	2,993	2.3%

Total Oregon Health Authority Biennial Average Forecast comparison

	2011-2013 biennium			Fall 2012 Forecast		
Medical Assistance Programs	**Spring 12 Forecast 2011-13**	**Fall 12 Forecast 2011-13**	**% diff. Spring 12 to Fall 12 2011-13**	**Fall 12 Forecast 2011-13**	**Fall 12 Forecast 2013-15**	**% diff. Fall 12 2011-13 to 2013-15**
OHP Plus: Temporary Assistance to Needy Families (Medical)	184,499	184,603	0.1%	184,603	192,628	4.3%
OHP Plus: Children (PLMC and CHIP)	222,196	220,381	-0.8%	220,381	226,484	2.8%
OHP Plus: Aging and People with Disabilities (ABAD and OAA)	116,088	115,505	-0.5%	115,505	124,130	7.5%
OHP Plus: Poverty Level Medical Women	13,047	13,012	-0.3%	13,012	13,314	2.3%
OHP Plus: Substitute Care and Adoption Services	18,492	18,748	1.4%	18,748	19,208	2.5%
OHP Plus: Standard	61,433	64,070	4.3%	64,070	59,042	-7.8%

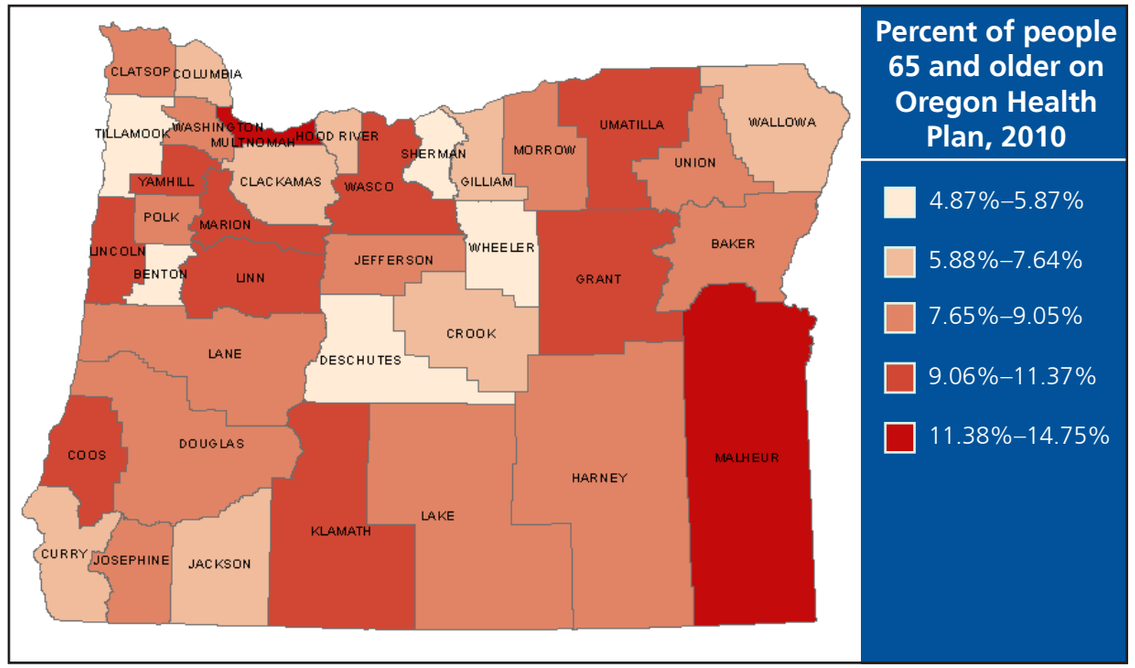
Selected populations on the Oregon Health Plan

Large portions of those covered by the Oregon Health Plan are either children under age 19 or adults 65 and older. These demographic groups – and the portion of those groups eligible for Oregon Health Plan – are not even distributed throughout the state. Local economics plays a very important part in the distribution of those on OHP. For example, Benton County has the smallest proportion of residents in both categories (under 19 and 65 and older) eligible for OHP, but the counties surrounding Benton are not in the same boat. The combination of small size and a university employment base make Benton County far less likely to have OHP clients than the surrounding area.



Children under age 19 on Oregon Health Plan

The percentage of children on OHP runs from a low of 24% in Benton County to a high of 54% in Jefferson. The high percentage in Jefferson does not translate into a large number of children, however, since Jefferson is a sparsely populated county. Washington and Clackamas Counties, as bedroom communities of Portland, have a high concentration of families with children, but a relatively low proportion of children on OHP. Demographics only plays a small part in determining the percentage of children on OHP in any given county – income is far more telling. And the suburbs of Portland contain people with relatively high incomes.



Adults age 65 and older on Oregon Health Plan

The percentage of people over age 65 on OHP runs from a low of 4.87% in Benton County to a high of 14.75% in Multnomah. This high concentration of elderly on OHP is likely due to older people moving to Multnomah County to take advantage of age- and disability-related services that are more plentiful in the Portland area than in other parts of the state. Curry County, which has a high concentration of Oregonians over 65, has a small proportion on OHP compared to other parts of the state. The elderly in the Gold Coast area are more likely to be retired, and have steady income, than be poor and on the Oregon Health Plan.

A spotlight on seasonal variation

Variation in caseloads based on the season can be quite pronounced. Usually, this seasonal change is caused by agricultural employment. During the time of the year from planting to harvest, many families have a steady income. But after harvest, their income is reduced, sometimes to zero. As a result, agricultural workers go on and off DHS and OHA caseloads with regularity. This is especially true of the SNAP caseload. The agricultural pattern can be seen more readily at the county level than statewide, since statewide patterns are dominated by urban areas, which do not have this kind of seasonal variation.

Hood River County has one of the most pronounced seasonal patterns in the state (see Figure 1). Each year, SNAP caseloads rise through the late spring, until May or June, when they fall dramatically until October. Caseloads rise again from October until the next spring. This pattern stands in stark contrast to Curry County, which has a comparable population, but no pronounced seasonal pattern. Curry County, like many coastal counties, relies more on tourism-related businesses for employment than agricultural ones (see Figure 2).

When seasonal patterns dominate a caseload, efforts are undertaken to generate forecasting models that maintain that pattern (see Figure 3). The amount of seasonality, however, differs from county to county and caseload to caseload. They also may vary due to other economic factors. For many rural counties, seasonal enrollment patterns disappeared during the recession due to additional families coming onto SNAP in circumstances unrelated to agricultural employment patterns. For Hood River, which had a bit of an easier time during the recession than many other counties, the agricultural pattern remained.

These patterns may not be apparent when looking at a forecasted monthly average caseload across a biennium, but they may influence the final averaged values. Also, being aware of seasonal patterns, and developing forecasts that take them into account can positively influence forecast accuracy overall, and should always be kept in mind when thinking about rural Self Sufficiency caseloads.

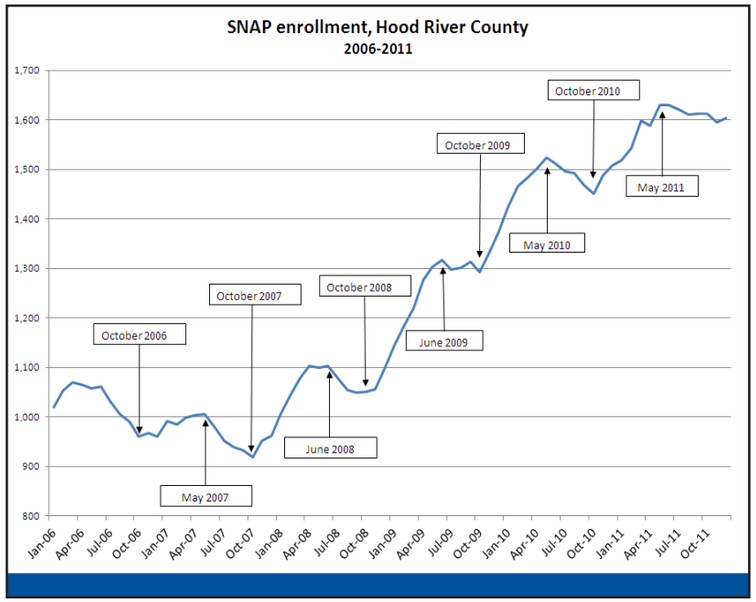


Figure 1: SNAP enrollment in Hood River County shows pronounced variation over time with increases in caseload from October to May or June, and then a reduction in caseload until the following October. This change is likely due to agricultural employment, and it appears in many Oregon counties with a strong agricultural base.

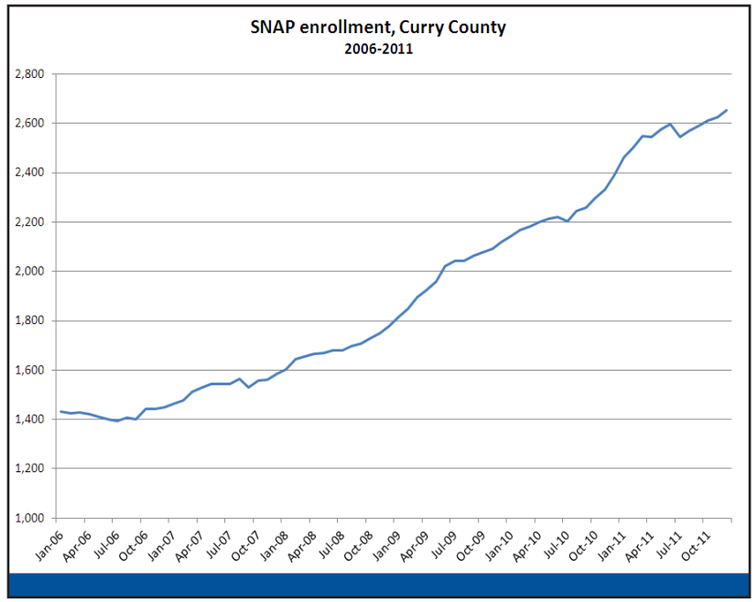


Figure 2: Curry County has approximately the same population as Hood River, but does not have the same "saw-tooth" pattern of rises and falls that is found in Hood River. Curry County's economy is based less on agriculture than Hood River, and more on costal tourism.

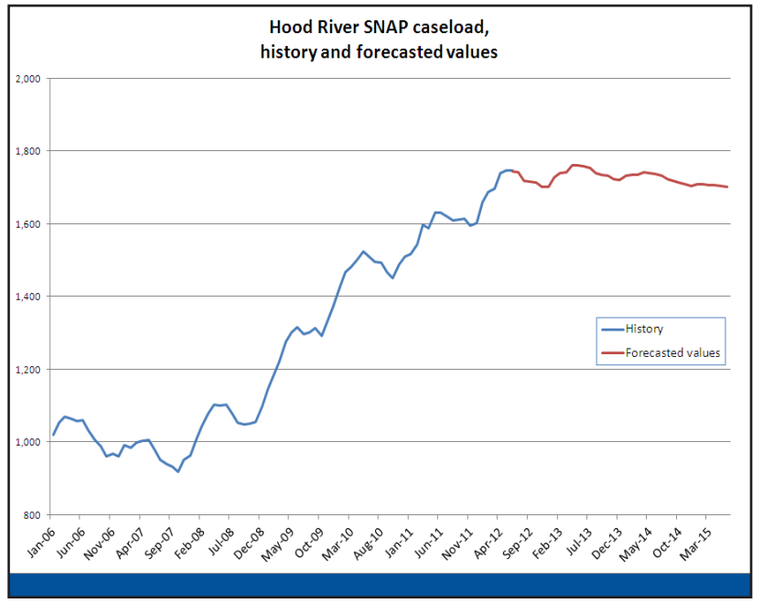


Figure 3: Hood River's forecasted caseload values through 2015 show the same seasonal variation. Preserving this fluctuation in the forecasted values can help improve forecast accuracy in counties with a strong agricultural base.

District 1 Regional Forecast

Although the economy has been growing in District 1, there has been an obvious slow-down of late. September jobs numbers show fewer people employed in District 1 compared to the same time last year, with reductions coming most sharply in Tillamook County. However, compared to 2011, the general trend remains positive. The continued weakness of the construction and manufacturing sectors may account for the relatively high unemployment in Columbia County. The usual back-to-school increase in local government employment occurred in September, but it was more tepid than in 2011.

DISTRICT 1					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
CLATSOP	37,145	20.5	17.2	12.8	20.7	13.9	8.5	7.7
COLUMBIA	49,625	23.3	14.5	10.3	12.9	7.9	10.2	9.6
TILLAMOOK	25,255	20.0	21.4	16.9	16.4	14.4	8.8	8.1

District 1 Regional Forecast, Oregon Department of Human Services

Counties served
Clatsop, Columbia and Tillamook

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Clatsop	4,371	4,558	4.3%	4,558	4,673	2.5%
Columbia	5,309	5,384	1.4%	5,384	5,314	-1.3%
Tillamook	2,696	2,694	-0.1%	2,694	2,745	1.9%
District 1 total	**12,375**	**12,636**	**2.1%**	**12,636**	**12,732**	**0.8%**
TANF						
Clatsop	132	138	4.4%	138	135	-2.2%
Columbia	329	340	3.3%	340	313	-7.9%
Tillamook	71	98	38.6%	98	98	0.0%
District 1 total	**532**	**576**	**8.2%**	**576**	**546**	**-5.2%**
Employment Related Day Care						
Clatsop	75	78	4.7%	78	106	35.9%
Columbia	84	87	3.7%	87	113	29.9%
Tillamook	63	49	-22.7%	49	42	-14.3%
District 1 total	**222**	**214**	**-3.5%**	**214**	**261**	**22.0%**

District 1 Regional Forecast, Oregon Department of Human Services (*continued*)

Counties served
Clatsop, Columbia and Tillamook

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Clatsop	90	68	-24.4%	68	68	0.0%
Columbia	88	83	-5.9%	83	84	1.2%
Tillamook	47	43	-8.5%	43	47	9.3%
District 1 total	**225**	**194**	**-13.8%**	**194**	**199**	**2.6%**
Community-Based Care						
Clatsop	161	148	-7.9%	148	156	5.4%
Columbia	133	131	-1.4%	131	144	9.9%
Tillamook	74	81	9.2%	81	87	7.4%
District 1 total	**368**	**360**	**-2.1%**	**360**	**387**	**7.5%**
Nursing Care						
Clatsop	42	45	6.7%	45	45	0.0%
Columbia	57	55	-4.2%	55	54	-1.8%
Tillamook	26	28	7.4%	28	28	0.0%
District 1 total	**126**	**128**	**1.9%**	**128**	**127**	**-0.8%**

District 1 Regional Forecast, Oregon Health Authority (clients)

Counties served
Clatsop, Columbia and Tillamook

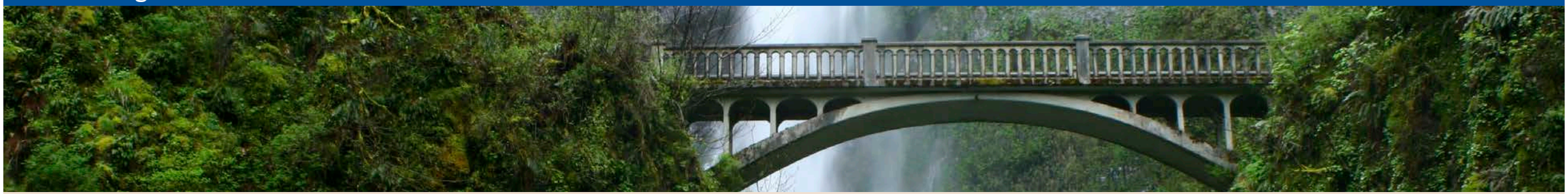
	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
TANF-Related Medical						
Clatsop	1,360	1,313	-3.5%	1,313	1,375	4.7%
Columbia	2,103	2,219	5.5%	2,219	2,392	7.8%
Tillamook	956	997	4.3%	997	1,049	5.2%
District 1 total	**4,420**	**4,529**	**2.5%**	**4,529**	**4,816**	**6.3%**
Poverty-Level Medical: Children						
Clatsop	1,508	1,506	-0.2%	1,506	1,523	1.1%
Columbia	1,613	1,600	-0.8%	1,600	1,618	1.1%
Tillamook	944	894	-5.3%	894	889	-0.6%
District 1 total	**4,065**	**4,000**	**-1.6%**	**4,000**	**4,030**	**0.8%**
Children's Health Insurance Program (CHIP)						
Clatsop	757	809	6.9%	809	1,028	27.1%
Columbia	722	714	-1.1%	714	766	7.3%
Tillamook	550	544	-1.2%	544	650	19.5%
District 1 total	**2,029**	**2,067**	**1.9%**	**2,067**	**2,444**	**18.2%**
Poverty Level Medical: Women						
Clatsop	136	148	9.2%	148	147	-0.7%
Columbia	135	135	0.2%	135	135	0.0%
Tillamook	76	73	-4.3%	73	74	1.4%
District 1 total	**347**	**356**	**2.7%**	**356**	**356**	**0.0%**
Foster Care & Adoption Services						
Clatsop	216	238	10.2%	238	265	11.3%
Columbia	361	357	-1.1%	357	381	6.7%
Tillamook	113	128	13.1%	128	135	5.5%
District 1 total	**690**	**723**	**4.8%**	**723**	**781**	**8.0%**

District 1 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Clatsop, Columbia and Tillamook

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Clatsop	847	839	-0.9%	839	876	4.4%
Columbia	1,013	1,039	2.5%	1,039	1,154	11.1%
Tillamook	495	510	3.1%	510	545	6.9%
District 1 total	**2,355**	**2,388**	**1.4%**	**2,388**	**2,575**	**7.8%**
Old Age Assistance						
Clatsop	301	298	-0.9%	298	318	6.7%
Columbia	319	320	0.2%	320	359	12.2%
Tillamook	179	196	9.2%	196	218	11.2%
District 1 total	**800**	**814**	**1.8%**	**814**	**895**	**10.0%**
OHP Standard						
Clatsop	642	684	6.5%	684	635	-7.2%
Columbia	1,045	1,073	2.7%	1,073	1,039	-3.2%
Tillamook	358	369	3.1%	369	340	-7.9%
District 1 total	**2,045**	**2,126**	**3.9%**	**2,126**	**2,014**	**-5.3%**

District 2 Regional Forecast



The economy continues to grow rather robustly in Portland, although still not at the pace of a usual economic recovery. Construction, trade/transportation/utilities and leisure/hospitality jobs have picked up. The only dark spot is government employment, which contracted in September for federal, state and local government employment. Business through the Port of Portland could be disrupted by a further downturn in the Asian economy or a new round of labor disputes; however, barring those events, things remain positive.

Stakeholders who responded to the survey indicated that Portland may be a magnet for those looking to access waivered services currently offered in Oregon that are no longer available in other states, leading to increased caseloads.

DISTRICT 2					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
MULTNOMAH	741,925	20.3	10.8	16.0	16.5	4.2	8.5	7.7

District 2 Regional Forecast, Oregon Department of Human Services

Counties served
Multnomah

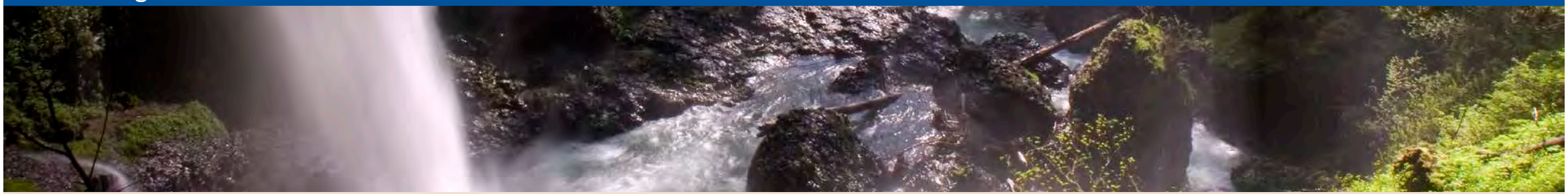
	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Multnomah	95,133	97,187	2.2%	97,187	94,617	-2.6%
District 2 total	**95,133**	**97,187**	**2.2%**	**97,187**	**94,617**	**-2.6%**
TANF						
Multnomah	9,169	8,881	-3.1%	8,881	8,265	-6.9%
District 2 total	**9,169**	**8,881**	**-3.1%**	**8,881**	**8,265**	**-6.9%**
Employment Related Day Care						
Multnomah	1,817	1,788	-1.6%	1,788	2,035	13.8%
District 2 total	**1,817**	**1,788**	**-1.6%**	**1,788**	**2,035**	**13.8%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Multnomah	2,670	2,524	-5.5%	2,524	2,538	0.6%
District 2 total	**2,670**	**2,524**	**-5.5%**	**2,524**	**2,538**	**0.6%**
Community-Based Care						
Multnomah	2,716	2,699	-0.6%	2,699	2,836	5.1%
District 2 total	**2,716**	**2,699**	**-0.6%**	**2,699**	**2,836**	**5.1%**
Nursing Care						
Multnomah	1,284	1,250	-2.7%	1,250	1,243	-0.6%
District 2 total	**1,284**	**1,250**	**-2.7%**	**1,250**	**1,243**	**-0.6%**

District 2 Regional Forecast, Oregon Health Authority (clients)

Counties served
Multnomah

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Multnomah	39,797	38,925	-2.2%	38,925	40,354	3.7%
District 2 total	**39,797**	**38,925**	**-2.2%**	**38,925**	**40,354**	**3.7%**
Poverty-Level Medical: Children						
Multnomah	24,651	24,821	0.7%	24,821	25,203	1.5%
District 2 total	**24,651**	**24,821**	**0.7%**	**24,821**	**25,203**	**1.5%**
Children's Health Insurance Program (CHIP)						
Multnomah	11,601	11,377	-1.9%	11,377	11,463	0.8%
District 2 total	**11,601**	**11,377**	**-1.9%**	**11,377**	**11,463**	**0.8%**
Poverty Level Medical: Women						
Multnomah	2,312	2,236	-3.3%	2,236	2,283	2.1%
District 2 total	**2,312**	**2,236**	**-3.3%**	**2,236**	**2,283**	**2.1%**
Foster Care & Adoption Services						
Multnomah	3,038	3,038	0.0%	3,038	2,978	-2.0%
District 2 total	**3,038**	**3,038**	**0.0%**	**3,038**	**2,978**	**-2.0%**
Aid to Blind/Disabled						
Multnomah	17,760	17,697	-0.4%	17,697	18,490	4.5%
District 2 total	**17,760**	**17,697**	**-0.4%**	**17,697**	**18,490**	**4.5%**
Old Age Assistance						
Multnomah	9,288	9,129	-1.7%	9,129	10,348	13.4%
District 2 total	**9,288**	**9,129**	**-1.7%**	**9,129**	**10,348**	**13.4%**
OHP Standard						
Multnomah	12,481	12,876	3.2%	12,876	11,440	-11.2%
District 2 total	**12,481**	**12,876**	**3.2%**	**12,876**	**11,440**	**-11.2%**

District 3 Regional Forecast

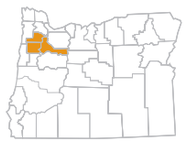


District 3's economy has been sluggish at best since the Great Recession. Although jobs are being created, they are not at a pace to replace the jobs lost since 2008, especially not in construction, which contracted in September 2012 compared to the previous year. However, most other areas of the economy, including manufacturing, are improving. Like most of the state, District 3 has seen a contraction of government jobs at the federal, state and local levels compared to last year, despite the usual increased hiring with the start of the school year.

DISTRICT 3					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
MARION	318,150	26.3	13.1	16.0	18.0	6.0	10.2	9.5
POLK	75,965	24.4	15.1	12.9	12.3	8.9	8.7	8.5
YAMHILL	99,850	24.8	13.8	12.7	15.8	8.5	9.0	8.3

District 3 Regional Forecast, Oregon Department of Human Services

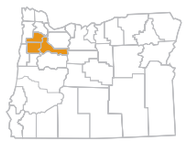
Counties served
Marion, Polk and Yamhill



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Marion	38,572	39,096	1.4%	39,096	38,608	-1.2%
Polk	8,239	7,881	-4.3%	7,881	7,684	-2.5%
Yamhill	10,736	10,436	-2.8%	10,436	10,560	1.2%
District 3 total	**57,547**	**57,413**	**-0.2%**	**57,413**	**56,852**	**-1.0%**
TANF						
Marion	4,075	4,131	1.4%	4,131	3,796	-8.1%
Polk	800	812	1.4%	812	763	-6.0%
Yamhill	949	955	0.6%	955	1,094	14.6%
District 3 total	**5,824**	**5,898**	**1.3%**	**5,898**	**5,653**	**-4.2%**
Employment Related Day Care						
Marion	842	871	3.5%	871	1,047	20.2%
Polk	159	158	-0.3%	158	195	23.4%
Yamhill	217	220	1.2%	220	261	18.6%
District 3 total	**1,218**	**1,249**	**2.6%**	**1,249**	**1,503**	**20.3%**

District 3 Regional Forecast, Oregon Department of Human Services (*continued*)

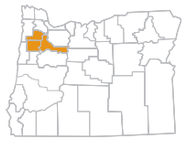
Counties served
Marion, Polk and Yamhill



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Marion	812	780	-3.9%	780	791	1.4%
Polk	232	215	-7.5%	215	212	-1.4%
Yamhill	166	166	0.0%	166	197	18.7%
District 3 total	**1,210**	**1,161**	**-4.0%**	**1,161**	**1,200**	**3.4%**
Community-Based Care						
Marion	1,035	1,057	2.2%	1,057	1,119	5.9%
Polk	248	247	-0.5%	247	260	5.3%
Yamhill	383	377	-1.6%	377	407	8.0%
District 3 total	**1,666**	**1,681**	**0.9%**	**1,681**	**1,786**	**6.2%**
Nursing Care						
Marion	344	349	1.5%	349	348	-0.3%
Polk	103	109	5.7%	109	109	0.0%
Yamhill	161	152	-5.3%	152	156	2.6%
District 3 total	**607**	**610**	**0.4%**	**610**	**613**	**0.5%**

District 3 Regional Forecast, Oregon Health Authority (clients)

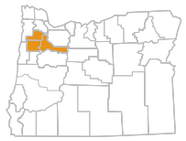
Counties served
Marion, Polk and Yamhill



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Marion	20,507	20,546	0.2%	20,546	21,370	4.0%
Polk	4,099	3,846	-6.2%	3,846	3,995	3.9%
Yamhill	4,770	4,801	0.7%	4,801	5,012	4.4%
District 3 total	**29,376**	**29,193**	**-0.6%**	**29,193**	**30,377**	**4.1%**
Poverty-Level Medical: Children						
Marion	18,628	18,611	-0.1%	18,611	19,036	2.3%
Polk	2,880	2,851	-1.0%	2,851	2,882	1.1%
Yamhill	4,218	4,225	0.2%	4,225	4,261	0.9%
District 3 total	**25,726**	**25,687**	**-0.2%**	**25,687**	**26,179**	**1.9%**
Children's Health Insurance Program (CHIP)						
Marion	8,522	8,316	-2.4%	8,316	8,659	4.1%
Polk	1,344	1,331	-1.0%	1,331	1,426	7.1%
Yamhill	2,176	2,147	-1.3%	2,147	2,296	6.9%
District 3 total	**12,041**	**11,794**	**-2.1%**	**11,794**	**12,381**	**5.0%**
Poverty Level Medical: Women						
Marion	1,180	1,184	0.3%	1,184	1,208	2.0%
Polk	230	230	-0.2%	230	232	0.9%
Yamhill	362	349	-3.5%	349	355	1.7%
District 3 total	**1,772**	**1,763**	**-0.5%**	**1,763**	**1,795**	**1.8%**
Foster Care & Adoption Services						
Marion	1,804	1,771	-1.8%	1,771	1,787	0.9%
Polk	488	464	-4.9%	464	493	6.3%
Yamhill	456	474	3.9%	474	480	1.3%
District 3 total	**2,748**	**2,709**	**-1.4%**	**2,709**	**2,760**	**1.9%**

District 3 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Marion, Polk and Yamhill



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Aid to Blind/Disabled						
Marion	6,933	6,964	0.4%	6,964	7,345	5.5%
Polk	1,586	1,543	-2.7%	1,543	1,653	7.1%
Yamhill	1,696	1,693	-0.2%	1,693	1,804	6.6%
District 3 total	**10,215**	**10,200**	**-0.2%**	**10,200**	**10,802**	**5.9%**
Old Age Assistance						
Marion	2,906	2,907	0.0%	2,907	3,161	8.7%
Polk	650	634	-2.4%	634	670	5.7%
Yamhill	805	766	-4.9%	766	796	3.9%
District 3 total	**4,361**	**4,307**	**-1.2%**	**4,307**	**4,627**	**7.4%**
OHP Standard						
Marion	5,508	5,687	3.3%	5,687	5,287	-7.0%
Polk	1,176	1,206	2.6%	1,206	1,165	-3.4%
Yamhill	1,501	1,585	5.6%	1,585	1,472	-7.1%
District 3 total	**8,185**	**8,478**	**3.6%**	**8,478**	**7,924**	**-6.5%**

District 4 Regional Forecast

District 4 is the only region of the state to record significant losses in jobs comparing September employment to the previous year. Trade and transportation jobs are up, but not enough to offset losses elsewhere. All three counties showed reductions in manufacturing employment. Government jobs losses remain a drag on the economy, even in Benton County, which was otherwise spared from the worst aspects of the recession.

DISTRICT 4					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
BENTON	85,995	17.8	12.6	19.1	8.4	3.0	6.6	6.4
LINCOLN	46,155	17.3	22.4	16.2	19.3	12.8	9.9	9.0
LINN	117,340	24.1	15.7	15.6	15.6	16.3	11.7	11.1

District 4 Regional Forecast, Oregon Department of Human Services

Counties served
Benton, Lincoln and Linn

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Benton	6,308	6,502	3.1%	6,502	6,451	-0.8%
Lincoln	6,436	6,554	1.8%	6,554	6,175	-5.8%
Linn	16,055	15,666	-2.4%	15,666	15,942	1.8%
District 4 total	**28,799**	**28,722**	**-0.3%**	**28,722**	**28,568**	**-0.5%**
TANF						
Benton	319	318	-0.4%	318	290	-8.8%
Lincoln	351	390	11.1%	390	372	-4.6%
Linn	1,032	1,077	4.4%	1,077	1,007	-6.5%
District 4 total	**1,702**	**1,785**	**4.9%**	**1,785**	**1,669**	**-6.5%**
Employment Related Day Care						
Benton	110	105	-4.2%	105	116	10.5%
Lincoln	97	102	5.3%	102	134	31.4%
Linn	261	268	2.8%	268	329	22.8%
District 1 total	**467**	**475**	**1.7%**	**475**	**579**	**21.9%**

District 4 Regional Forecast, Oregon Department of Human Services (*continued*)

Counties served
Benton, Lincoln and Linn

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Benton	138	130	-6.0%	130	128	-1.5%
Lincoln	284	282	-0.6%	282	292	3.5%
Linn	555	499	-10.1%	499	497	-0.4%
District 4 total	**977**	**911**	**-6.8%**	**911**	**917**	**0.7%**
Community-Based Care						
Benton	126	133	5.8%	133	138	3.8%
Lincoln	166	176	6.3%	176	179	1.7%
Linn	415	427	2.9%	427	445	4.2%
District 4 total	**706**	**736**	**4.2%**	**736**	**762**	**3.5%**
Nursing Care						
Benton	42	47	12.3%	47	47	0.0%
Lincoln	38	44	16.3%	44	51	15.9%
Linn	167	151	-9.4%	151	158	4.6%
District 4 total	**246**	**242**	**-1.8%**	**242**	**256**	**5.8%**

District 4 Regional Forecast, Oregon Health Authority (clients)

Counties served
Benton, Lincoln and Linn

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Benton	2,165	2,106	-2.7%	2,106	2,208	4.8%
Lincoln	2,293	2,397	4.5%	2,397	2,563	6.9%
Linn	6,893	7,044	2.2%	7,044	7,433	5.5%
District 4 total	**11,351**	**11,547**	**1.7%**	**11,547**	**12,204**	**5.7%**
Poverty-Level Medical: Children						
Benton	1,832	1,817	-0.8%	1,817	1,828	0.6%
Lincoln	1,953	1,941	-0.6%	1,941	1,944	0.2%
Linn	5,491	5,483	-0.2%	5,483	5,534	0.9%
District 4 total	**9,276**	**9,241**	**-0.4%**	**9,241**	**9,306**	**0.7%**
Children's Health Insurance Program (CHIP)						
Benton	889	892	0.4%	892	958	7.4%
Lincoln	867	883	1.9%	883	956	8.3%
Linn	2,381	2,422	1.7%	2,422	2,563	5.8%
District 4 total	**4,136**	**4,197**	**1.5%**	**4,197**	**4,477**	**6.7%**
Poverty Level Medical: Women						
Benton	154	176	14.2%	176	192	9.1%
Lincoln	188	182	-3.0%	182	188	3.3%
Linn	470	460	-2.1%	460	462	0.4%
District 4 total	**812**	**818**	**0.8%**	**818**	**842**	**2.9%**
Foster Care & Adoption Services						
Benton	248	265	7.1%	265	265	0.0%
Lincoln	276	285	3.4%	285	284	-0.4%
Linn	707	731	3.4%	731	740	1.2%
District 4 total	**1,230**	**1,281**	**4.1%**	**1,281**	**1,289**	**0.6%**

District 4 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Benton, Lincoln and Linn

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Benton	1,222	1,193	-2.4%	1,193	1,253	5.0%
Lincoln	1,332	1,320	-0.9%	1,320	1,412	7.0%
Linn	3,247	3,259	0.4%	3,259	3,491	7.1%
District 4 total	**5,800**	**5,772**	**-0.5%**	**5,772**	**6,156**	**6.7%**
Old Age Assistance						
Benton	333	330	-0.8%	330	367	11.2%
Lincoln	552	523	-5.2%	523	543	3.8%
Linn	1,125	1,089	-3.2%	1,089	1,155	6.1%
District 4 total	**2,010**	**1,942**	**-3.4%**	**1,942**	**2,065**	**6.3%**
OHP Standard						
Benton	799	873	9.3%	873	850	-2.6%
Lincoln	1,104	1,147	3.9%	1,147	1,048	-8.6%
Linn	2,383	2,492	4.6%	2,492	2,304	-7.5%
District 4 total	**4,287**	**4,512**	**5.3%**	**4,512**	**4,202**	**-6.9%**

District 5 Regional Forecast

The economy continues to improve in Lane County, with increases in manufacturing, trade and leisure/hospitality having outweighed recent job losses in government employment. Although unemployment remains high in the county, it is now slightly lower than the state overall.

Stakeholders in Lane County noted that future economic performance might cause caseloads to fall, indicating that social services providers are feeling the effects of an improving economy. However, this opinion was not uniform — others said that caseloads will only level off due to economic improvements, and still others thought that caseloads would continue to rise.

Many stakeholders noted the rise in Lane County's bilingual caseload. They said this increase is reducing access to needed services and increasing the amount of time social service providers spend on casework.

DISTRICT 5					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
LANE	353,155	19.7	15.5	16.7	15.4	6.0	9.4	8.5

District 5 Regional Forecast, Oregon Department of Human Services

County served
Lane

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Lane	48,007	48,174	0.3%	48,174	47,763	-0.9%
District 5 total	**48,007**	**48,174**	**0.3%**	**48,174**	**47,763**	**-0.9%**
TANF						
Lane	2,661	2,756	3.6%	2,756	2,577	-6.5%
District 5 total	**2,661**	**2,756**	**3.6%**	**2,756**	**2,577**	**-6.5%**
Employment Related Day Care						
Lane	999	1,008	0.9%	1,008	1,190	18.1%
District 5 total	**999**	**1,008**	**0.9%**	**1,008**	**1,190**	**18.1%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Lane	885	987	11.5%	987	907	-8.1%
District 5 total	**885**	**987**	**11.5%**	**987**	**907**	**-8.1%**
Community-Based Care						
Lane	1,129	1,139	0.9%	1,139	1,234	8.3%
District 5 total	**1,129**	**1,139**	**0.9%**	**1,139**	**1,234**	**8.3%**
Nursing Care						
Lane	449	442	-1.6%	442	440	-0.5%
District 5 total	**449**	**442**	**-1.6%**	**442**	**440**	**-0.5%**

District 5 Regional Forecast, Oregon Health Authority (clients)

County served
Lane

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Lane	15,387	15,769	2.5%	15,769	16,564	5.0%
District 5 total	**15,387**	**15,769**	**2.5%**	**15,769**	**16,564**	**5.0%**
Poverty-Level Medical: Children						
Lane	12,803	12,652	-1.2%	12,652	12,848	1.5%
District 5 total	**12,803**	**12,652**	**-1.2%**	**12,652**	**12,848**	**1.5%**
Children's Health Insurance Program (CHIP)						
Lane	6,110	5,809	-4.9%	5,809	6,144	5.8%
District 5 total	**6,110**	**5,809**	**-4.9%**	**5,809**	**6,144**	**5.8%**
Poverty Level Medical: Women						
Lane	1,313	1,362	3.8%	1,362	1,401	2.9%
District 5 total	**1,313**	**1,362**	**3.8%**	**1,362**	**1,401**	**2.9%**
Foster Care & Adoption Services						
Lane	2,377	2,409	1.3%	2,409	2,521	4.6%
District 5 total	**2,377**	**2,409**	**1.3%**	**2,409**	**2,521**	**4.6%**
Aid to Blind/Disabled						
Lane	9,345	9,403	0.6%	9,403	10,274	9.3%
District 5 total	**9,345**	**9,403**	**0.6%**	**9,403**	**10,274**	**9.3%**
Old Age Assistance						
Lane	3,003	2,934	-2.3%	2,934	3,232	10.2%
District 5 total	**3,003**	**2,934**	**-2.3%**	**2,934**	**3,232**	**10.2%**
OHP Standard						
Lane	6,933	7,207	4.0%	7,207	6,628	-8.0%
District 5 total	**6,933**	**7,207**	**4.0%**	**7,207**	**6,628**	**-8.0%**

District 6 Regional Forecast

Unemployment continues to hover around 12 percent in Douglas County, which has not seen the kind of improvement in jobs enjoyed in other parts of the state. There are signs of economic improvement, however. Manufacturing, especially wood products manufacturing, has been on the rise, along with hiring in professional and business services. These jobs tend to pay more than service sector jobs, and may point to improvement in District 6's overall economic health. The most consistent downside to these improvements has been in government sector job loss, which has tended to cancel out improvements in the private sector. Indian tribal government hiring may be the one bright spot in this employment sector.

Respondents to the Stakeholder Survey indicated that Spanish-speaking clients are putting strains on this district's social services, especially for mental health providers.

DISTRICT 6					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
DOUGLAS	107,795	20.3	21.6	15.6	18.0	17.9	13.2	12.0

District 6 Regional Forecast, Oregon Department of Human Services

County served
Douglas

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Douglas	15,815	15,859	0.3%	15,859	15,643	-1.4%
District 6 total	**15,815**	**15,859**	**0.3%**	**15,859**	**15,643**	**-1.4%**
TANF						
Douglas	1,440	1,296	-10.0%	1,296	1,225	-5.5%
District 6 total	**1,440**	**1,296**	**-10.0%**	**1,296**	**1,225**	**-5.5%**
Employment Related Day Care						
Douglas	241	229	-5.0%	229	268	17.0%
District 6 total	**241**	**229**	**-5.0%**	**229**	**268**	**17.0%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Douglas	481	482	0.2%	482	478	-0.8%
District 6 total	**481**	**482**	**0.2%**	**482**	**478**	**-0.8%**
Community-Based Care						
Douglas	469	474	1.0%	474	519	9.5%
District 6 total	**469**	**474**	**1.0%**	**474**	**519**	**9.5%**
Nursing Care						
Douglas	99	102	2.7%	102	108	5.9%
District 6 total	**99**	**102**	**2.7%**	**102**	**108**	**5.9%**

District 6 Regional Forecast, Oregon Health Authority (clients)

County served
Douglas

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Douglas	6,762	6,507	-3.8%	6,507	6,736	3.5%
District 6 total	**6,762**	**6,507**	**-3.8%**	**6,507**	**6,736**	**3.5%**
Poverty-Level Medical: Children						
Douglas	4,725	4,649	-1.6%	4,649	4,739	1.9%
District 6 total	**4,725**	**4,649**	**-1.6%**	**4,649**	**4,739**	**1.9%**
Children's Health Insurance Program (CHIP)						
Douglas	1,884	1,788	-5.1%	1,788	1,869	4.5%
District 6 total	**1,884**	**1,788**	**-5.1%**	**1,788**	**1,869**	**4.5%**
Poverty Level Medical: Women						
Douglas	486	467	-3.8%	467	467	0.0%
District 6 total	**486**	**467**	**-3.8%**	**467**	**467**	**0.0%**
Foster Care & Adoption Services						
Douglas	717	726	1.2%	726	799	10.1%
District 6 total	**717**	**726**	**1.2%**	**726**	**799**	**10.1%**
Aid to Blind/Disabled						
Douglas	3,058	3,062	0.1%	3,062	3,223	5.3%
District 6 total	**3,058**	**3,062**	**0.1%**	**3,062**	**3,223**	**5.3%**
Old Age Assistance						
Douglas	1,089	1,066	-2.1%	1,066	1,110	4.1%
District 6 total	**1,089**	**1,066**	**-2.1%**	**1,066**	**1,110**	**4.1%**
OHP Standard						
Douglas	2,489	2,588	4.0%	2,588	2,421	-6.5%
District 6 total	**2,489**	**2,588**	**4.0%**	**2,588**	**2,421**	**-6.5%**

District 7 Regional Forecast

Coos and Curry counties started bleeding jobs before the Great Recession, and that pattern only accelerated during the economic downturn. As a result, the region was in a deep hole when things started to turn around in 2011. The Southwest Coast has been adding jobs over the last year; however, like many other regions, government-based employment losses have erased some of those gains.

The economies of Coos and Curry counties are fighting uphill against a demographic tide: The region has lost population over the last 10 years, especially young working-age adults. This hampers the ability of the region to grow economically. Coos and Curry counties have a high percentage of retirement-age adults and will likely continue to feel the strain of a population in need of age-related services; at the same time, the district has a smaller base of employment-age adults.

DISTRICT 7					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
COOS	62,960	19.1	21.9	16.4	16.4	11.1	11.3	10.5
CURRY	22,335	15.5	28.6	13.9	18.1	15.0	12.1	11.6

District 7 Regional Forecast, Oregon Department of Human Services

Counties served
Coos and Curry

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Coos	10,412	10,302	-1.1%	10,302	11,345	10.1%
Curry	2,809	2,723	-3.1%	2,723	2,714	-0.3%
District 7 total	**13,221**	**13,025**	**-1.5%**	**13,025**	**14,059**	**7.9%**
TANF						
Coos	743	753	1.4%	753	699	-7.2%
Curry	155	149	-3.7%	149	154	3.4%
District 7 total	**897**	**902**	**0.5%**	**902**	**853**	**-5.4%**
Employment Related Day Care						
Coos	154	151	-1.9%	151	179	18.5%
Curry	49	42	-14.0%	42	43	2.4%
District 7 total	**203**	**193**	**-4.8%**	**193**	**222**	**15.0%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Coos	530	458	-13.5%	458	449	-2.0%
Curry	69	63	-9.3%	63	68	7.9%
District 7 total	**599**	**521**	**-13.0%**	**521**	**517**	**-0.8%**
Community-Based Care						
Coos	324	330	1.9%	330	347	5.2%
Curry	134	144	7.6%	144	150	4.2%
District 7 total	**458**	**474**	**3.6%**	**474**	**497**	**4.9%**
Nursing Care						
Coos	91	85	-6.3%	85	89	4.7%
Curry	28	27	-2.4%	27	28	3.7%
District 7 total	**118**	**112**	**-5.4%**	**112**	**117**	**4.5%**

District 7 Regional Forecast, Oregon Health Authority (clients)

Counties served
Coos and Curry

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Coos	3,376	3,322	-1.6%	3,322	3,394	2.2%
Curry	859	824	-4.0%	824	859	4.2%
District 7 total	**4,235**	**4,146**	**-2.1%**	**4,146**	**4,253**	**2.6%**
Poverty-Level Medical: Children						
Coos	2,535	2,561	1.0%	2,561	2,614	2.1%
Curry	683	732	7.1%	732	756	3.3%
District 7 total	**3,218**	**3,293**	**2.3%**	**3,293**	**3,370**	**2.3%**
Children's Health Insurance Program (CHIP)						
Coos	1,174	1,127	-4.0%	1,127	1,177	4.4%
Curry	333	321	-3.6%	321	338	5.3%
District 7 total	**1,507**	**1,448**	**-3.9%**	**1,448**	**1,515**	**4.6%**
Poverty Level Medical: Women						
Coos	283	263	-7.0%	263	271	3.0%
Curry	88	95	8.5%	95	101	6.3%
District 7 total	**370**	**358**	**-3.3%**	**358**	**372**	**3.9%**
Foster Care & Adoption Services						
Coos	511	515	0.8%	515	527	2.3%
Curry	92	89	-3.7%	89	92	3.4%
District 7 total	**603**	**604**	**0.1%**	**604**	**619**	**2.5%**

District 7 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Coos and Curry

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Coos	2,335	2,309	-1.1%	2,309	2,422	4.9%
Curry	594	611	2.9%	611	644	5.4%
District 7 total	**2,929**	**2,920**	**-0.3%**	**2,920**	**3,066**	**5.0%**
Old Age Assistance						
Coos	851	839	-1.4%	839	886	5.6%
Curry	258	278	7.6%	278	309	11.2%
District 7 total	**1,109**	**1,117**	**0.7%**	**1,117**	**1,195**	**7.0%**
OHP Standard						
Coos	1,571	1,641	4.4%	1,641	1,513	-7.8%
Curry	407	431	5.9%	431	396	-8.1%
District 7 total	**1,978**	**2,072**	**4.7%**	**2,072**	**1,909**	**-7.9%**

District 8 Regional Forecast

Medford, as the regional population center for Southwest Oregon, is producing new jobs and is the region's economic bright spot. Unemployment remains stubbornly high for the Rogue Valley, however. Manufacturing and construction are slowly improving. Lower-paying service sector jobs are returning, especially in leisure/hospitality and retail trade. Job losses at all levels of government — federal, state and local — have mitigated some of the private sector improvements.

DISTRICT 8					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
JACKSON	203,950	21.7	18.1	14.0	20.4	12.2	11.6	10.6
JOSEPHINE	82,820	20.2	22.8	17.8	17.8	11.0	12.6	11.9

District 8 Regional Forecast, Oregon Department of Human Services

Counties served
Jackson and Josephine

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Jackson	28,462	28,567	0.4%	28,567	28,058	-1.8%
Josephine	14,513	14,216	-2.0%	14,216	13,988	-1.6%
District 8 total	**42,975**	**42,783**	**-0.4%**	**42,783**	**42,046**	**-1.7%**
TANF						
Jackson	2,022	2,179	7.7%	2,179	2,299	5.5%
Josephine	1,237	1,233	-0.3%	1,233	1,150	-6.7%
District 8 total	**3,259**	**3,412**	**4.7%**	**3,412**	**3,449**	**1.1%**
Employment Related Day Care						
Jackson	555	568	2.3%	568	724	27.5%
Josephine	163	158	-3.1%	158	176	11.4%
District 8 total	**718**	**726**	**1.1%**	**726**	**900**	**24.0%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Jackson	555	697	25.5%	697	698	0.1%
Josephine	342	358	4.8%	358	357	-0.3%
District 8 total	**897**	**1,055**	**17.6%**	**1,055**	**1,055**	**0.0%**
Community-Based Care						
Jackson	801	781	-2.4%	781	800	2.4%
Josephine	307	307	0.1%	307	316	2.9%
District 8 total	**1,107**	**1,088**	**-1.7%**	**1,088**	**1,116**	**2.6%**
Nursing Care						
Jackson	186	172	-7.3%	172	172	0.0%
Josephine	139	142	2.1%	142	150	5.6%
District 8 total	**325**	**314**	**-3.3%**	**314**	**322**	**2.5%**

District 8 Regional Forecast, Oregon Health Authority (clients)

Counties served
Jackson and Josephine

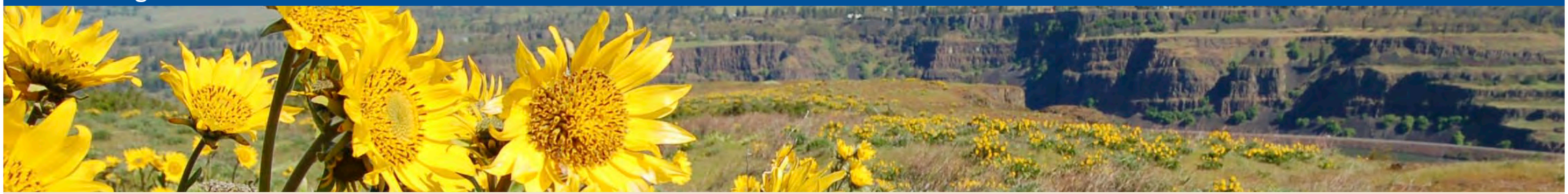
	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Jackson	11,375	11,436	0.5%	11,436	11,939	4.4%
Josephine	5,862	5,818	-0.7%	5,818	5,995	3.0%
District 8 total	**17,236**	**17,254**	**0.1%**	**17,254**	**17,934**	**3.9%**
Poverty-Level Medical: Children						
Jackson	9,413	9,367	-0.5%	9,367	9,485	1.3%
Josephine	3,681	3,709	0.8%	3,709	3,737	0.8%
District 8 total	**13,093**	**13,076**	**-0.1%**	**13,076**	**13,222**	**1.1%**
Children's Health Insurance Program (CHIP)						
Jackson	4,638	4,561	-1.7%	4,561	4,848	6.3%
Josephine	1,662	1,639	-1.4%	1,639	1,736	5.9%
District 8 total	**6,300**	**6,200**	**-1.6%**	**6,200**	**6,584**	**6.2%**
Poverty Level Medical: Women						
Jackson	986	956	-3.1%	956	961	0.5%
Josephine	373	376	0.7%	376	394	4.8%
District 8 total	**1,360**	**1,332**	**-2.0%**	**1,332**	**1,355**	**1.7%**
Foster Care & Adoption Services						
Jackson	1,029	1,065	3.5%	1,065	1,132	6.3%
Josephine	529	552	4.4%	552	600	8.7%
District 8 total	**1,558**	**1,617**	**3.8%**	**1,617**	**1,732**	**7.1%**

District 8 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Jackson and Josephine

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Jackson	4,658	4,657	0.0%	4,657	4,987	7.1%
Josephine	2,580	2,615	1.4%	2,615	2,759	5.5%
District 8 total	**7,238**	**7,272**	**0.5%**	**7,272**	**7,746**	**6.5%**
Old Age Assistance						
Jackson	1,952	1,908	-2.3%	1,908	2,223	16.5%
Josephine	998	992	-0.6%	992	1,067	7.6%
District 8 total	**2,950**	**2,900**	**-1.7%**	**2,900**	**3,290**	**13.4%**
OHP Standard						
Jackson	4,082	4,197	2.8%	4,197	3,844	-8.4%
Josephine	2,538	2,668	5.1%	2,668	2,497	-6.4%
District 8 total	**6,620**	**6,865**	**3.7%**	**6,865**	**6,341**	**-7.6%**

District 9 Regional Forecast



District 9 contains the least populous counties in the state, and the economy is narrowly focused on tourism and agriculture. In general, the area's economy was somewhat sheltered from the Great Recession; this was especially true in Hood River, which has a stronger employment base than its neighbors.

District 9 stakeholders indicated an influx of new residents to the area, lured by cheap rents but unprepared for the higher food costs and long travel necessary to find basic services that comes with rural life. Many of these new residents came from Washington, lured by the possibility that they would qualify for social assistance in Oregon after losing benefits in Washington.

DISTRICT 9					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
GILLIAM	1,880	18.6	23.0	10.6	15.7	9.7	7.9	8.7
HOOD RIVER	22,625	25.7	12.8	9.5	18.5	9.7	7.6	6.8
SHERMAN	1,765	19.8	22.3	20.0	15.7	9.7	9.3	8.5
WASCO	25,300	23.2	18.0	15.5	21.7	12.5	8.4	7.6
WHEELER	1,435	18.4	29.5	11.4	15.7	9.7	10.0	7.2

District 9 Regional Forecast, Oregon Department of Human Services

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler**

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Gilliam	129	127	-1.4%	127	127	0.0%
Hood River	1,654	1,699	2.7%	1,699	1,720	1.2%
Sherman	138	142	3.1%	142	132	-7.0%
Wasco	2,885	2,952	2.3%	2,952	2,905	-1.6%
Wheeler	148	150	1.3%	150	147	-2.0%
District 9 total	**4,954**	**5,070**	**2.3%**	**5,070**	**5,031**	**-0.8%**
TANF						
Gilliam	9	9	0.9%	9	8	-11.1%
Hood River	52	70	34.1%	70	59	-15.7%
Sherman	10	10	-2.7%	10	9	-10.0%
Wasco	146	166	13.7%	166	164	-1.2%
Wheeler	12	11	-5.2%	11	11	0.0%
District 9 total	**229**	**266**	**16.2%**	**266**	**251**	**-5.6%**
Employment Related Day Care						
Gilliam	1	3	155.2%	3	4	33.3%
Hood River	37	35	-5.6%	35	43	22.9%
Sherman	2	2	2.1%	2	2	0.0%
Wasco	68	65	-4.1%	65	64	-1.5%
Wheeler	1	1	0.6%	1	1	0.0%
District 9 total	**109**	**106**	**-2.7%**	**106**	**114**	**7.5%**

District 9 Regional Forecast, Oregon Department of Human Services (*continued*)

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler**

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Gilliam	5	5	-1.8%	5	6	20.0%
Hood River	19	17	-10.6%	17	17	0.0%
Sherman	5	7	28.2%	7	8	14.3%
Wasco	83	80	-3.4%	80	79	-1.3%
Wheeler	6	5	-21.8%	5	5	0.0%
District 9 total	**119**	**114**	**-4.0%**	**114**	**115**	**0.9%**
Community-Based Care						
Gilliam	11	11	-1.8%	11	13	18.2%
Hood River	43	44	3.4%	44	45	2.3%
Sherman	0	1	100.0%	1	2	100.0%
Wasco	88	91	3.2%	91	95	4.4%
Wheeler	6	5	-12.2%	5	5	0.0%
District 9 total	**148**	**152**	**2.9%**	**152**	**160**	**5.3%**
Nursing Care						
Gilliam	1	2	100.0%	2	2	0.0%
Hood River	48	53	9.8%	53	53	0.0%
Sherman	2	2	2.6%	2	2	0.0%
Wasco	105	110	4.7%	110	111	0.9%
Wheeler	1	2	100.0%	2	2	0.0%
District 9 total	**157**	**169**	**7.4%**	**169**	**170**	**0.6%**

District 9 Regional Forecast, Oregon Health Authority (clients)

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler**

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Gilliam	56	54	-3.4%	54	56	3.7%
Hood River	657	704	7.2%	704	723	2.7%
Sherman	49	50	1.9%	50	48	-4.0%
Wasco	1,162	1,083	-6.8%	1,083	1,166	7.7%
Wheeler	54	52	-4.1%	52	57	9.6%
District 9 total	**1,978**	**1,943**	**-1.7%**	**1,943**	**2,050**	**5.5%**
Poverty-Level Medical: Children						
Gilliam	37	46	25.3%	46	50	8.7%
Hood River	1,249	1,288	3.1%	1,288	1,290	0.2%
Sherman	51	65	26.9%	65	69	6.2%
Wasco	1,212	1,251	3.2%	1,251	1,244	-0.6%
Wheeler	48	54	11.3%	54	53	-1.9%
District 9 total	**2,597**	**2,704**	**4.1%**	**2,704**	**2,706**	**0.1%**
Children's Health Insurance Program (CHIP)						
Gilliam	21	24	15.4%	24	25	4.2%
Hood River	792	817	3.1%	817	892	9.2%
Sherman	29	31	7.0%	31	35	12.9%
Wasco	652	639	-1.9%	639	665	4.1%
Wheeler	23	15	-34.9%	15	15	0.0%
District 9 total	**1,517**	**1,526**	**0.6%**	**1,526**	**1,632**	**6.9%**
Poverty Level Medical: Women						
Gilliam	3	4	29.6%	4	5	25.0%
Hood River	82	88	7.8%	88	98	11.4%
Sherman	4	6	64.1%	6	7	16.7%
Wasco	110	119	8.3%	119	124	4.2%
Wheeler	6	6	2.0%	6	7	16.7%
District 9 total	**204**	**223**	**9.2%**	**223**	**241**	**8.1%**

District 9 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served: **Gilliam, Hood River, Sherman, Wasco and Wheeler**

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Foster Care & Adoption Services						
Gilliam	10	12	20.9%	12	12	0.0%
Hood River	83	80	-3.3%	80	82	2.5%
Sherman	23	20	-14.8%	20	19	-5.0%
Wasco	151	154	2.3%	154	155	0.6%
Wheeler	9	10	10.9%	10	11	10.0%
District 9 total	**276**	**276**	**0.1%**	**276**	**279**	**1.1%**
Aid to Blind/Disabled						
Gilliam	33	32	-2.3%	32	34	6.3%
Hood River	229	270	17.9%	270	275	1.9%
Sherman	35	35	-0.8%	35	35	0.0%
Wasco	665	658	-1.0%	658	711	8.1%
Wheeler	28	26	-8.6%	26	26	0.0%
District 9 total	**990**	**1,021**	**3.1%**	**1,021**	**1,081**	**5.9%**
Old Age Assistance						
Gilliam	25	24	-2.3%	24	26	8.3%
Hood River	147	152	3.3%	152	165	8.6%
Sherman	14	11	-21.4%	11	12	9.1%
Wasco	304	309	1.5%	309	324	4.9%
Wheeler	29	17	-40.6%	17	19	11.8%
District 9 total	**519**	**513**	**-1.1%**	**513**	**546**	**6.4%**
OHP Standard						
Gilliam	30	32	5.7%	32	31	-3.1%
Hood River	226	277	22.7%	277	279	0.7%
Sherman	23	23	0.0%	23	23	0.0%
Wasco	425	454	6.7%	454	431	-5.1%
Wheeler	42	42	0.0%	42	36	-14.3%
District 9 total	**746**	**828**	**10.9%**	**828**	**800**	**-3.4%**

District 10 Regional Forecast

Unemployment remains a serious concern in Central Oregon, which suffered some of the worst jobs losses in the state during the Great Recession. Manufacturing and construction — staples of a thriving economy in the region — have been slow to recover but are showing signs of life. Leisure/hospitality and retail jobs associated with tourism improved in 2011, although that progress has somewhat tapered off. Government hiring is up from 2011, although some of that activity may be temporary hiring to fight wildfires in the area.

DISTRICT 10					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
CROOK	20,855	21.6	20.9	14.0	14.2	3.9	14.6	13.8
DESCHUTES	158,875	22.9	15.3	10.5	16.0	11.3	12.3	11.1
JEFFERSON	21,845	25.0	15.8	20.1	20.9	17.0	13.3	12.2

District 10 Regional Forecast, Oregon Department of Human Services

Counties served
Crook, Deschutes and Jefferson

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Crook	2,578	2,664	3.3%	2,664	2,769	3.9%
Deschutes	16,928	18,083	6.8%	18,083	17,853	-1.3%
Jefferson	3,489	3,598	3.1%	3,598	3,518	-2.2%
District 10 total	**22,995**	**24,345**	**5.9%**	**24,345**	**24,140**	**-0.8%**
TANF						
Crook	174	182	4.8%	182	219	20.3%
Deschutes	1,150	1,218	5.9%	1,218	1,110	-8.9%
Jefferson	389	423	8.7%	423	412	-2.6%
District 10 total	**1,712**	**1,823**	**6.5%**	**1,823**	**1,741**	**-4.5%**
Employment Related Day Care						
Crook	18	25	40.7%	25	38	52.0%
Deschutes	273	289	5.8%	289	354	22.5%
Jefferson	65	55	-15.5%	55	79	43.6%
District 10 total	**356**	**369**	**3.7%**	**369**	**471**	**27.6%**

District 10 Regional Forecast, Oregon Department of Human Services (*continued*)

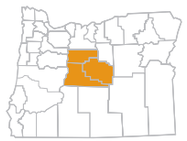
Counties served
Crook, Deschutes and Jefferson

Aging and People with Disabilities, Long-Term Care (clients)

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
In-Home Care						
Crook	96	84	-12.3%	84	84	0.0%
Deschutes	229	268	17.0%	268	262	-2.2%
Jefferson	58	54	-6.5%	54	55	1.9%
District 10 total	**383**	**406**	**6.1%**	**406**	**401**	**-1.2%**
Community-Based Care						
Crook	63	62	-2.1%	62	65	4.8%
Deschutes	447	464	3.9%	464	512	10.3%
Jefferson	92	82	-10.5%	82	89	8.5%
District 10 total	**602**	**608**	**1.1%**	**608**	**666**	**9.5%**
Nursing Care						
Crook	20	21	4.6%	21	22	4.8%
Deschutes	89	86	-3.0%	86	87	1.2%
Jefferson	20	18	-9.9%	18	18	0.0%
District 10 total	**129**	**125**	**-2.9%**	**125**	**127**	**1.6%**

District 10 Regional Forecast, Oregon Health Authority (clients)

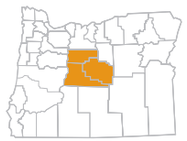
Counties served
Crook, Deschutes and Jefferson



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Crook	1,095	1,126	2.8%	1,126	1,193	6.0%
Deschutes	7,553	7,636	1.1%	7,636	7,996	4.7%
Jefferson	2,188	2,268	3.6%	2,268	2,368	4.4%
District 10 total	**10,837**	**11,030**	**1.8%**	**11,030**	**11,557**	**4.8%**
Poverty-Level Medical: Children						
Crook	852	870	2.1%	870	887	2.0%
Deschutes	6,490	6,370	-1.9%	6,370	6,420	0.8%
Jefferson	1,327	1,236	-6.9%	1,236	1,242	0.5%
District 10 total	**8,669**	**8,476**	**-2.2%**	**8,476**	**8,549**	**0.9%**
Children's Health Insurance Program (CHIP)						
Crook	518	521	0.5%	521	574	10.2%
Deschutes	3,533	3,343	-5.4%	3,343	3,551	6.2%
Jefferson	605	550	-9.1%	550	595	8.2%
District 10 total	**4,657**	**4,414**	**-5.2%**	**4,414**	**4,720**	**6.9%**
Poverty Level Medical: Women						
Crook	51	59	15.5%	59	63	6.8%
Deschutes	625	558	-10.7%	558	558	0.0%
Jefferson	125	103	-17.8%	103	105	1.9%
District 10 total	**801**	**720**	**-10.2%**	**720**	**726**	**0.8%**
Foster Care & Adoption Services						
Crook	85	78	-8.3%	78	79	1.3%
Deschutes	471	489	3.9%	489	491	0.4%
Jefferson	177	176	-0.4%	176	178	1.1%
District 10 total	**732**	**743**	**1.4%**	**743**	**748**	**0.7%**

District 10 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Crook, Deschutes and Jefferson



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Crook	450	453	0.7%	453	520	14.8%
Deschutes	2,315	2,375	2.6%	2,375	2,571	8.3%
Jefferson	531	529	-0.3%	529	596	12.7%
District 10 total	**3,296**	**3,357**	**1.9%**	**3,357**	**3,687**	**9.8%**
Old Age Assistance						
Crook	195	191	-1.9%	191	199	4.2%
Deschutes	831	852	2.5%	852	904	6.1%
Jefferson	196	194	-1.2%	194	231	19.1%
District 10 total	**1,222**	**1,237**	**1.2%**	**1,237**	**1,334**	**7.8%**
OHP Standard						
Crook	411	443	7.7%	443	420	-5.2%
Deschutes	2,468	2,686	8.8%	2,686	2,433	-9.4%
Jefferson	424	438	3.2%	438	422	-3.7%
District 10 total	**3,304**	**3,567**	**8.0%**	**3,567**	**3,275**	**-8.2%**

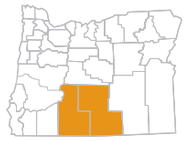
District 11 Regional Forecast

Unemployment in District 11 remains among the highest in the state, but there are signs of an improving economy. Klamath County has seen a rise in construction employment and jobs in the financial services sector throughout 2012, and trade jobs are on the rise. Government employment, a sore spot in many regions, is faring a little better in District 11.

DISTRICT 11					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
KLAMATH	66,580	22.2	17.6	16.6	18.3	7.1	12.4	11.5
LAKE	7,885	19.0	21.0	17.5	17.8	8.1	13.7	12.9

District 11 Regional Forecast, Oregon Department of Human Services

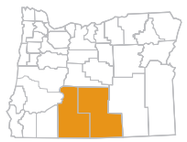
Counties served
Klamath and Lake



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Klamath	10,126	9,946	-1.8%	9,946	9,805	-1.4%
Lake	867	863	-0.4%	863	855	-0.9%
District 11 total	**10,993**	**10,809**	**-1.7%**	**10,809**	**10,660**	**-1.4%**
TANF						
Klamath	697	727	4.3%	727	696	-4.3%
Lake	37	41	11.3%	41	44	7.3%
District 11 total	**734**	**768**	**4.7%**	**768**	**740**	**-3.6%**
Employment Related Day Care						
Klamath	101	98	-3.1%	98	120	22.4%
Lake	6	5	-9.3%	5	9	80.0%
District 11 total	**107**	**103**	**-3.4%**	**103**	**129**	**25.2%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Klamath	207	199	-3.7%	199	199	0.0%
Lake	21	14	-33.4%	14	14	0.0%
District 11 total	**228**	**213**	**-6.5%**	**213**	**213**	**0.0%**
Community-Based Care						
Klamath	231	225	-2.7%	225	226	0.4%
Lake	12	13	12.8%	13	14	7.7%
District 11 total	**243**	**238**	**-1.9%**	**238**	**240**	**0.8%**
Nursing Care						
Klamath	41	39	-4.0%	39	38	-2.6%
Lake	17	14	-19.5%	14	12	-14.3%
District 11 total	**58**	**53**	**-8.7%**	**53**	**50**	**-5.7%**

District 11 Regional Forecast, Oregon Health Authority (clients)

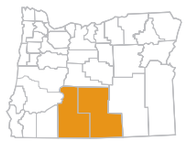
Counties served
Klamath and Lake



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Klamath	4,279	4,308	0.7%	4,308	4,458	3.5%
Lake	360	370	2.8%	370	383	3.5%
District 11 total	**4,640**	**4,678**	**0.8%**	**4,678**	**4,841**	**3.5%**
Poverty-Level Medical: Children						
Klamath	3,149	3,105	-1.4%	3,105	3,138	1.1%
Lake	285	274	-3.8%	274	271	-1.1%
District 11 total	**3,434**	**3,379**	**-1.6%**	**3,379**	**3,409**	**0.9%**
Children's Health Insurance Program (CHIP)						
Klamath	1,245	1,251	0.5%	1,251	1,348	7.8%
Lake	117	114	-2.3%	114	122	7.0%
District 11 total	**1,361**	**1,365**	**0.3%**	**1,365**	**1,470**	**7.7%**
Poverty Level Medical: Women						
Klamath	333	321	-3.5%	321	324	0.9%
Lake	39	35	-9.1%	35	38	8.6%
District 11 total	**371**	**356**	**-4.1%**	**356**	**362**	**1.7%**
Foster Care & Adoption Services						
Klamath	503	537	6.8%	537	551	2.6%
Lake	47	51	8.3%	51	51	0.0%
District 11 total	**550**	**588**	**6.9%**	**588**	**602**	**2.4%**

District 11 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Klamath and Lake



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Klamath	1,951	1,927	-1.2%	1,927	2,032	5.4%
Lake	174	182	4.4%	182	188	3.3%
District 11 total	**2,125**	**2,109**	**-0.8%**	**2,109**	**2,220**	**5.3%**
Old Age Assistance						
Klamath	585	576	-1.6%	576	598	3.8%
Lake	75	74	-1.2%	74	77	4.1%
District 11 total	**660**	**650**	**-1.6%**	**650**	**675**	**3.8%**
OHP Standard						
Klamath	1,472	1,495	1.6%	1,495	1,379	-7.8%
Lake	176	178	1.3%	178	170	-4.5%
District 11 total	**1,647**	**1,673**	**1.5%**	**1,673**	**1,549**	**-7.4%**

District 12 Regional Forecast

The economy in District 12 is expanding, with improvements from 2011 in manufacturing, trade and leisure/hospitality. Unemployment is more or less in line with the state as a whole.

DISTRICT 12					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
MORROW	11,270	28.0	13.2	15.3	15.7	9.7	8.7	8.9
UMATILLA	76,580	26.6	13.0	15.8	16.9	5.2	9.0	8.3

District 12 Regional Forecast, Oregon Department of Human Services

Counties served
Morrow and Umatilla

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Morrow	1,082	1,073	-0.8%	1,073	1,092	1.8%
Umatilla	8,415	8,334	-1.0%	8,334	8,276	-0.7%
District 11 total	**9,497**	**9,407**	**-0.9%**	**9,407**	**9,368**	**-0.4%**
TANF						
Morrow	97	105	8.1%	105	99	-5.7%
Umatilla	671	702	4.6%	702	633	-9.8%
District 11 total	**769**	**807**	**5.0%**	**807**	**732**	**-9.3%**
Employment Related Day Care						
Morrow	20	15	-25.9%	15	19	26.7%
Umatilla	180	189	4.9%	189	238	25.9%
District 11 total	**200**	**204**	**1.8%**	**204**	**257**	**26.0%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Morrow	37	34	-7.6%	34	33	-2.9%
Umatilla	272	271	-0.4%	271	272	0.4%
District 11 total	**309**	**305**	**-1.2%**	**305**	**305**	**0.0%**
Community-Based Care						
Morrow	13	14	11.1%	14	17	21.4%
Umatilla	267	278	3.9%	278	286	2.9%
District 11 total	**280**	**292**	**4.3%**	**292**	**303**	**3.8%**
Nursing Care						
Morrow	7	10	50.9%	10	12	20.0%
Umatilla	83	77	-7.4%	77	75	-2.6%
District 11 total	**90**	**87**	**-3.1%**	**87**	**87**	**0.0%**

District 12 Regional Forecast, Oregon Health Authority (clients)

Counties served
Morrow and Umatilla

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Morrow	678	705	4.0%	705	757	7.4%
Umatilla	4,480	4,452	-0.6%	4,452	4,733	6.3%
District 12 total	**5,157**	**5,157**	**0.0%**	**5,157**	**5,490**	**6.4%**
Poverty-Level Medical: Children						
Morrow	542	572	5.6%	572	595	4.0%
Umatilla	3,809	3,932	3.2%	3,932	4,020	2.2%
District 12 total	**4,351**	**4,504**	**3.5%**	**4,504**	**4,615**	**2.5%**
Children's Health Insurance Program (CHIP)						
Morrow	357	352	-1.5%	352	366	4.0%
Umatilla	1,958	1,930	-1.4%	1,930	2,047	6.1%
District 12 total	**2,315**	**2,282**	**-1.4%**	**2,282**	**2,413**	**5.7%**
Poverty Level Medical: Women						
Morrow	41	47	16.0%	47	48	2.1%
Umatilla	366	374	2.3%	374	387	3.5%
District 12 total	**406**	**421**	**3.6%**	**421**	**435**	**3.3%**
Foster Care & Adoption Services						
Morrow	44	42	-3.9%	42	43	2.4%
Umatilla	404	393	-2.8%	393	399	1.5%
District 12 total	**448**	**435**	**-2.9%**	**435**	**442**	**1.6%**

District 12 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Morrow and Umatilla

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Morrow	220	219	-0.5%	219	256	16.9%
Umatilla	1,618	1,596	-1.4%	1,596	1,665	4.3%
District 12 total	**1,838**	**1,815**	**-1.3%**	**1,815**	**1,921**	**5.8%**
Old Age Assistance						
Morrow	70	72	2.4%	72	77	6.9%
Umatilla	797	783	-1.7%	783	820	4.7%
District 12 total	**867**	**855**	**-1.4%**	**855**	**897**	**4.9%**
OHP Standard						
Morrow	136	136	0.0%	136	130	-4.4%
Umatilla	788	846	7.4%	846	823	-2.7%
District 7 total	**924**	**982**	**6.3%**	**982**	**953**	**-3.0%**

District 13 Regional Forecast

The Great Recession hit Northeast Oregon hard, but District 13 has been showing signs of improvement, especially Wallowa and Union counties where unemployment has nearly reached a four-year low. Baker and Wallowa counties have a high percentage of retirement-age people and will likely feel the strain of a population in need of age-related services; at the same time, the district has a smaller base of employment-age adults.

DISTRICT 13					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
BAKER	16,215	20.2	22.5	19.9	20.6	9.8	10.6	9.9
UNION	25,980	22.7	17.2	16.1	16.0	16.1	9.7	9.0
WALLOWA	6,995	19.2	24.1	12.9	20.6	9.8	11.1	10.2

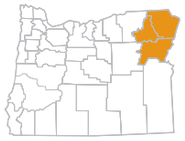
District 13 Regional Forecast, Oregon Department of Human Services

Counties served
Baker, Union and Wallowa

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Baker	1,959	1,970	0.6%	1,970	1,935	-1.8%
Union	2,754	2,835	2.9%	2,835	2,811	-0.8%
Wallowa	633	611	-3.5%	611	612	0.2%
District 13 total	**5,346**	**5,416**	**1.3%**	**5,416**	**5,358**	**-1.1%**
TANF						
Baker	163	167	2.5%	167	155	-7.2%
Union	253	274	8.1%	274	261	-4.7%
Wallowa	40	42	5.8%	42	38	-9.5%
District 13 total	**456**	**483**	**5.9%**	**483**	**454**	**-6.0%**
Employment Related Day Care						
Baker	50	45	-10.5%	45	56	24.4%
Union	78	65	-17.1%	65	62	-4.6%
Wallowa	11	11	2.1%	11	11	0.0%
District 13 total	**140**	**121**	**-13.3%**	**121**	**129**	**6.6%**

District 13 Regional Forecast, Oregon Department of Human Services (*continued*)

Counties served
Baker, Union and Wallowa



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Baker	36	35	-2.4%	35	33	-5.7%
Union	77	80	3.4%	80	80	0.0%
Wallowa	31	29	-6.5%	29	28	-3.4%
District 13 total	**144**	**144**	**-0.2%**	**144**	**141**	**-2.1%**
Community-Based Care						
Baker	94	89	-5.4%	89	94	5.6%
Union	104	102	-1.8%	102	107	4.9%
Wallowa	30	35	17.7%	35	38	8.6%
District 13 total	**228**	**226**	**-0.7%**	**226**	**239**	**5.8%**
Nursing Care						
Baker	23	23	-0.1%	23	22	-4.3%
Union	39	42	8.7%	42	44	4.8%
Wallowa	15	13	-11.4%	13	14	7.7%
District 13 total	**76**	**78**	**2.2%**	**78**	**80**	**2.6%**

District 13 Regional Forecast, Oregon Health Authority (clients)

Counties served
Baker, Union and Wallowa

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Baker	781	844	8.1%	844	873	3.4%
Union	1,493	1,521	1.8%	1,521	1,585	4.2%
Wallowa	239	233	-2.5%	233	242	3.9%
District 13 total	**2,513**	**2,598**	**3.4%**	**2,598**	**2,700**	**3.9%**
Poverty-Level Medical: Children						
Baker	694	675	-2.8%	675	680	0.7%
Union	1,090	1,071	-1.7%	1,071	1,080	0.8%
Wallowa	235	214	-8.8%	214	232	8.4%
District 13 total	**2,019**	**1,960**	**-2.9%**	**1,960**	**1,992**	**1.6%**
Children's Health Insurance Program (CHIP)						
Baker	291	280	-3.7%	280	286	2.1%
Union	465	441	-5.2%	441	482	9.3%
Wallowa	119	116	-2.3%	116	119	2.6%
District 13 total	**875**	**837**	**-4.3%**	**837**	**887**	**6.0%**
Poverty Level Medical: Women						
Baker	69	78	12.4%	78	84	7.7%
Union	118	108	-8.4%	108	109	0.9%
Wallowa	18	14	-21.6%	14	13	-7.1%
District 13 total	**205**	**200**	**-2.5%**	**200**	**206**	**3.0%**
Foster Care & Adoption Services						
Baker	119	118	-0.8%	118	114	-3.4%
Union	128	125	-2.1%	125	127	1.6%
Wallowa	27	27	-0.5%	27	27	0.0%
District 13 total	**274**	**270**	**-1.4%**	**270**	**268**	**-0.7%**

District 13 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Baker, Union and Wallowa

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Aid to Blind/Disabled						
Baker	428	433	1.1%	433	455	5.1%
Union	591	578	-2.2%	578	569	-1.6%
Wallowa	169	183	8.1%	183	194	6.0%
District 13 total	**1,189**	**1,194**	**0.4%**	**1,194**	**1,218**	**2.0%**
Old Age Assistance						
Baker	192	183	-4.7%	183	205	12.0%
Union	245	247	0.7%	247	256	3.6%
Wallowa	73	72	-0.8%	72	76	5.6%
District 13 total	**510**	**502**	**-1.6%**	**502**	**537**	**7.0%**
OHP Standard						
Baker	340	357	5.0%	357	330	-7.6%
Union	401	428	6.8%	428	413	-3.5%
Wallowa	120	121	0.5%	121	114	-5.8%
District 13 total	**861**	**906**	**5.2%**	**906**	**857**	**-5.4%**

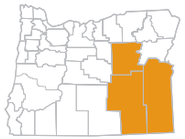
District 14 Regional Forecast

It's a mixed bag in Southeast Oregon, where unemployment is down noticeably in Harney and Malheur counties, but not at all in Grant County. Employment has contracted over the year, mostly due to reductions in government jobs equaling or surpassing improvements in private sector employment, especially in Malheur County.

DISTRICT 14					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
GRANT	7,450	18.8	24.8	14.4	15.7	9.7	13.3	13.6
HARNEY	7,375	22.1	19.6	18.5	17.8	8.1	14.2	12.6
MALHEUR	31,445	25.4	15.3	22.7	23.8	14.3	10.3	9.9

District 14 Regional Forecast, Oregon Department of Human Services

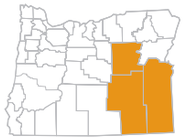
Counties served
Grant, Harney and Malheur



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
Self Sufficiency (households)						
SNAP						
Grant	691	693	0.2%	693	676	-2.5%
Harney	839	850	1.4%	850	839	-1.3%
Malheur	3,791	3,848	1.5%	3,848	3,783	-1.7%
District 14 total	**5,320**	**5,391**	**1.3%**	**5,391**	**5,298**	**-1.7%**
TANF						
Grant	25	25	-0.9%	25	25	0.0%
Harney	22	30	33.9%	30	31	3.3%
Malheur	219	239	9.0%	239	223	-6.7%
District 14 total	**267**	**294**	**10.1%**	**294**	**279**	**-5.1%**
Employment Related Day Care						
Grant	6	5	-13.6%	5	7	40.0%
Harney	14	10	-27.4%	10	15	50.0%
Malheur	65	68	4.1%	68	79	16.2%
District 14 total	**85**	**83**	**-2.3%**	**83**	**101**	**21.7%**

District 14 Regional Forecast, Oregon Department of Human Services (*continued*)

Counties served
Grant, Harney and Malheur

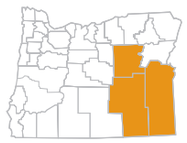


Aging and People with Disabilities, Long-Term Care (clients)

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
In-Home Care						
Grant	22	17	-24.1%	17	17	0.0%
Harney	29	27	-7.7%	27	27	0.0%
Malheur	110	142	28.6%	142	138	-2.8%
District 14 total	**162**	**186**	**14.8%**	**186**	**182**	**-2.2%**
Community-Based Care						
Grant	38	38	0.2%	38	38	0.0%
Harney	28	32	15.3%	32	36	12.5%
Malheur	167	160	-4.0%	160	175	9.4%
District 14 total	**232**	**230**	**-1.0%**	**230**	**249**	**8.3%**
Nursing Care						
Grant	19	17	-12.2%	17	18	5.9%
Harney	1	0	-100.0%	0	0	0.0%
Malheur	26	29	12.2%	29	29	0.0%
District 14 total	**46**	**46**	**-0.4%**	**46**	**47**	**2.2%**

District 14 Regional Forecast, Oregon Health Authority (clients)

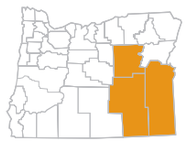
Counties served
Grant, Harney and Malheur



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Grant	218	250	14.5%	250	262	4.8%
Harney	208	229	10.1%	229	250	9.2%
Malheur	2,199	2,241	1.9%	2,241	2,336	4.2%
District 14 total	**2,625**	**2,720**	**3.6%**	**2,720**	**2,848**	**4.7%**
Poverty-Level Medical: Children						
Grant	262	243	-7.2%	243	245	0.8%
Harney	359	332	-7.4%	332	333	0.3%
Malheur	2,061	1,944	-5.7%	1,944	1,921	-1.2%
District 14 total	**2,682**	**2,519**	**-6.1%**	**2,519**	**2,499**	**-0.8%**
Children's Health Insurance Program (CHIP)						
Grant	123	120	-2.6%	120	131	9.2%
Harney	158	158	0.0%	158	173	9.5%
Malheur	738	741	0.5%	741	774	4.5%
District 14 total	**1,019**	**1,019**	**0.0%**	**1,019**	**1,078**	**5.8%**
Poverty Level Medical: Women						
Grant	19	21	7.9%	21	21	0.0%
Harney	37	37	-0.4%	37	37	0.0%
Malheur	135	142	5.0%	142	148	4.2%
District 14 total	**192**	**200**	**4.2%**	**200**	**206**	**3.0%**
Foster Care & Adoption Services						
Grant	44	42	-5.2%	42	42	0.0%
Harney	58	67	14.5%	67	70	4.5%
Malheur	137	152	11.2%	152	158	3.9%
District 14 total	**239**	**261**	**9.0%**	**261**	**270**	**3.4%**

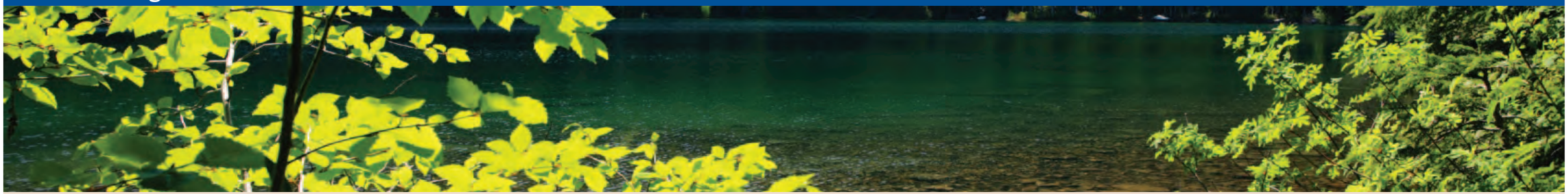
District 14 Regional Forecast, Oregon Health Authority (clients) (*continued*)

Counties served
Grant, Harney and Malheur



	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Aid to Blind/Disabled						
Grant	126	131	3.8%	131	131	0.0%
Harney	183	197	7.9%	197	222	12.7%
Malheur	840	850	1.2%	850	928	9.2%
District 14 total	**1,148**	**1,178**	**2.6%**	**1,178**	**1,281**	**8.7%**
Old Age Assistance						
Grant	103	99	-4.2%	99	103	4.0%
Harney	71	71	0.0%	71	76	7.0%
Malheur	428	422	-1.4%	422	470	11.4%
District 14 total	**603**	**592**	**-1.7%**	**592**	**649**	**9.6%**
OHP Standard						
Grant	115	123	7.3%	123	117	-4.9%
Harney	138	149	8.0%	149	148	-0.7%
Malheur	430	448	4.1%	448	417	-6.9%
District 14 total	**683**	**720**	**5.4%**	**720**	**682**	**-5.3%**

District 15 Regional Forecast



Recovery is in full swing in the Portland Metro area, although not at the pace of a usual post-recession pattern. Construction jobs are on the rise and will likely pick up steam as foreclosed-on properties are removed from the housing inventory. Manufacturing, professional services, and trade sectors are adding jobs in Clackamas County. However, recent job cuts in the government sector have somewhat muted the effects of the expansion.

DISTRICT 15					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
CLACKAMAS	378,480	23.4	14.1	9.0	12.2	6.3	8.6	7.7

District 15 Regional Forecast, Oregon Department of Human Services

County served
Clackamas

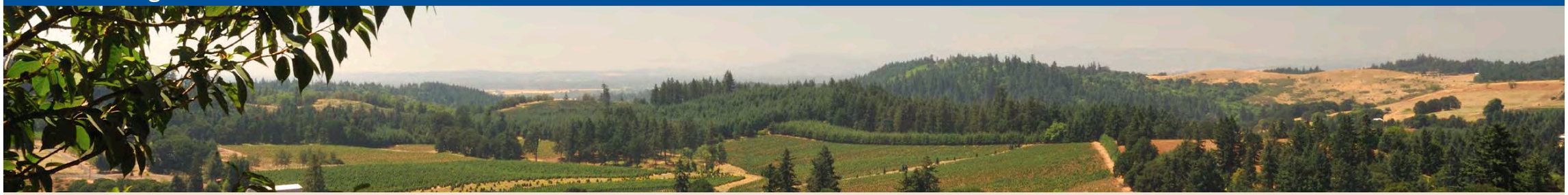
	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Clackamas	26,287	27,352	4.0%	27,352	26,356	-3.6%
District 15 total	**26,287**	**27,352**	**4.0%**	**27,352**	**26,356**	**-3.6%**
TANF						
Clackamas	1,820	1,908	4.8%	1,908	1,782	-6.6%
District 15 total	**1,820**	**1,908**	**4.8%**	**1,908**	**1,782**	**-6.6%**
Employment Related Day Care						
Clackamas	503	540	7.3%	540	652	20.7%
District 15 total	**503**	**540**	**7.3%**	**540**	**652**	**20.7%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Clackamas	943	932	-1.2%	932	926	-0.6%
District 15 total	**943**	**932**	**-1.2%**	**932**	**926**	**-0.6%**
Community-Based Care						
Clackamas	1,123	1,087	-3.2%	1,087	1,119	2.9%
District 15 total	**1,123**	**1,087**	**-3.2%**	**1,087**	**1,119**	**2.9%**
Nursing Care						
Clackamas	331	352	6.3%	352	349	-0.9%
District 15 total	**331**	**352**	**6.3%**	**352**	**349**	**-0.9%**

District 15 Regional Forecast, Oregon Health Authority (clients)

County served
Clackamas

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	Fall 2012 Forecast 2011-2013	% diff. Fall 2012 vs. Spring 2012	Fall 2012 Forecast 2011-2013	Fall 2012 Forecast 2013-2015	Fall 2012 % diff. 2011-2013 to 2013-2015
TANF-Related Medical						
Clackamas	12,043	11,984	-0.5%	11,984	12,561	4.8%
District 15 total	**12,043**	**11,984**	**-0.5%**	**11,984**	**12,561**	**4.8%**
Poverty-Level Medical: Children						
Clackamas	10,550	10,399	-1.4%	10,399	10,420	0.2%
District 15 total	**10,550**	**10,399**	**-1.4%**	**10,399**	**10,420**	**0.2%**
Children's Health Insurance Program (CHIP)						
Clackamas	5,451	5,557	1.9%	5,557	6,006	8.1%
District 15 total	**5,451**	**5,557**	**1.9%**	**5,557**	**6,006**	**8.1%**
Poverty Level Medical: Women						
Clackamas	846	891	5.3%	891	921	3.4%
District 15 total	**846**	**891**	**5.3%**	**891**	**921**	**3.4%**
Foster Care & Adoption Services						
Clackamas	1,555	1,604	3.1%	1,604	1,615	0.7%
District 15 total	**1,555**	**1,604**	**3.1%**	**1,604**	**1,615**	**0.7%**
Aid to Blind/Disabled						
Clackamas	5,339	5,182	-2.9%	5,182	5,480	5.8%
District 15 total	**5,339**	**5,182**	**-2.9%**	**5,182**	**5,480**	**5.8%**
Old Age Assistance						
Clackamas	2,776	2,731	-1.6%	2,731	3,115	14.1%
District 15 total	**2,776**	**2,731**	**-1.6%**	**2,731**	**3,115**	**14.1%**
OHP Standard						
Clackamas	4,084	4,248	4.0%	4,248	3,929	-7.5%
District 15 total	**4,084**	**4,248**	**4.0%**	**4,248**	**3,929**	**-7.5%**

District 16 Regional Forecast



Washington County has fully recovered from the Great Recession, and has one of the lowest unemployment rates in the state. Construction jobs are on the rise and will likely pick up steam as foreclosed properties are removed from the housing inventory. Most sectors of the economy are adding jobs in Washington County, although government employment is lower than in 2011.

DISTRICT 16					Percent uninsured		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Percent in poverty	Total	Children	September 2011	September 2012
OREGON	3,857,625	22.5	14.3	11.9	15.7	7.3	8.8	8.7
WASHINGTON	536,370	25.3	10.4	9.5	13.8	7.5	7.6	6.9

District 16 Regional Forecast, Oregon Department of Human Services

County served
Washington

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
Self Sufficiency (households)						
SNAP						
Washington	36,062	36,595	1.5%	36,595	36,740	0.4%
District 16 total	**36,062**	**36,595**	**1.5%**	**36,595**	**36,740**	**0.4%**
TANF						
Washington	3,164	3,079	-2.7%	3,079	2,768	-10.1%
District 15 total	**3,164**	**3,079**	**-2.7%**	**3,079**	**2,768**	**-10.1%**
Employment Related Day Care						
Washington	1,064	1,053	-1.1%	1,053	1,229	16.7%
District 15 total	**1,064**	**1,053**	**-1.1%**	**1,053**	**1,229**	**16.7%**
Aging and People with Disabilities, Long-Term Care (clients)						
In-Home Care						
Washington	705	699	-0.8%	699	705	0.9%
District 15 total	**705**	**699**	**-0.8%**	**699**	**705**	**0.9%**
Community-Based Care						
Washington	1,155	1,201	4.0%	1,201	1,251	4.2%
District 15 total	**1,155**	**1,201**	**4.0%**	**1,201**	**1,251**	**4.2%**
Nursing Care						
Washington	386	380	-1.6%	380	370	-2.6%
District 15 total	**386**	**380**	**-1.6%**	**380**	**370**	**-2.6%**

District 16 Regional Forecast, Oregon Health Authority (clients)

County served
Washington

	2011-2013 Biennium			Fall 2012 Forecast		
	Spring 2012 Forecast 2011-2013	**Fall 2012 Forecast 2011-2013**	**% diff. Fall 2012 vs. Spring 2012**	**Fall 2012 Forecast 2011-2013**	**Fall 2012 Forecast 2013-2015**	**Fall 2012 % diff. 2011-2013 to 2013-2015**
TANF-Related Medical						
Washington	16,143	16,623	3.0%	16,623	17,344	4.3%
District 16 total	**16,143**	**16,623**	**3.0%**	**16,623**	**17,344**	**4.3%**
Poverty-Level Medical: Children						
Washington	17,673	17,663	-0.1%	17,663	17,906	1.4%
District 16 total	**17,673**	**17,663**	**-0.1%**	**17,663**	**17,906**	**1.4%**
Children's Health Insurance Program (CHIP)						
Washington	9,859	9,673	-1.9%	9,673	10,413	7.7%
District 16 total	**9,859**	**9,673**	**-1.9%**	**9,673**	**10,413**	**7.7%**
Poverty Level Medical: Women						
Washington	1,250	1,312	5.0%	1,312	1,349	2.8%
District 16 total	**1,250**	**1,312**	**5.0%**	**1,312**	**1,349**	**2.8%**
Foster Care & Adoption Services						
Washington	1,455	1,464	0.6%	1,464	1,505	2.8%
District 16 total	**1,455**	**1,464**	**0.6%**	**1,464**	**1,505**	**2.8%**
Aid to Blind/Disabled						
Washington	5,899	5,856	-0.7%	5,856	6,067	3.6%
District 16 total	**5,899**	**5,856**	**-0.7%**	**5,856**	**6,067**	**3.6%**
Old Age Assistance						
Washington	3,799	3,793	-0.2%	3,793	4,330	14.2%
District 16 total	**3,799**	**3,793**	**-0.2%**	**3,793**	**4,330**	**14.2%**
OHP Standard						
Washington	4,165	4,421	6.1%	4,421	4,117	-6.9%
District 16 total	**4,165**	**4,421**	**6.1%**	**4,421**	**4,117**	**-6.9%**

DHS Oregon Department of Human Services

Oregon Health Authority

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OREGON HEALTH AUTHORITY

Annual Performance Progress Report (APPR) for Fiscal Year (2011-2012)

Original Submission Date: 2012

Finalize Date: 10/1/2012

2011-2012 KPM #	2011-2012 Approved Key Performance Measures (KPMs)
1	ALCOHOL AND DRUG TREATMENT EFFECTIVENESS (income) - The percentage of clients whose income increases by completing alcohol and drug treatment services
2	ALCOHOL AND DRUG TREATMENT EFFECTIVENESS - ITRS - Percentage of children reunited with parents participating in Intensive Treatment Recovery Services.
3	ALCOHOL AND DRUG TREATMENT EFFECTIVENESS (school performance) – The percentage of children whose school performance improves after receiving alcohol and drug treatment.
4	8TH GRADER USE OF ALCOHOL - The percentage of 8th graders who have used alcohol within the past 30 days
5	8TH GRADER USE OF ILLICIT DRUGS - The percentage of 8th graders who have used illicit drugs within the past 30 days.
6	ALCOHOL AND DRUG TREATMENT SERVICES - CRIME-FREE - Percentage of clients who remain crime free during alcohol and drug treatment services
7	PROBLEM GAMBLING - The percentage of adults who gamble much less or not at all 180 days after ending problem gambling treatment.
8	CHILD MENTAL HEALTH SERVICES - The percentage of children receiving mental health services whose attendance at school improves
9	YOUTH MENTAL HEALTH SERVICES - ARRESTS - The percentage of children demonstrating a decrease in the number of arrests in the 12 months following the initiation of mental health services
10	ACCESS TO MENTAL HEALTH SYSTEM - Percentage of people with severe emotional disorders or severe mental illness served within the public mental health system
11	DOLLARS SPENT ON MENTAL HEALTH SERVICES - FACILITY VS COMMUNITY - The percentage of dollars spent on facility-based mental health services compared to community-based mental health services
12	RESTRAINT RATE - Reduction in restraint hours per thousand patient hours at Oregon State Hospital.
13	SECLUSION RATES - Occurrences of seclusion per 1,000 patient hours in facility-based mental health care
14	LENGTH OF STAY AT Oregon State Hopital - Reduction in overall length of stay at Oregon State Hospital (days)

2011-2012 KPM #	2011-2012 Approved Key Performance Measures (KPMs)
15	PREVENTIVE SERVICES FOR OREGON HEALTH PLAN (OHP) CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP
16	PREVENTIVE SERVICES FOR OREGON HEALTH PLAN (OHP) YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP
17	APPROPRIATE PRENATAL CARE FOR OREGON HEALTH PLAN (OHP) CLIENTS - Percentage of pregnant OHP clients who received an appropriate number of prenatal care visits while on OHP
18	PREVENTIVE QUALITY INDICATOR (PQI) - HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients by condition
19 a	SAFETY NET CLINIC USE - MEDICAID - Oregonians on Medicaid served by safety net clinics as a percentage of total Oregonians on Medicaid
19 b	SAFETY NET CLINIC USE - MEDICARE - Oregonians on Medicare served by safety net clinics as a percentage of total Oregonians on Medicare
19 c	SAFETY NET CLINIC USE - UNINSURED -Uninsured Oregonians served by safety net clinics as a percentage of total uninsured Oregonians
20	HEALTHY KIDS CONNECT PARTNER PERFORMANCE AND MEMBER SATISFACTION - The percentage of Healthy Kids Connect (HKC) and Healthy Kids ESI members who rate their experience with their contracted insurance carriers as "good" or "excellent".
21	HEALTHY KIDS MEMBER OUT OF POCKET EXPENSE - The percentage of Healthy Kids Connect (HKC) members who spend less than 5% of their annual family income for healthcare expenses.
22	OPHP TRAINING - Percentage of attendees rating the training received as 'meets or exceeds learning experience expectations'.
23	TEEN SUICIDE -The rate of suicides among adolescents per 100,000.
24	TEEN PREGNANCY - The number of female Oregonians ages 15 - 17, per 1,000, who are pregnant.
25	INTENDED PREGNANCY - The percentage of births where mothers report that the pregnancy was intended.
26 a	EARLY PRENATAL CARE - The percentage of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women: a) WIC enrolled (low-income women)

2011-2012 KPM #	2011-2012 Approved Key Performance Measures (KPMs)
26 b	EARLY PRENATAL CARE - The percentage of low income women who initiated prenatal care in the first 3 months of pregnancy compared to non-low income women: b) Non WIC enrolled (non low-income women)
27 a	TOBACCO USE - Tobacco use among adults.
27 b	TOBACCO USE - Tobacco use among youth.
27 c	TOBACCO USE - Tobacco use among pregnant women.
28	CIGARETTE PACKS SOLD - Number of cigarette packs sold per capita.
29	CHILD IMMUNIZATIONS - The percentage of 24-35 month old children who are adequately immunized.
30	INFLUENZA VACCINATIONS FOR SENIORS - The percentage of adults aged 65 and over who receive an influenza vaccine.
31	HIV/AIDS - The percentage of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment.
32 a	OVERWEIGHT AND OBESITY PREVALENCE - ADULT OVERWEIGHT - The percentage of people who are overweight or obese among Oregonians.
32 b	OVERWEIGHT AND OBESITY PREVALENCE - ADULT OBESITY - The percentage of people who are overweight or obese among Oregonians.
32 c	OVERWEIGHT AND OBESITY PREVALENCE - YOUTH OVERWEIGHT - The percentage of people who are overweight or obese among Oregonians.
32 d	OVERWEIGHT AND OBESITY PREVALENCE - YOUTH OBESITY - The percentage of people who are overweight or obese among Oregonians.
33	CUSTOMER SERVICE (OHA) - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.

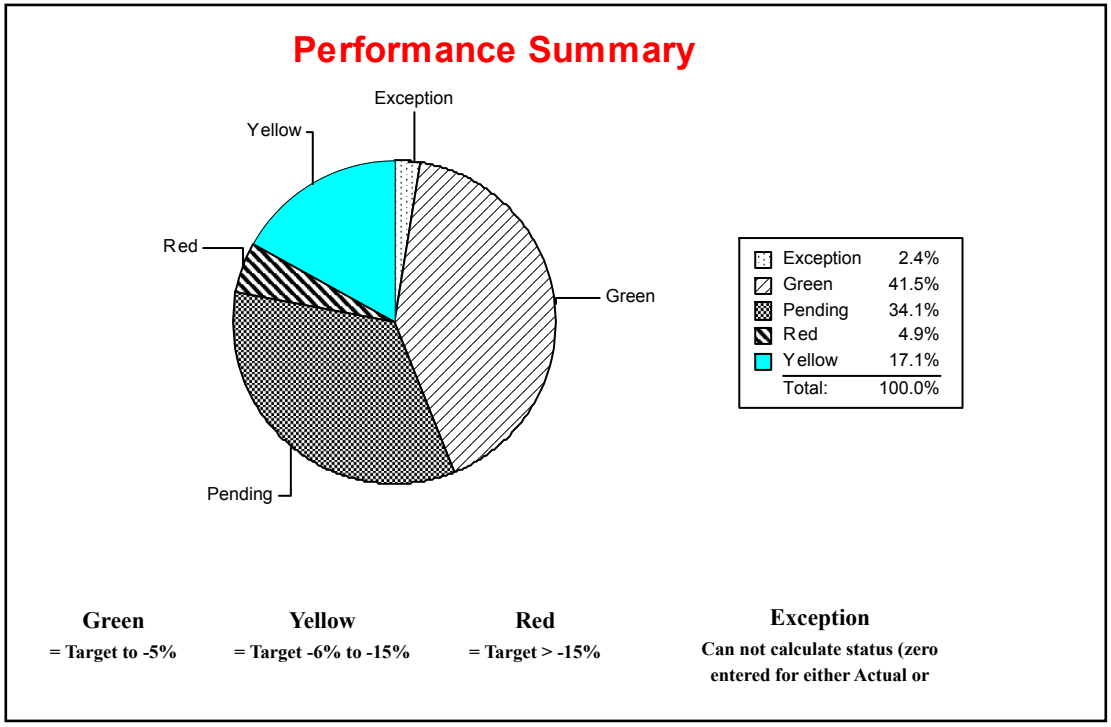
New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2013-2015
	Title: **Rationale:**

Proposed Key Performance Measures Targets for Biennium 2011-2013	2012	2013
Title: TEEN PREGNANCY - The number of female Oregonians ages 15 - 17, per 1,000, who are pregnant.	21.50	21.00
Title: ALCOHOL AND DRUG TREATMENT EFFECTIVENESS (school performance) – The percentage of children whose school performance improves after receiving alcohol and drug treatment.	70.00	70.50
Title: TOBACCO USE - Tobacco use among adults.	18.30	18.30
Title: CIGARETTE PACKS SOLD - Number of cigarette packs sold per capita.	44.50	43.00
Title: CHILD IMMUNIZATIONS - The percentage of 24-35 month old children who are adequately immunized.	76.50	77.00
Title: INFLUENZA VACCINATIONS FOR SENIORS - The percentage of adults aged 65 and over who receive an influenza vaccine.	77.00	77.00
Title: PREVENTIVE SERVICES FOR OREGON HEALTH PLAN (OHP) YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP	0.98	1.00
Title: PREVENTIVE SERVICES FOR OREGON HEALTH PLAN (OHP) CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP	4.95	5.00
Title: APPROPRIATE PRENATAL CARE FOR OREGON HEALTH PLAN (OHP) CLIENTS - Percentage of pregnant OHP clients who received an appropriate number of prenatal care visits while on OHP	65.50	67.10
Title: 8TH GRADER USE OF ALCOHOL - The percentage of 8th graders who have used alcohol within the past 30 days	27.00	26.50
Title: 8TH GRADER USE OF ILLICIT DRUGS - The percentage of 8th graders who have used illicit drugs within the past 30 days.	13.50	13.00
Title: PROBLEM GAMBLING - The percentage of adults who gamble much less or not at all 180 days after ending problem gambling treatment.	76.50	77.00
Title: LENGTH OF STAY AT Oregon State Hopital - Reduction in overall length of stay at Oregon State Hospital (days)	230.00	225.00

OREGON HEALTH AUTHORITY	I. EXECUTIVE SUMMARY

Agency Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Contact:	Cathy Iles, DHS/OHA Shared Services	**Contact Phone:**	503-602-1507
Alternate:	John Britton	**Alternate Phone:**	503-945-6597



1. SCOPE OF REPORT

This report covers a broad array of programs throughout the Oregon Health Authority (OHA), such as addiction services, health/medical services, mental health services, health policy and research, insurance assistance and public health. that support the mission and goals of the agency. Of course these measures don't capture all the work that's done within OHA.The purpose of this annual performance report is to communicate the results of the work that is done. While the primary audience is the Oregon Legislature and other key stakeholders, it is also a communication tool for staff, other governmental agencies and the public.

2. THE OREGON CONTEXT

OHA helps achieve Oregon's goals around safe, caring and engaged communities, and healthy, sustainable surroundings. The OHA Key Performance Measures support many Oregon Benchmarks such as: #39 Teen pregnancy; #40 Prenatal care; #41 Infant mortality, #42 Immunizations; #43 HIV diagnosis; #44 Adult non-smokers; #45 Preventable death; #50 8th grade substance abuse; #53 Alcohol/Tobacco abstinence during pregnancy. More information about Oregon Benchmarks can be accessed at http://www.oregon.gov/DAS/OPB/KPM_links.shtml

3. PERFORMANCE SUMMARY

OHA has achieved green status on 42% of the KPMs. 17% of the KPMs achieved yellow status. 5% achieved red status. 34% of the KPMs received "pending" status until comparisons to targets can be made. 2% are exceptions until data can be collected.

Green status = Target to -5% Yellow status = Target -6% to -15% Red status = Target > -15%

4. CHALLENGES

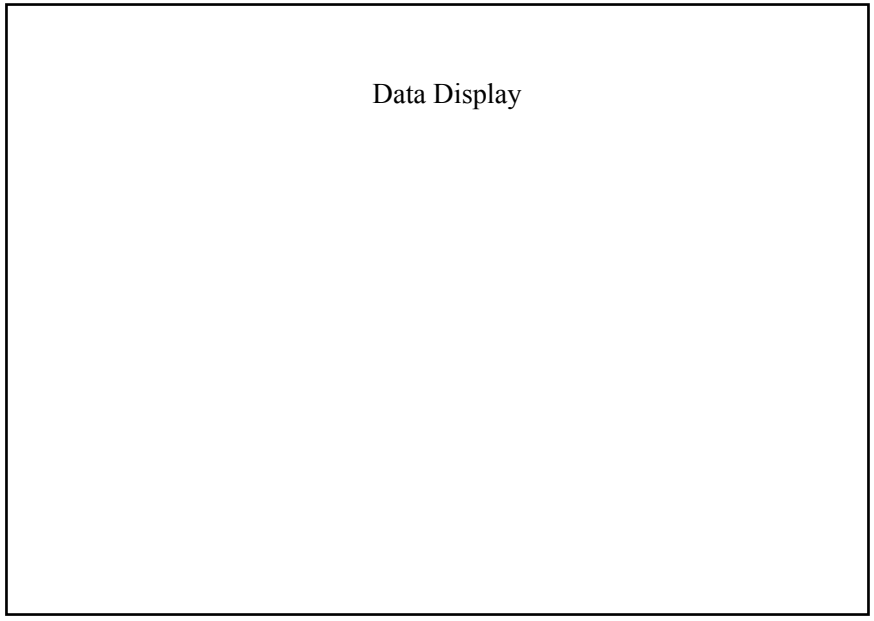
Poor economic conditions and unemployment appear to have an influence on many measures. Cuts in funding and limited resources (such as staff and providers) have an impact on whether or not we can achieve our desired results. Other challenges include the fact that the work of OHA is complex and requires coordinated efforts to see an impact in the results. It's not uncommon for clients to have multiple barriers to face. They may have drug or alcohol abuse issues, involvement with law enforcement, have mental health challenges, or be unemployed. Many of our outcomes are about human behavior changes, such as teen pregnancy and alcohol and drug abuse, which makes it challenging to achieve the desired results.

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

5. RESOURCES AND EFFICIENCY

2011-13 Total Fund Budget by DivisionThis section provides overall budget information for OHA and the major program areas. Division | Total Funds (in millions) | % FundsAddictions and Mental Health (AMH) | $959.4 | 7.9%
Medical Assistance Programs (DMAP) | $6,556.7 | 54.6%
Oregon Educator's Benefit Board (OEBB) | $1,448.6 | 12.1%
 | $409.0 | 3.9%
Office of Private Health Partnerships (OPHP)/Office of Medical Insurance Pools (OMIP) | $640.9 | 5.3%Oregon Healthy Kids (OHK) | $11.1 | .09%
Public Employees' Benefit Board (PEBB) | $1,413.9 | 11.8%
Public Health Division (PHD) | $492.0 | 4.1%Central and Shared Services | $417.9 | 3.5%Capital Construction/Capital Improvement | $60.6 | .01% TOTAL FUNDS = $12,001.3
** Source: DHS/OHA Budget, Planning and Analysis

KPM #1	ALCOHOL AND DRUG TREATMENT EFFECTIVENESS (income) - The percentage of clients whose income increases by completing alcohol and drug treatment services	2010
Goal	People are living as independently as possible	
Oregon Context	Achieving increased independence by end of treatment	
Data Source	Client Process Monitoring System (CPMS)	
Owner	OHA - Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

AMH will measure the percent of individuals whose income increases by the completion of alcohol and drug treatment services. One of the goals of successful treatment is employment or improvement in employment, which should result in an increase in legal income.

2. ABOUT THE TARGETS

Data collected from 2008 through 2011 will be used to establish a baseline from which targets will be set.

3. HOW WE ARE DOING

This is a new measure and AMH does not have data yet.

4. HOW WE COMPARE

This is a new measure and AMH does not have comparison data yet.

5. FACTORS AFFECTING RESULTS

Some Oregon counties continue to experience double-digit unemployment which affects income of the community. This factor may influc3ence the outcomes of this measure.

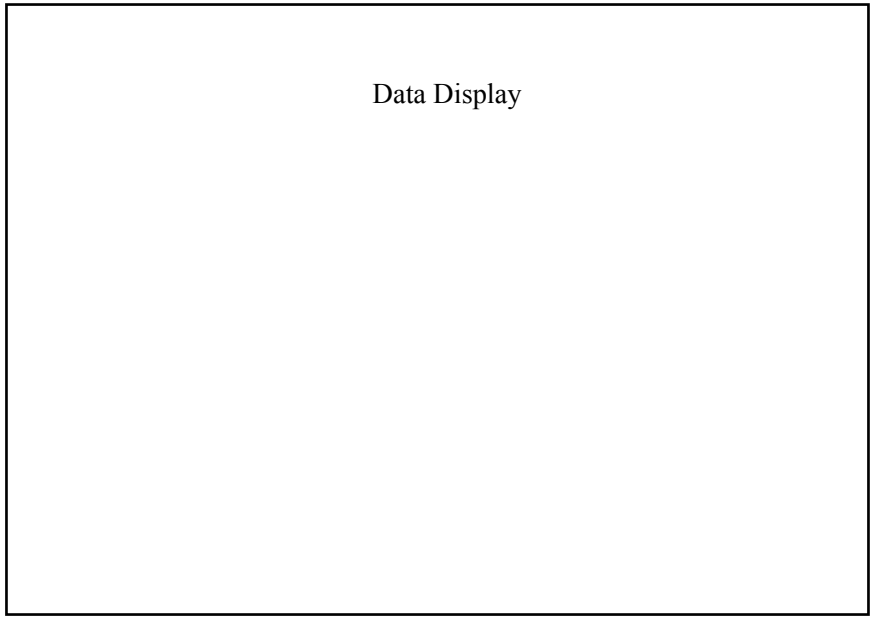
6. WHAT NEEDS TO BE DONE

This is a new measure and AMH does not have data to compare to baseline data nor has a target been established.

7. ABOUT THE DATA

Data are extracted from the Client Process Monitoring System (CPMS). This measure is calculated using CPMS data for adults that have completed treatment during the calendar year. Treatment includes the following chemical dependency services: residential, outpatient, and DUII-rehabilitation. The denominator includes all persons that completed treatment, and had an estimated gross monthly income reported at admission and termination. The numerator is a count of the total number of persons with a greater income at termination than admission.

KPM #2	ALCOHOL AND DRUG TREATMENT EFFECTIVENESS - ITRS - Percentage of children reunited with parents participating in Intensive Treatment Recovery Services.	2010
Goal	People are healthy. People are safe.	
Oregon Context	Prevention of out-of-home placements	
Data Source	Client Process Monitoring System (CPMS), Child Welfare Data SystemBaseline data to be collected. Targets to be set.	
Owner	OHA - Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

To deliver services promoting family reunification.

2. ABOUT THE TARGETS

Targets have not yet been determined. The higher the actual rate, the better.

3. HOW WE ARE DOING

At this time, we are unable to match the clients served through ITRS providers to Child Welfare's ORKids data system so we are unable to state the percentage of children that were reunited with parents participating in ITRS programs. AMH's Client Process Monitoring System (CPMS) does have data on whether parents are complying with the Child Welfare Service Agreement sufficiently to progress towards regaining custody of their children. These data show an increasing percentage of parents are complying (49.9 % in 2008, 55.3% in 2009, 54.7% in 2010 and 59.0% in 2011).

4. HOW WE COMPARE

We do not have any national data to compare.

5. FACTORS AFFECTING RESULTS

A factor that may affect results involves collection of data from Child Welfare. AMH is limited in its ability to match those receiving ITRS treatment and recovery services with parents and children involved in the Child Welfare system. AMH continues to work with Child Welfare to gather this data. This data gathering limitation could affect the ability to document the results.

6. WHAT NEEDS TO BE DONE

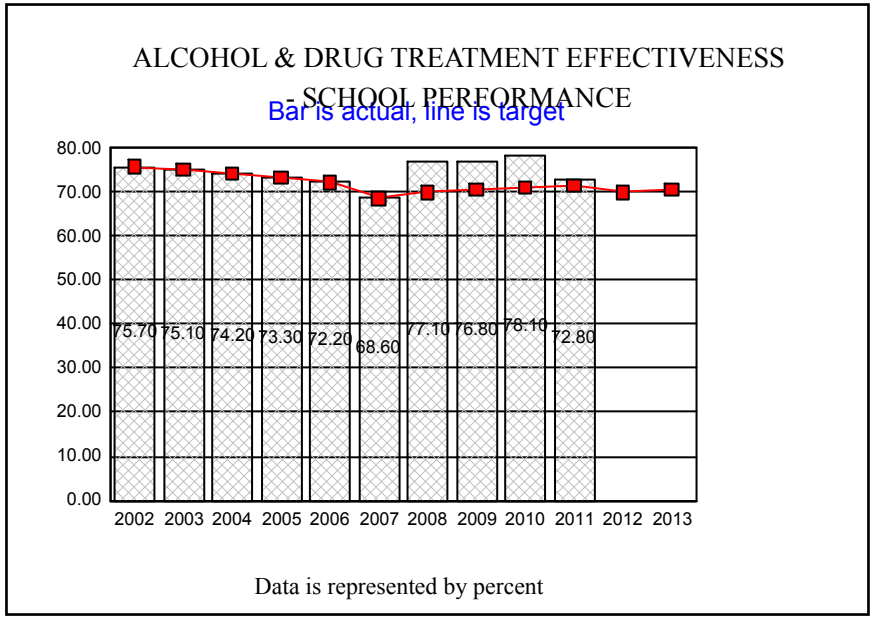
Maintain capacity for clinical treatment and recovery services provided to parents at risk or involved in the child welfare system. AMH will continue to be an assertive purchaser of these services by holding contractors accountable for outcomes and performance. AMH will emphasize process improvement strategies for addiction service providers serving parents and families involved in the child welfare system .Performance-based contract management tools will continue to be used to ensure retention in services.

7. ABOUT THE DATA

Data cited in question 3 above were extracted from the Division's Client Process Monitoring System (CPMS), which tracks all publicly funded addiction treatment services. The data include adults referred to treatment by the child welfare system and receiving outpatient, intensive outpatient or residential treatment services through an ITRS provider and discharged from treatment during the calendar year. For the purposes of this measure, parents referred to treatment by the child welfare system were assigned a value of "yes" or "no" based on the data collection procedure for capturing whether or not the individual sufficiently met the Child Welfare Service Agreement requirements to progress towards regaining custody of their children. It should be noted that this does not mean family reunification occurred.

AMH will be working with Child Welfare to capture system-level outcomes associated with parent-child reunification by matching administrative data. AMH and Child Welfare are unable to conduct the administrative match at this time. Once the ORKids data system is fully functional, this process will begin.

KPM #3	ALCOHOL AND DRUG TREATMENT EFFECTIVENESS (school performance) – The percentage of children whose school performance improves after receiving alcohol and drug treatment.	2007
Goal	People are healthy	
Oregon Context	Alcohol and drug treatment effectiveness	
Data Source	Client Process Monitoring System database	
Owner	OHA - Addictions and Mental Health Division, Karen Wheeler, 503-945-6191	



1. OUR STRATEGY

AMH seeks to deliver services promoting healthy youth by focusing on a holistic approach to treatment. A goal of treatment is to help children perform to their potential. Improved academic performance is definitely a step in the right direction.

2. ABOUT THE TARGETS

AMH's target is to push overall improvement rates to beyond 70 percent during the next few years.

3. HOW WE ARE DOING

AMH continues to meet or exceed the target for this measure each year.

4. HOW WE COMPARE

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

5. FACTORS AFFECTING RESULTS

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

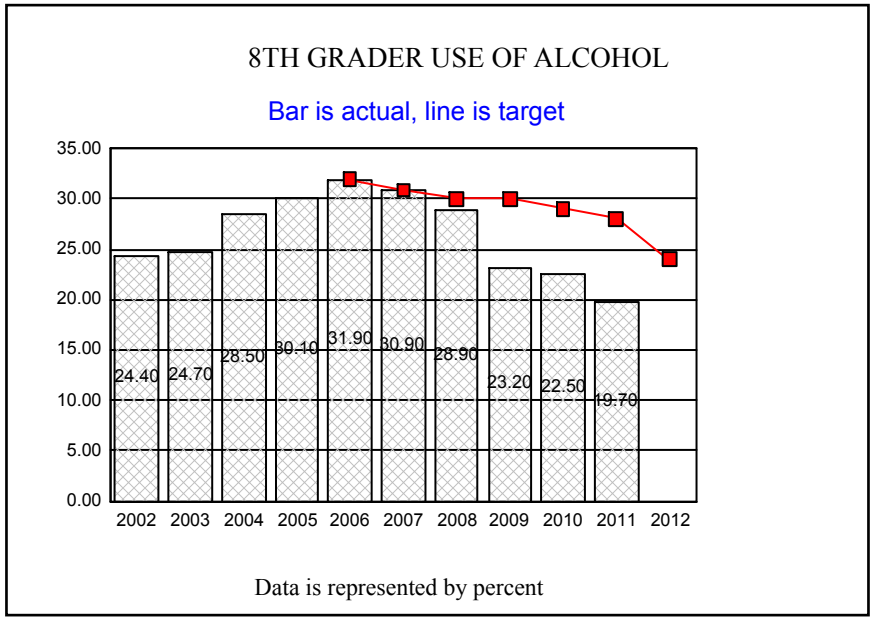
6. WHAT NEEDS TO BE DONE

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

7. ABOUT THE DATA

Data are extracted from the Division's Client Process Monitoring System (CPMS), which tracks publicly funded substance abuse treatment services. This measure is calculated using CPMS data for those youth that closed treatment in the calendar year, are attending school and have not yet graduated from high school. Treatment includes the following chemical dependency treatment: residential, outpatient, intensive outpatient and DUII rehab. Academic performance improvement (yes/no) is reported at discharge. The denominator includes all youth that have completed grade 12 or less and have academic information reported upon termination of services. The numerator includes the total number that showed improvement.

KPM #4	8TH GRADER USE OF ALCOHOL - The percentage of 8th graders who have used alcohol within the past 30 days	2009
Goal	People are healthy	
Oregon Context	Eighth Grade Substance Abuse, Alcohol	
Data Source	Data is gathered annually through the Oregon Healthy Teens Survey and the Student Wellness Survey	
Owner	OHA – Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

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

In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking. These include minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy efforts directed at social policies related to underage drinking and parent programs that aid the parents in setting clear and specific guidelines for their siblings concerning alcohol and other drug use. AMH will continue to provide community grants to implement programs to reduce underage drinking on the local level, utilizing Oregon Healthy Teens Survey data.

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

2. ABOUT THE TARGETS

The lower the rate the better.

3. HOW WE ARE DOING

The percent of 8th graders at risk of alcohol use declined for the fourth consecutive year, and is below the target.

4. HOW WE COMPARE

Oregon's rate of 8th grade alcohol use in the past 30 days is 63 percent higher than the national rate. In 2010, 13.8% of 8th graders in the United States reported using alcohol in the past 30 days, compared to 22.5% of Oregon 8th graders. U.S. data are published in Monitoring the Future 1975–2010, Volume I: Secondary school students (NIH Publication No. 08-6418A)

5. FACTORS AFFECTING RESULTS

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

6. WHAT NEEDS TO BE DONE

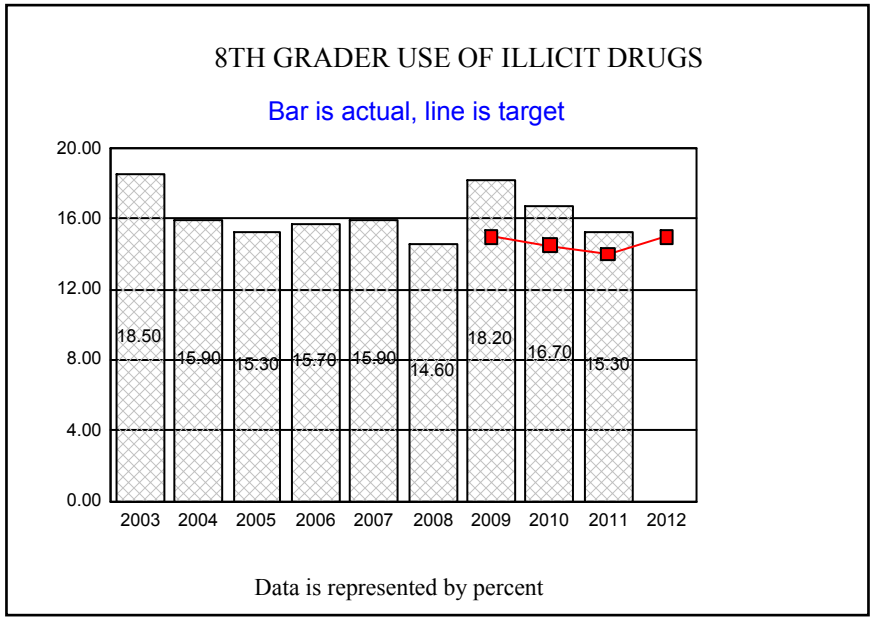
Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol use. Providing communities with adequate prevention

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 are extracted from the Oregon Healthy Teens Survey in odd years and the Student Wellness Survey in even years. The Oregon Healthy Teens Survey is administered in odd years to 8th and 11th graders across the state. Beginning in 2010, the Student Wellness Survey is administered in even years in to 6th, 8th and 11th graders in public, private and charter schools.

KPM #5	8TH GRADER USE OF ILLICIT DRUGS - The percentage of 8th graders who have used illicit drugs within the past 30 days.	2009
Goal	People are healthy	
Oregon Context	Eighth Grade Substance Abuse, Illicit Drugs	
Data Source	Data is gathered annually through the Oregon Healthy Teens Survey and the Student Wellness Survey	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

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

In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Closely associated

with underage drinking is the use of marijuana. Marijuana is sometimes referred to at the 'turn-key drug' leading to other illicit drug use. Counties and Tribes have implemented programs to directly address underage drinking and illicit drug use. These include strategic media advocacy efforts directed at parents to set clear and specific guidelines for their children's not using alcohol and other drugs. AMH will continue to provide community grants to implement programs to reduce underage drinking and illicit drug use on the local level. The assessment of progress on KPM #6 will utilize data from the Oregon Healthy Teens Survey and Student Wellness Survey.

2. ABOUT THE TARGETS

The lower the rate the better.

3. HOW WE ARE DOING

The percent of 8th graders at risk of drug use decreased from the previous year but it is above the target.

4. HOW WE COMPARE

Oregon's rate of illicit drug use in the past 30 days is 76 percent higher than national rate of 9.5% for 2010. U.S. data are published in Monitoring the Future 1975–2010, Volume I: Secondary school students (NIH Publication No. 08-6418A).

5. FACTORS AFFECTING RESULTS

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes towards drug use have a tremendous effect on youth use. Youth whose parents feel that drug use is a "rite of passage" or that "kids will be kids" have much higher rates of illicit drug use those whose parents are clear that youth should not use drugs.

6. WHAT NEEDS TO BE DONE

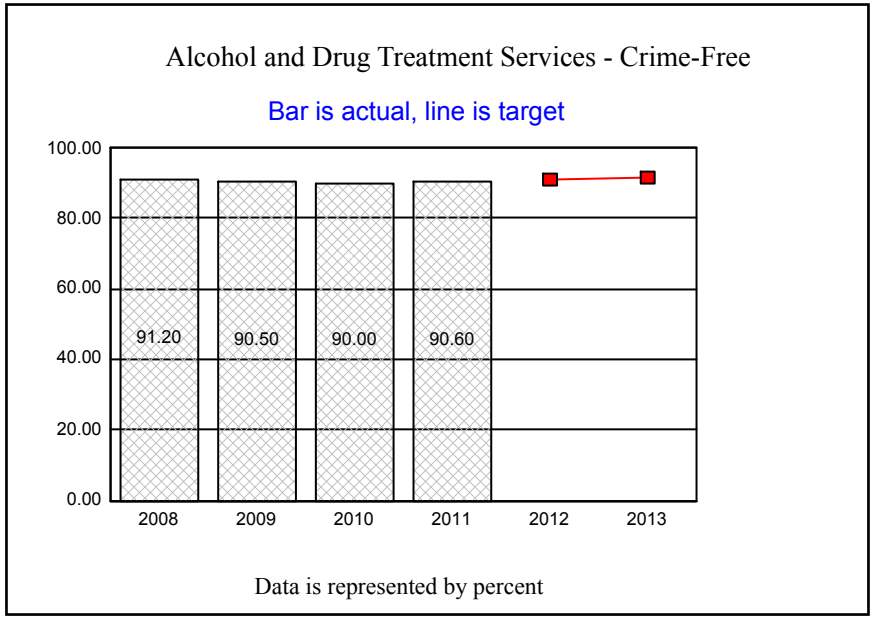
Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. Parents who set clear and specific rules for their children continue to be a major prevention strategy to address illicit drug use.

7. ABOUT THE DATA

Data are extracted from the Oregon Healthy Teens Survey in odd years and the Student Wellness Survey in even years. The Oregon Healthy Teens Survey is administered in odd years to 8th and 11th graders across the state. Beginning in 2010, the Student Wellness Survey is administered in even years in to 6th, 8th and 11th graders in public, private and

charter schools.

KPM #6	ALCOHOL AND DRUG TREATMENT SERVICES - CRIME-FREE - Percentage of clients who remain crime free during alcohol and drug treatment services	2010
Goal	People are healthy. People are safe.	
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 and DHS ORCA	
Owner	OHA - Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

Effective therapeutic treatment should realize reduced criminal activity. Absence of criminal activity is a proxy to positive prosocial community outcomes.

2. ABOUT THE TARGETS

Higher percentages indicate lower criminal activity. Maintaining targets at less than 10% recidivism are indications of consistency.

3. HOW WE ARE DOING

Over the past four years, less than one in ten persons will recidivate as indicated by a new arrest during their treatment episode. In an outpatient treatment setting where up to 70% of the individuals are criminal justice referrals this is a positive reflection of prosocial behavior, recovery, and lives free of subsequent criminal activity.

4. HOW WE COMPARE

Comparable national or other state measures are not available. If national data is available through TEDS Oregon could be compared against the nation or with other states based on population, prevalence, and region. Other recidivism measures define recidivism from new arrest, to new charge, to new conviction for violations, misdemeanors, and felonies. Other recidivism measures are not limited to subsequent criminal behavior during the treatment episode.

5. FACTORS AFFECTING RESULTS

Individual treatment engagement, the treatment continuum care, and the availability of ancillary community services including education, workforce development, and recovery support are factors that affect subsequent criminal activity.

6. WHAT NEEDS TO BE DONE

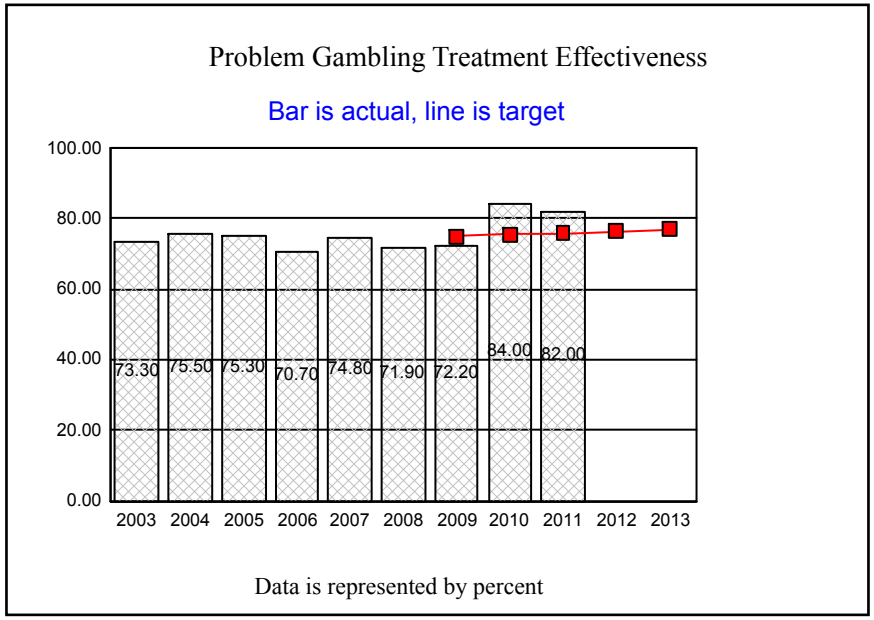
Continued coordinated case management with criminal justice continuum partners. Referrals to ancillary community services.

7. ABOUT THE DATA

Data are extracted from the Client Process Monitoring System (CPMS). This measure is calculated using CPMS data for adults whose treatment closed during the calendar year. Treatment includes the following chemical dependency services: residential, outpatient, intensive outpatient and

DUII-rehabilitation. The denominator includes all persons whose treatment closed for which arrest information was known. The numerator is a count of the total number of persons that had one or more arrests during treatment. This does not imply convictions and relates to alleged offenses committed during the treatment episode.

KPM #7	PROBLEM GAMBLING - The percentage of adults who gamble much less or not at all 180 days after ending problem gambling treatment.	2009
Goal	People are healthy	
Oregon Context	People are healthy	
Data Source	The data are collected by an independent contractor after the client has given permission to participate in a post-treatment outcomes assessment.	
Owner	OHA - Addictions and Mental Health Division, Jon Collins, 503-945-6429	



1. OUR STRATEGY

Problem gamblers and their families experience a complex array of mental health, social, financial and legal issues. The estimated social-economic cost of each pathological gambler

is up to $11,000 a year. Increasing the effectiveness of treatment contributes to the overall health of the community by eliminating these social-economic costs by aiding those treated to remain abstinent from gambling. Our partners in this effort are county and private-not-for-profit community agencies who provide treatment for problem gamblers and their families.

2. ABOUT THE TARGETS

Our historical data shows a baseline trend between 70.7% and 75.5% of adults reporting gambling much less or not at all at 180 days post treatment. We chose to begin with a 75% target level and striving for a 0 .5% per year improvement.

3. HOW WE ARE DOING

This year we significantly exceeded the target. Before this year, we had met the target in two out of the last seven years of reporting and have always remained within 5% of the target.

4. HOW WE COMPARE

There is very little national data regarding a similar measure to compare with Oregon. We will continue to monitor national treatment outcomes and analyze any possible comparisons when that data becomes available.

5. FACTORS AFFECTING RESULTS

Problem gambling treatment is a relatively new area of practice. The field lacks necessary standardized outcome measures. This makes it difficult to ensure that the appropriate measures are identified and changed as indicated. The current year results may be attributable to the fact that we have made ongoing and consistent efforts at workforce development that are paying off in terms of client outcomes, and that in the current economic climate some clients may be more motivated in treatment so they can get their productive lives back.

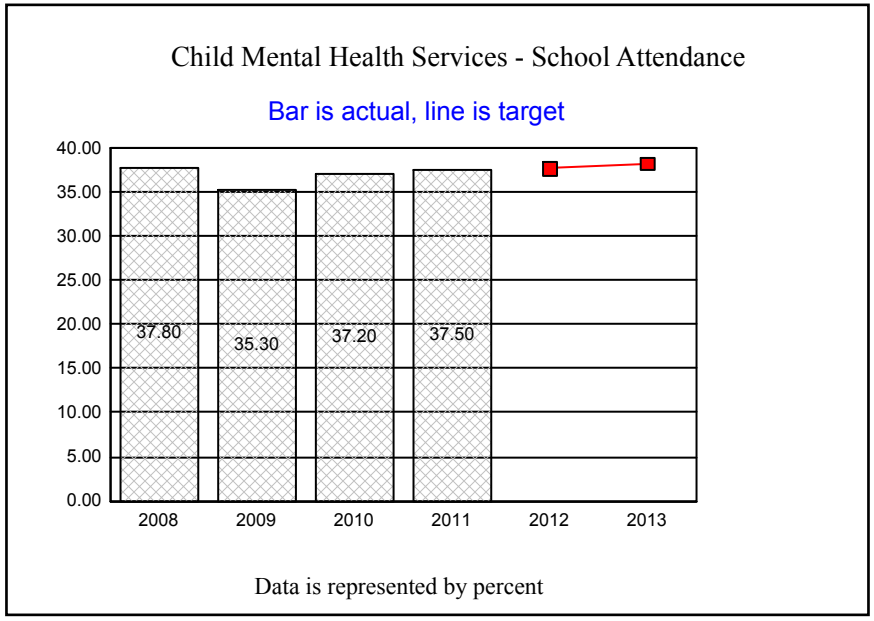
6. WHAT NEEDS TO BE DONE

Continuing to monitor this measure will provide Oregon with an indicator of the effectiveness of the treatment programs and will support continued investment.

7. ABOUT THE DATA

This data is collected and managed by Herbert & Louis, Thomas L. Moore, CEO. It is reported to AMH-Problem Gambling Services Manager as requested and at least annually. Much more data is contained in the Gambling Programs Evaluation Update authored annually by the contractor.

KPM #8	CHILD MENTAL HEALTH SERVICES - The percentage of children receiving mental health services whose attendance at school improves	2010
Goal	People are healthy	
Oregon Context	#22 High School Dropout Rate	
Data Source	The data source is the Youth Services Survey for Families and is based on reported data from a representative sample of caregivers of children receiving mental health services. This information is also reported to the Substance Abuse & Mental Health Services Administration as part of AMH's Community Mental Health Block Grant requirements	
Owner	OHA – Addictions and Mental Health Division, Jon C. Collins, 503 945 6429	



1. OUR STRATEGY

The Addictions and Mental Health Division (AMH) of the Oregon Health Authority is working steadily toward creating a statewide System of Care, using the Statewide Children's

Wraparound Initiative, for children receiving publicly funded mental health services. A System of Care using Wraparound incorporates a team approach inclusive of education in the planning and delivery of care. AMH expects that continued work with educational representatives at the child and family team level will assist in the improvement of children's school attendance.

2. ABOUT THE TARGETS

The Youth Services Survey for Families is administered annually to the families of children being served through the public mental health system. Targets are based on the 2011 baseline, taking into account the fluctuation over the past several years.

3. HOW WE ARE DOING

Over the four years for which this measure is reported, the highest rate, 37.8%, occurred in 2008, followed by the lowest rate, 35.3%, in 2009. In 2011, a baseline percentage of 37.5% was attained, slightly higher than the rate of 37.2% in 2010. Among children who receive mental health services school attendance is impacted by residency, diagnosis, treatment plan, and other factors.

4. HOW WE COMPARE

Among students in Oregon's educational system who receive special education services on an IEP and are designated as "emotionally disturbed," 22.6% showed an increase of 5% or more in school attendance between the school years 2010-11 and 2011-12[1]. This group of children is similar to the population served by the children's public mental health system. Comparison of these results with results from the YSSF must take into account differences in eligibility requirements and services provided as well as the methods used to measure changes in attendance. Even so, results of the 2011 YSSF (37.5% increased attendance) strongly suggest that receiving publicly funded mental health services may increase school attendance among children with mental health needs.

For cost comparison, based on a fairly rigorous estimate that, over their lifetime, a person who drops out of high school costs the public more than $200,000 in excess criminal justice, social service, and health care costs, and that habitual truancy is a major risk factor for dropping out of school, Heilbrunn (2003) [2] calculated that two different multimodal truancy reduction programs paid for themselves (that is, saved more public money than it spends) if each prevented one student from dropping out every four years.

[1] Based on 2010-11 and 2011-12 Average Daily Membership (ADM) of 3061 students enrolled during both school years. Enrolled students who were missing ADM data for one or both years (n=167) were excluded from the analysis, as were 842 students with ADM 95% or higher in both years, indicating school attendance was not problematic. Data provided by Oregon Department of Education, August 22, 2012.

[2] Heilbrunn, J (2003) The Costs and Benefits of Three Intensive Interventions With Colorado Truants. Denver: National Center for School Engagement.

5. FACTORS AFFECTING RESULTS

The following are known barriers to student attendance:

§ Negative peer influences

- Feeling resentment toward authority
- Putting time into a job to earn money for themselves or for their families
- Using drugs or alcohol
- Having problems relating to people
- Being the victim of bullying
- Feeling little support or experiencing conflict at home
- Believing the school doesn't offer interesting, challenging, or rewarding classes or activities

- Falling behind others in math or reading skills and skipping classes when not doing well, thereby perpetuating a lack of skills and a tendency to avoid school
- Experiencing personal barriers, such as language problems, racial or cultural conflicts, embarrassment because of a lack of suitable or clean clothing, or teen pregnancy
- Being held back a grade or more
- Being suspended or expelled
- Having transportation problems
- Fearing community violence

6. WHAT NEEDS TO BE DONE

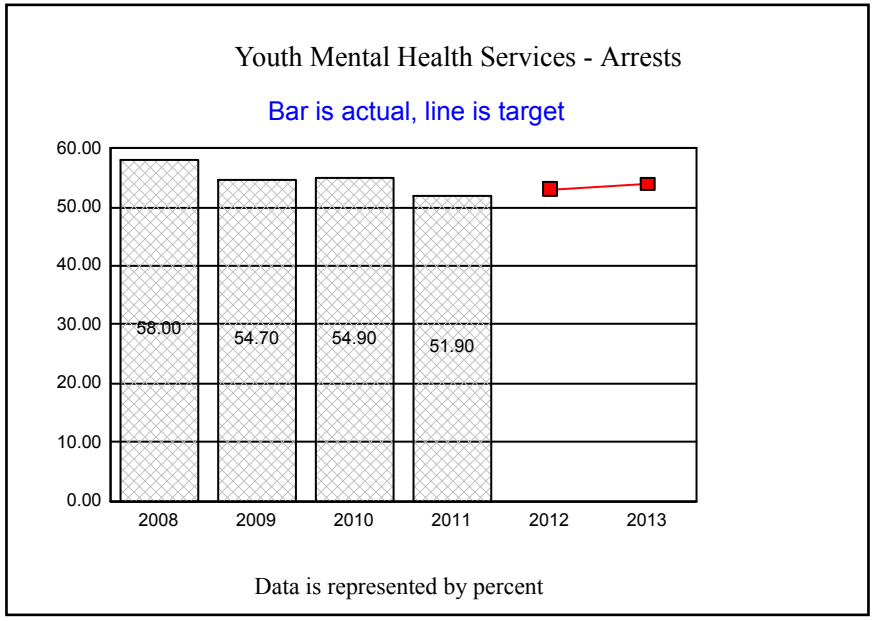
Actions to support children being served in the publicly funded mental health system through a System of Care using the Statewide Children's Wraparound Initiative to address the above barriers would be helpful, particularly in addressing family struggles (conflict in the home, working to help the family with finances), in bullying and violence prevention, in making school classes and activities more appealing to this youth population, and in assisting children with personal and educational barriers.

7. ABOUT THE DATA

The Youth Services Survey for Families (YSS-F) is a mailed and online survey self-administered by parents or other caregivers of children less than 18 years old who received any mental health services during the last six months of the prior calendar year. The survey is conducted annually and asks about the child and family's experience with their most recent mental health services provider. The survey is mailed to more than 12,000 families and includes all clients who received mental health care in psychiatric residential and day treatment programs; all outpatient clients who are Hispanic, non-White, or whose race and ethnicity are unknown; and a random sample of White, non-Hispanic children who received outpatient services.

Strengths of this data source are: 1) the information is obtained directly from families of youth served; 2) participants are assured that their responses are confidential; 3) survey items used for this measure are included every year so that results are comparable over time; and 4) the study sample is representative of the population of children receiving services. Overall response rates for the 2007-2011 YSS-F average 19% (range 16%-22%), yielding an average of 2327 valid responses. The number of responses is sufficient for reliable statistical estimation in descriptive analysis. The low response rate is compensated for in part by oversampling of treatment type and race-ethnicity subgroups that might otherwise have been under represented. Additional information may be obtained by contacting Jon C. Collins, Oregon Health Authority, 503 945 6429.

KPM #9	YOUTH MENTAL HEALTH SERVICES - ARRESTS - The percentage of children demonstrating a decrease in the number of arrests in the 12 months following the initiation of mental health services	2010
Goal	People are healthy. People are safe.	
Oregon Context	#66 Juvenile Recidivism	
Data Source	The data source is the Youth Services Survey for Families and is based on reported data from a representative sample of caregivers of children receiving mental health services. This information is also reported to the Substance Abuse & Mental Health Services Administration as part of AMH's Community Mental Health Block Grant requirements.	
Owner	OHA – Addictions and Mental Health Division, Jon C. Collins, 503 945 6429	



1. OUR STRATEGY

The Addictions and Mental Health Division (AMH) of the Oregon Health Authority is working steadily toward creating a statewide System of Care using the Statewide Children's Wraparound Initiative, for children receiving publicly funded mental health services. A System of Care using Wraparound incorporates a team approach inclusive of juvenile justice in the planning and delivery of care. AMH expects that continued work with juvenile justice representatives at the child and family team level will assist in the improvement of children's juvenile justice recidivism rates.

2. ABOUT THE TARGETS

Targets for 2012-2013 are based on the 2011 baseline, taking into account the fluctuation over past several years. These targets measure the extent to which recidivism is reduced after initiation of mental health services for children who were involved in the criminal justice system prior to treatment. Increases in the percentage of families reporting fewer police encounters after initiation of treatment are indicators of success in achieving this goal.

3. HOW WE ARE DOING

Among children with recent arrests who were served in the publicly funded mental health system, the percent reporting fewer police contacts after initiation of mental health services has declined over the past four years.

4. HOW WE COMPARE

The Sentencing Project, an advocacy and reform organization, has published a list of recidivism rates for adults and juveniles spanning the 50 states. The states somewhat comparable to Oregon had the following rates for juveniles for decreased recidivism: Missouri (2009 data) 74%; Virginia (2005) 50.6%, and Washington (2005), 23% boys, 28% girls. Please note that these populations were general juvenile justice populations and not restricted to the mental health treatment receiving group that our numbers reflect.

For further information: http://sentencingproject.org/doc/publications/inc_StateRecidivismFinalPaginated.pdf

5. FACTORS AFFECTING RESULTS

Risk factors associated with youth ending up in the juvenile justice system are cognitive deficits, low school involvement, experiencing significant trauma, drug and alcohol use, being diagnosed with a mental health disorder, living in poverty, or being runaway or homeless. Many children being served in the publicly funded mental health system also carry these risk factors.

Mental illness in the juvenile justice system has become an increasingly obvious problem. A report from the National Center for Mental Health and Juvenile Justice found that 70 percent of youths in the juvenile justice system are afflicted with a mental health disorder, and 27 percent suffer from a disorder so severe it

significantly impairs their ability to function (Cocozza and Shufelt 2006).

6. WHAT NEEDS TO BE DONE

Actions to support children being served in the publicly funded mental health system to address the above risk factors are crucial. Youth with mental health treatment needs are overrepresented in the juvenile justice system. The mental health, juvenile justice and other systems serving youth need to work closely together implementing Wraparound statewide in a System of Care to minimize risk factors and decrease recidivism rates.

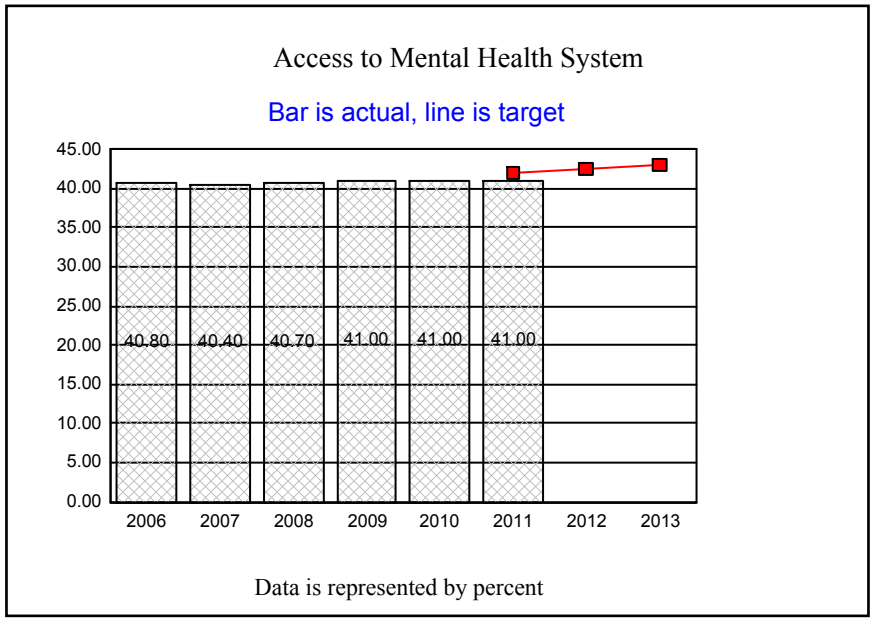
7. ABOUT THE DATA

The Youth Services Survey for Families (YSS-F) is a mailed and online survey self-administered by parents or other caregivers of children less than 18 years old who received any mental health services during the last six months of the previous calendar year. The survey is conducted annually and asks about the child and family's experience with their most recent mental health services provider.

Strengths of this data source are: 1) the information is obtained directly from families of youth served; 2) participants are assured that their responses are confidential; 3) survey items used for this measure are included every year so that results are comparable over time; and 4) the study sample is representative of the population of children receiving services. The survey is mailed to 12,000 or more families and includes all clients who received mental health care in psychiatric residential and day treatment programs; all outpatient clients who are Hispanic, non-White, or whose race and ethnicity are unknown; and a random sample of White, non-Hispanic children who received outpatient services.

Overall response rates for the 2007-2011 YSS-F average 19% (range 16%-22%), yielding an average of 2327 valid responses. The number of responses is sufficient for reliable statistical estimation in descriptive analysis. The low response rate is compensated for in part by oversampling of treatment type and race-ethnicity subgroups that might otherwise have been under represented. Additional information may be obtained by contacting Jon C. Collins, Oregon Health Authority, 503 945 6429.

KPM #10	ACCESS TO MENTAL HEALTH SYSTEM - Percentage of people with severe emotional disorders or severe mental illness served within the public mental health system	2010
Goal	People are healthy. People are independent.	
Oregon Context	Access to services	
Data Source	Data sources are MMIS, CPMS, and OPRCS. This information is also reported to the Substance Abuse & Mental Health Services Administration as part of AMH's Community Mental Health Block Grant requirements.	
Owner	OHA – Addictions and Mental Health Division, Jon C. Collins, 503 945 6429	



1. OUR STRATEGY

The goal is promote access to publicly funded mental health services for all individuals' need of services.

2. ABOUT THE TARGETS

The goal is to increase the percentage served. The expectation is not 100% since many of the individuals needing services get them through private insurance and/or without support from OHA funding. OHA is working to better understand how many people may be receiving services through means other than public support. Once this information is available it would make sense to revise this measure.

3. HOW WE ARE DOING

This measure has been stable for some time. Given some of the budget cuts that have occurred over the recent years this is good. It is expected that as the CCOs become operational and Medicaid coverage continues to expand that the percentage will increase.

4. HOW WE COMPARE

National data does not compare usage to need, however it does provide comparative information regarding the number of the people served. Oregon serves 27.9 people per 1,000 population. Nationally this figure stands at 20.9 per 1,000 population. This indicates that Oregon has done a very good job at assisting its citizens access to mental health services.

5. FACTORS AFFECTING RESULTS

Medicaid is probably the biggest influence on access to mental health services in Oregon compared to other states.

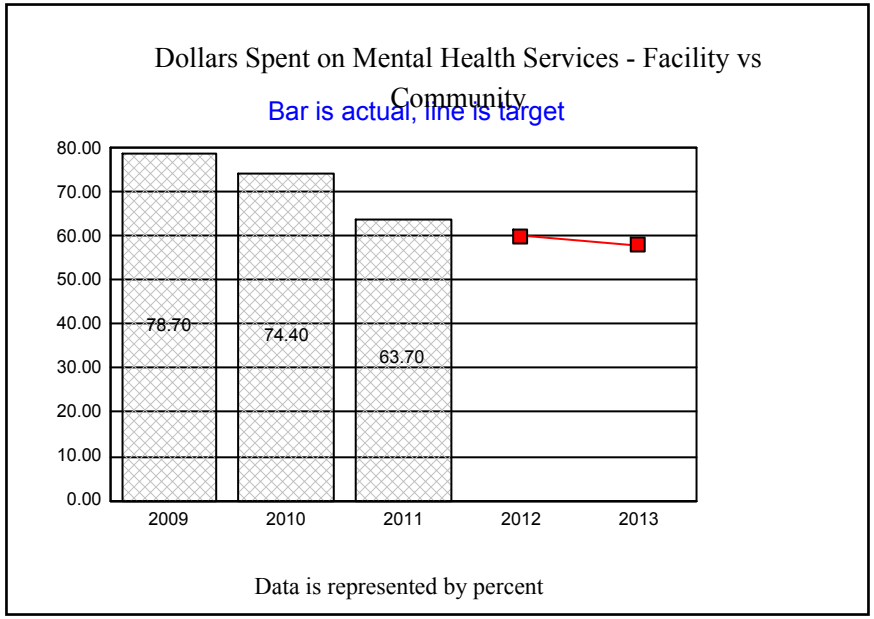
6. WHAT NEEDS TO BE DONE

As mentioned early, as access becomes a performance metric associated with the CCOs and coverage expands under Medicaid the percentage of need met will continue to increase.

7. ABOUT THE DATA

This data is derived from a number of sources including databases that track services to individuals supported by state dollars and Medicaid dollars . An important caveat is that this information only means that individuals have accessed services, it does not mean that they have gotten all the services they need.

KPM #11	DOLLARS SPENT ON MENTAL HEALTH SERVICES - FACILITY VS COMMUNITY - The percentage of dollars spent on facility-based mental health services compared to community-based mental health services	2010
Goal	People are healthy. People are independent.	
Oregon Context	Adult and Youth Mental Health Treatment Clients Receiving Facility- or Community-Based Services	
Data Source	Division of Medical Assistance Programs, Medicaid Management Information System (MMIS)	
Owner	OHA - Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

Our goal is to transfer all facility-based clients meeting transfer criteria to less restrictive community-based services while they continue receiving same or better treatment. We work with County Mental Health Programs (CMHPs), Mental Health Organizations (MHOs), Coordinated Care Organizations (CCOs), and community of providers to make

the transfer efficient and support the client's recovery process.

2. ABOUT THE TARGETS

Facility-based services are restrictive and more expensive. Transfer to community-based services allows AMH to provide same or better services to clients at less cost in a less restrictive setting. The less restrictive nature of community-based services makes re-integrating clients with the community upon completion of treatment more supportive. The measure should decline with time as less clients would be served in facility-based setting.

3. HOW WE ARE DOING

This is a new measure reported for the first time in 2012.However, we are reporting beginning for calendar year 2009, the first year facility-based data is accessible. The trend shows that the measure is moving in the desired direction and we expect this trend to continue for some time.

4. HOW WE COMPARE

There are no comparative statistics in like agencies and we are unable to compare. But we feel in the context of our programs, the level and trend of the measure is consistent with our expectations.

5. FACTORS AFFECTING RESULTS

Slow growth in community provider capacity and lack of skills to prepare patients for transition are two important factors. We anticipate the emergence of Coordinated Care Organizations (CCOs) would alleviate the capacity issue.

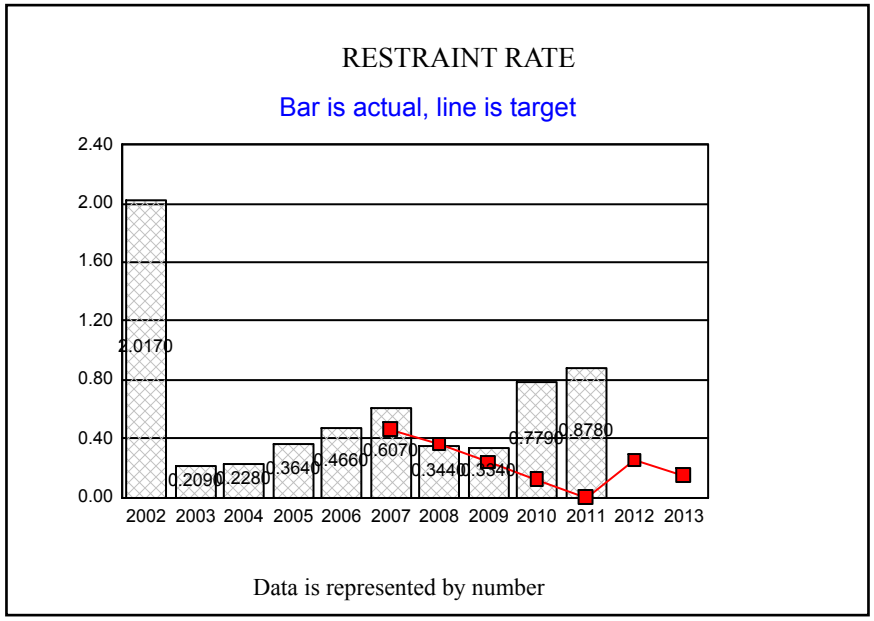
6. WHAT NEEDS TO BE DONE

We anticipate the operationalization of Coordinated Care Organizations (CCOs) will concurrently address the capacity issue. However, this effort will have to be augmented with improving staff skills specific to identifying needs and training patients to prepare them for transition to community within reasonable time.

7. ABOUT THE DATA

This measure is reported on a calendar year basis. At this time the measure is based on facility and community based services paid for through the Medicaid system. This excluded services paid for in the state hospitals. Data from the Medicaid Management Information System are pulled on an individual claim/encounter level. These are paid and final claims.

KPM #12	RESTRAINT RATE - Reduction in restraint hours per thousand patient hours at Oregon State Hospital.	2009
Goal	People are healthy. People are safe.	
Oregon Context	People are healthy and safe.	
Data Source	Data are tracked in a free-standing database at Oregon State Hospital.	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

Oregon State Hospital has a Seclusion/Restraint Review Committee that reviews aggregated data related to use of seclusion or restraint and makes recommendations to OSH Protection From Harm Committee. During 2011 the Seclusion/Restraint Review Committee continued to focus its reduction efforts on the units that moved or were scheduled to move into the new hospital building in 2011. Continued Workforce Development occurred via use of the master list of safety and reduction ideas and suggestions that were

generated by patients and staff in 2010. The list included training materials, books and/or training sessions as each section of the new hospital opened Working with Quality Management's Data & Analysis, the Seclusion/Restraint Committee further refined the data review processes with additional 'drill downs' regarding time of day, days of week, and detailed identification of outlier impact.

2. ABOUT THE TARGETS

The target is to minimize the use of restrictive events, particularly restraint, at Oregon State Hospital. Some restraint may be necessary for medical purposes (i.e., preventing a patient from self-harm, preventing a patient from removing stitches, preventing a patient from falling). However, the intent is to decrease and eliminate the use of restrictive events to control aggressive behavior. If the collaboration of the Seclusion/Restraint Committee is identified as needed in future target data element development, the S/R Committee would welcome that involvement.

3. HOW WE ARE DOING

We have not achieved the target of, .000 for 2011, but actually saw an increase over 2010. As noted previously, a very small number of patients account for more than half of the use of restrictive events at OSH. One patient in particular is considered an outlier, due to his frequent assaults on staff members and intense efforts at self-harm, which results in restrictive events. Internal reviews, external consultants, and a range of behavioral support plans have been used in an attempt to help this patient.

4. HOW WE COMPARE

The hospital receives monthly comparative statistics reports from the National Research Institute, which is a branch of the National Association of State Mental Health Program Directors. The reports indicate that our restraint rate has been above the national mean for the last 12 months (January 2011 thru December 2011). Our restraint rate has been within one standard deviation of national means. The comparative statistics reports include other state hospitals, but it is difficult to determine the size or patient populations treated by those other hospitals. OSH has a high forensic patient population, which tends to have higher restraint rates due to patients with a diagnosis of antisocial personality disorders. In addition, the hospital serves patients with dementia, brain injuries, and severe and persistent mental illness. Some of those patients act out aggressively and assault staff, as is the case with the identified outlier. Restrictive events are used as a last resort, to maintain safety.

5. FACTORS AFFECTING RESULTS

A very small number of patients account for the majority of restrictive event hours used at OSH. Several of the high utilizers received external consultative services. One male patient, because of the frequent restrictive events, has been identified as a statistical outlier that impacts the unit and hospital statistics. He has received multiple intensive case reviews and consultations, internally and externally.

6. WHAT NEEDS TO BE DONE

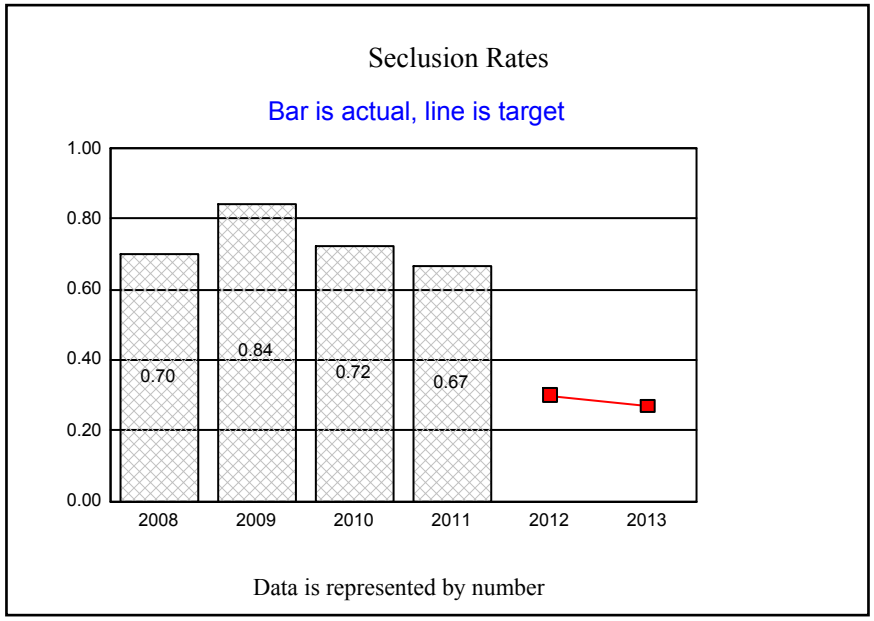
We continue to offer ProACT training, use consultants, and develop additional training modules that may help staff gain skills to intervene early with patients who may be

escalating. By the spring of 2012, all of the Salem campus patients will have transitioned to the new hospital. The hospital has its initiative to train all staff in the Recovery Model, Person-Centered Care, and Trauma Informed Services. The Seclusion and Restraint Review Committee provided three articles in the hospital's Recovery Times newsletter providing an overview of the S/R Committee with goals of 10% reduction in restrictive events, Workforce Development (training all of the new employees how to work with this challenging population) and effective debriefing techniques. The Seclusion/Restraint Committee will continue to provide cogent and current best practices regularly in the hospital publications.

7. ABOUT THE DATA

The data reported here came from hospital databases and is dependent on reports made by staff. The data is accurate, within the limitations of our current data systems.

KPM #13	SECLUSION RATES - Occurrences of seclusion per 1,000 patient hours in facility-based mental health care	2010
Goal	People are healthy. People are safe.	
Oregon Context	People are healthy. People are safe.	
Data Source	Data is tracked in a freestanding database at OSH.	
Owner	OHA - Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

Oregon State Hospital has a Seclusion/Restraint Review Committee that reviews aggregated data related to use of seclusion or restraint and makes recommendations to OSH Protection From Harm Committee. During 2011 the Seclusion/Restraint Review Committee continued to focus its reduction efforts on the units that moved or were scheduled to move into the new hospital building in 2011. Continued Workforce Development occurred via use of the master list of safety and reduction ideas and suggestions that were

generated by patients and staff in 2010. The list included training materials, books and/or training sessions as each section of the new hospital opened Working with the Data & Analysis department, the Seclusion/Restraint Committee further refined the data review processes with additional 'drill downs' regarding time of day, days of week, and detailed identification of outlier impact. Furthermore, the Seclusion and Restraint Committee increased the frequency of meetings from quarterly to monthly. Psychologists with specialized training in behavioral techniques are providing consultations for intervention strategies to help the units manage their patients without resorting to seclusions.

2. ABOUT THE TARGETS

The target is to minimize the use of restrictive events, particularly seclusion, at Oregon State Hospital. Some seclusions may be necessary for medical purposes (i.e., preventing a patient from self-harm, preventing a patient from removing stitches, preventing a patient from falling). However, the intent is to decrease and eliminate the use of seclusion events to control aggressive behavior.

3. HOW WE ARE DOING

We have not achieved the target of, .30 for 2011. As noted previously, a very small number of patients account for more than half of the use of seclusion events at OSH. One patient in particular is considered an outlier, due to his frequent assaults on staff member, intense efforts at self-harm which results in subsequent seclusion and restrictive events. Internal reviews, external consultants, and a range of behavioral support plans have been used in an attempt to help this patient and others.

4. HOW WE COMPARE

The hospital receives monthly comparative statistics reports from the National Research Institute, which is a branch of the National Association of State Mental Health Program Directors. The reports indicate that our seclusion rate has been above the national mean for the last 12 months (January 2011 thru December 2011). Our seclusion rate has been within one standard deviation of national means. The comparative statistics reports include other state hospitals, but it is difficult to determine the size or patient populations treated by those other hospitals. OSH has a high forensic patient population, which tends to have higher seclusion rates due to patients with diagnoses of antisocial personality disorders. In addition, the hospital serves patients with dementia, brain injuries, and severe and persistent mental illness. Some of those patients act out aggressively and assault staff, as is the case with the identified outlier. Seclusion events are used as a last resort, to maintain safety.

5. FACTORS AFFECTING RESULTS

A very small number of patients account for the majority of seclusion event hours used at OSH. Several of the high utilizers received external consultative services. One male patient, because of the frequent restrictive events, has been identified as a statistical outlier that impacts the unit and hospital statistics. He has received multiple intensive case reviews and consultations, internally and externally.

6. WHAT NEEDS TO BE DONE

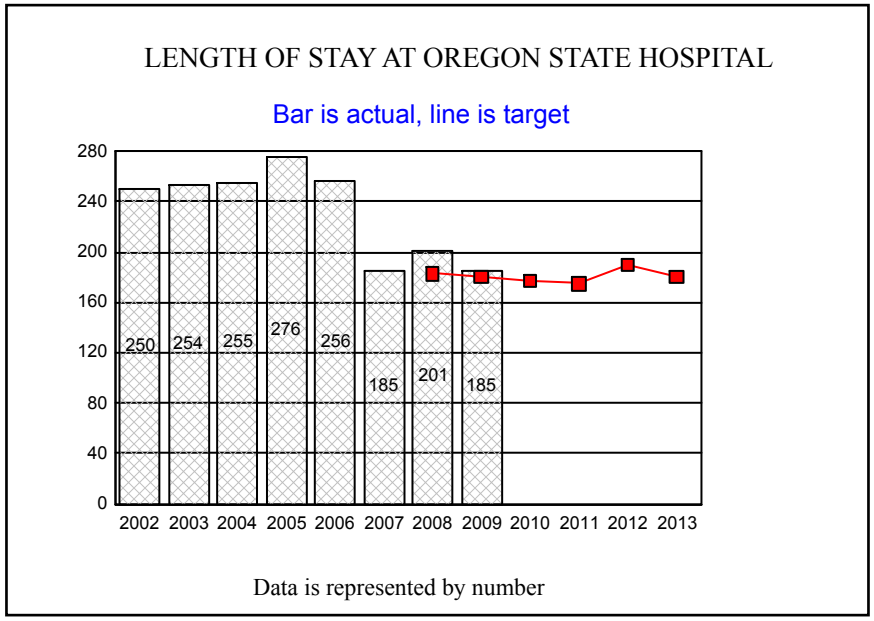
We continue to offer ProACT training, use consultants, and develop additional training modules that may help staff gain skills to intervene early with patients who may be

escalating. By the spring of 2012, all of the Salem campus patients will have transitioned to the new hospital. The hospital has its initiative to train all staff in the Recovery Model, Person-Centered Care, and Trauma Informed Services. The Seclusion and Restraint Review Committee provided three articles in the hospital's Recovery Times newsletter providing an overview of the S/R Committee with goals of 10% reduction in restrictive events, Workforce Development (training all of the new employees how to work with this challenging population) and effective debriefing techniques. The Seclusion/Restraint Committee will continue to provide cogent and current best practices regularly in the hospital publications.

7. ABOUT THE DATA

The data reported here came from hospital databases and is dependent on reports made by staff. The data is accurate, within the limitations of our current data systems.

KPM #14	LENGTH OF STAY AT Oregon State Hopital - Reduction in overall length of stay at Oregon State Hospital (days)	2009
Goal	People are healthy.	
Oregon Context	People are healthy.	
Data Source	Oregon Patient/Resident Care System (OP/RCS)	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

Our strategy is to deliver recovery-oriented services.

2. ABOUT THE TARGETS

In general AMH would like to continue to lower the average length of stay in the Oregon State Hospital.

3. HOW WE ARE DOING

The overall trend is decreasing, which is good.

4. HOW WE COMPARE

There is not a direct comparison available.

5. FACTORS AFFECTING RESULTS

There are many factors that influence this outcome that are internal and external to the state hospital. AMH is working to increase the hours of active treatment patients receive while in the hospital to promote quicker recovery. In addition, AMH is attempting to align community resources to provide adequate care for patients discharged from the hospital to decrease the likelihood of return to the hospital.

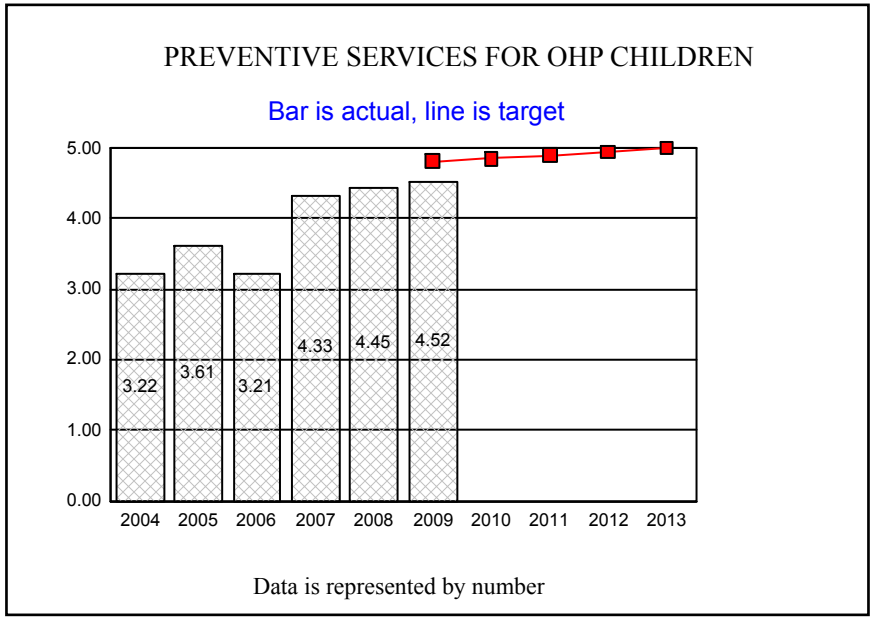
6. WHAT NEEDS TO BE DONE

See Factors Affecting Results.

7. ABOUT THE DATA

Data are based on information available in the Oregon Patent Resident Care System. It should be noted that the averages are estimates based on projected length of stay at time of admission.

KPM #15	PREVENTIVE SERVICES FOR OREGON HEALTH PLAN (OHP) CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP	2009
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	The rates and targets below have replaced the ones previously submitted. The ones below have been all re-calculated using the newest Medicaid Managed Information System (MMIS) database. Health Services Commission Prioritized List of Health Services April 1, 2009.Diagnosis and/CPT-HCPCS pairings on Line 3 for OHP client member years.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

Preventive health care and managed care are cornerstones of the Oregon Health Plan (OHP). People who have access to and use preventive care have

improved health outcomes. Preventive health care is delivered in a cost-effective manner as diseases can be avoided or diagnosed early and treated before becoming serious and debilitating. In addition, preventive health screens and anticipatory guidance helps to promote healthy lifestyles and wellness.

Starting in 2012, Coordinated Care Organizations (CCOs) are being contracted with to provide health services to OHP clients instead of managed care plans. A CCO is a network of all types of health care providers (i.e. physical health, mental health, hospitals) who have agreed to work together for people who receive health care coverage under the Oregon Health Plan. These providers have joined together to form one jointly governed entity that will contract with the Oregon Health Authority to serve people on the Oregon Health Plan in their local communities. CCOs will have increased flexibility to pay for things like preventive care, chronic disease care, coordination of care, and patient education. CCOs will have the ability to hire health care navigators and community based health workers to help parents and caregivers access preventive care for their children.

Working in conjunction with CCOs, are the newly recognized Patient-Centered Primary Care Homes. Coordinated Care Organizations are required to include recognized primary care homes in their networks of care to the extent possible. Expanding the availability of primary care homes will strengthen the primary care networks as CCOs emerge and thereby increase access to primary and preventive care. Patient-Centered Primary Care Homes are clinics that have been recognized for their commitment to a patient-centered approach to care. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Clinics improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions. For example, clinics will help patients navigate the health care system to get the type of care they need in a safe and timely way.

Another opportunity to improve health care is Oregon's Medicaid Electronic Health Record (EHR) Incentive Program. This program makes available grants through the federal American Recovery and Reinvestment Act to Oregon hospitals and health care providers who serve Medicaid patients. The grants will help providers and hospitals implement electronic health records. The goal for the grants is to provide incentives for the move to confidential records that can be more easily shared among different types of providers and patients.

2. ABOUT THE TARGETS

DMAP follows the U.S. Preventive Services Task Force (USPSTF) guidelines for recommended number of preventive services for OHP children. Higher is the stated favorable direction for this measure. Using the USPSTF guidelines and analyzing trends, a target of 5 preventive services per member year was chosen as the 2013 target. Projecting to 2013, we assigned yearly targets reflecting proportional increases. This measure is based on the prioritized list of health services and so is unique to OHP, and therefore has no comparison rates or targets.

DMAP plans to replace this measure with HEDIS® well child measures. HEDIS® measures are national standards widely used in the health care industry. Using HEDIS® measures will allow DMAP to compare overall OHP rates and CCO specific rates to each other and to commercial plans.

3. HOW WE ARE DOING

Although the 2009 target was not met, the trend for years 2004 through 2009 was increasing which is the favorable direction for this measure.

4. HOW WE COMPARE

There are no comparative rates as this measure is based on Line 3 of OHP's unique prioritized list of health care services developed by the Oregon Health Services Commission. The lines of the list determine which health care services are funded. The medical codes included on specific lines of the prioritized list sometimes change which adds to the problem of using measures based on the prioritized list.

5. FACTORS AFFECTING RESULTS

Barriers include health care providers that do not accept Medicaid clients and a lack of understanding among some parents and caregivers that regular well child visits are necessary and important.

6. WHAT NEEDS TO BE DONE

As stated above major changes have occurred to transform how Oregon Health Plan clients will receive their health care. Starting in 2012, Oregon Health Plan clients will participate in a new type of health plan and clinic - Care Coordinating Organizations and Patient Centered Primary Care Homes. These new plans and clinics will work to provide better care for Oregon Health Plan clients resulting increased access to timely preventive care.

DMAP in collaboration with the Maternal and Child Health section of the Oregon Public Health Division have spearheaded an initiative that promotes developmental screening for young children. These ABCD projects (Assuring Better Childhood Development) are public-private partnerships working to improve the early identification and referral of children with developmental, behavioral, and social-emotional delays.

7. ABOUT THE DATA

Reporting cycle is calendar year. The rates above have all been re-calculated using the new MMIS database and new corresponding targets were set. Another major change that occurred since DMAP first calculated this measure was immunizations were added to Lines 3. This change was taken into account by using the same list – the prioritized list of April 1, 2009 – for all the years.

For each measurement period (calendar year), the rate is calculated in the following way:

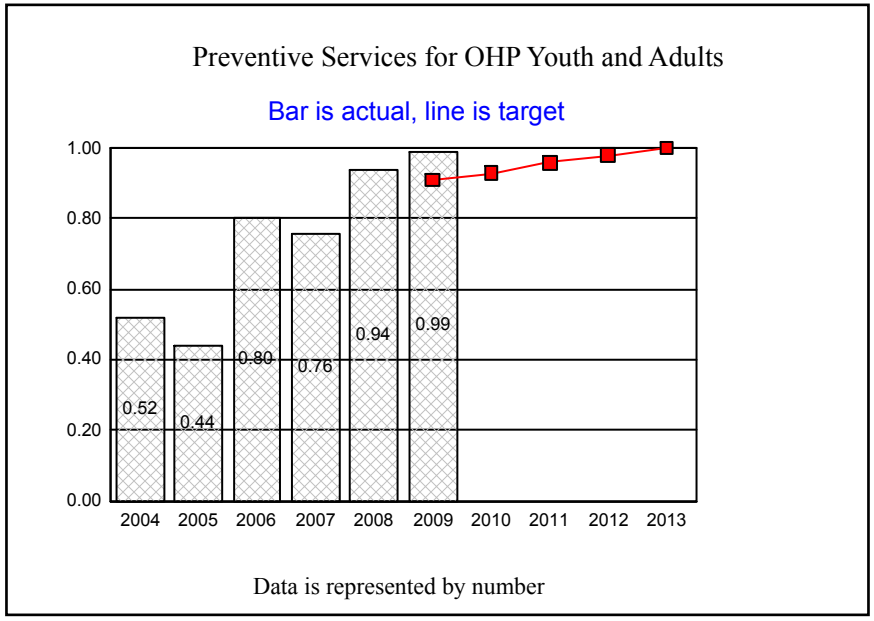
Numerator (upper number): the total number of Line 3 services provided to OHP clients birth through 10 years old
Divided by:
Denominator (lower number): the total number of member months for all clients birth through 10 years old
divided by 12 to calculate “member years”.

Many clients are not enrolled in OHP for all twelve months of the calendar year so this measure is based on the actual months that clients are enrolled in the measurement period - their combined member months in the calendar year. To calculate total combined member months, the number of months that each client, 10 years old and younger, was enrolled in the measurement period is added together. This number is than divided by 12 to create a member year.

Numbers of services for health care claims/encounters are in the MMIS database. All data used for the calculations are pulled at least six months past the last day of the calendar year to take into account the amount of time needed by some medical claims/encounters to enter the MMIS database.

Although not shown here as a KPM, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

KPM #16	PREVENTIVE SERVICES FOR OREGON HEALTH PLAN (OHP) YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP	2009
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	The rates and targets below have replaced the ones previously submitted. The ones below have been all re-calculated using the newest Medicaid Managed Information System (MMIS) EDS/HP database. Health Services Commission Prioritized List of Health Services April 1, 2009.Diagnosis and/CPT-HCPCS pairings on Line 4 for OHP client member years.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

Preventive health care and managed care are cornerstones of the Oregon Health Plan (OHP). People who have access to and use preventive care have

improved health outcomes. Preventive health care is delivered in a cost-effective manner as diseases can be avoided or diagnosed early and treated before becoming serious and debilitating. In addition, preventive health screens and anticipatory guidance helps to promote healthy lifestyles and wellness.

Starting in 2012, Coordinated Care Organizations (CCOs) are being contracted with to provide health services to OHP clients instead of managed care plans. A CCO is a network of all types of health care providers (i.e. physical health, mental health, hospitals) who have agreed to work together for people who receive health care coverage under the Oregon Health Plan. These providers have joined together to form one jointly governed entity that will contract with the Oregon Health Authority to serve people on the Oregon Health Plan in their local communities. CCOs will have increased flexibility to pay for things like preventive care, chronic disease care, coordination of care, and patient education. CCOs will have the ability to hire health care navigators and community based health workers to help OHP clients access care.

Working in conjunction with CCOs, are the newly recognized Patient-Centered Primary Care Homes. Coordinated Care Organizations are required to include recognized primary care homes in their networks of care to the extent possible. Expanding the availability of primary care homes will strengthen the primary care networks as CCOs emerge and thereby increase access to primary and preventive care. Patient-Centered Primary Care Homes are clinics that have been recognized for their commitment to a patient-centered approach to care. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Clinics improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions. For example, clinics will help patients navigate the health care system to get the type of care they need in a safe and timely way.

Another opportunity to improve health care is Oregon's Medicaid Electronic Health Record (EHR) Incentive Program. This program makes available grants through the federal American Recovery and Reinvestment Act to Oregon hospitals and health care providers who serve Medicaid patients. The grants will help providers and hospitals implement electronic health records. The goal for the grants is to provide incentives for the move to confidential records that can be more easily shared among different types of providers and patients.

2. ABOUT THE TARGETS

New targets have been set because all the above rates have been re-calculated using the new Medicaid Managed Information System (MMIS).DMAP follows the U.S. Preventive Services Task Force (USPSTF) guidelines for recommended number of preventive services. Higher is the stated favorable direction for this measure. Using the USPSTF guidelines and analyzing trends a target of 1 preventive service per member year was chosen as the 2013 target. Projecting to 2013, we assigned yearly targets reflecting proportional increases. This measure is based on the prioritized list of health services and so is unique to OHP, and therefore has no comparison rates or targets.

DMAP plans to replace this measure with HEDIS® well child and adolescent measures. HEDIS® measures are national standards widely used in the health care industry. Using HEDIS® measures will allow DMAP to compare overall OHP rates and CCO specific rates to each other and to commercial plans.

3. HOW WE ARE DOING

The trend for years 2004 through 2009 was increasing which is the favorable direction for this measure. The actual data for 2009 is higher than the set target. This measure has changed since the previous rates were calculated due to the replacement of the previous database with an entirely new MMIS database. All of the years 2004 through 2009 have been recalculated using the new database andnew corresponding targets were set.

4. HOW WE COMPARE

There are no comparative rates as this measure is based on Line 4 of OHP's unique prioritized list of health care services developed by the Oregon Health Services Commission. The lines of the list determine which health care services are funded. The medical codes included on specific lines of the prioritized list sometimes change which adds to the problem of using measures based on the prioritized list.

5. FACTORS AFFECTING RESULTS

Barriers include health care providers that do not accept Medicaid clients and a lack of understanding among some clients that routine medical exams are necessary and important.

6. WHAT NEEDS TO BE DONE

As stated above major changes have occurred to transform how Oregon Health Plan clients will receive their health care. Starting in 2012, Oregon Health Plan clients will participate in a new type of health plan and clinic - Care Coordinating Organizations and Patient Centered Primary Care Homes. These new plans and clinics will work to provide better care for Oregon Health Plan clients resulting increased access to timely preventive care.

DMAP spearheaded performance improvement projects involving OHP's physical health and mental health managed care plans. These projects aimed to strengthen collaboration resulting in improved care for OHP clients receiving both mental and physical health services. These projects have formed a base for collaboration that continues through the CCOs for the physical and behavioral health care systems.

7. ABOUT THE DATA

Reporting cycle is calendar year.

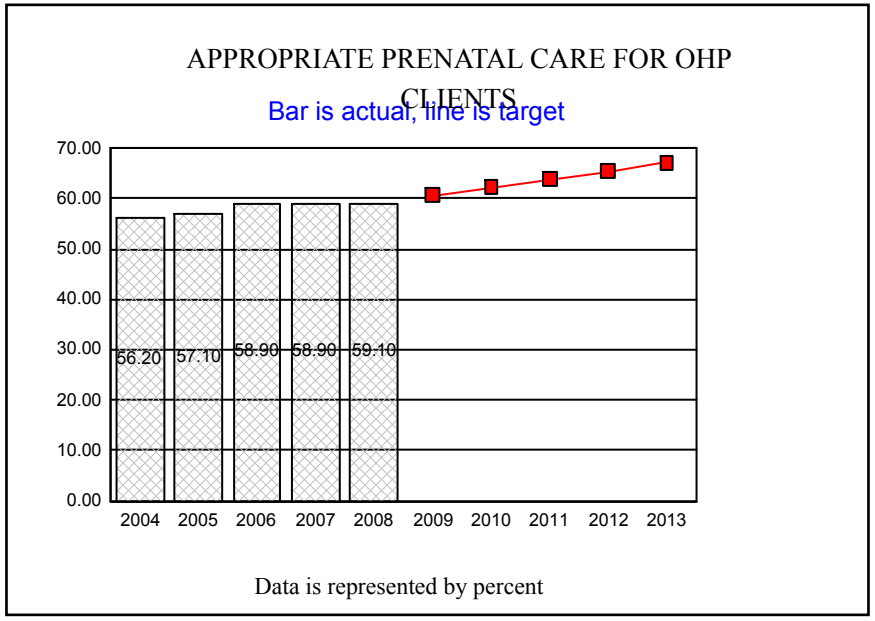
The rates above have all been re-calculated using the new MMIS database and new corresponding targets were set. Another major change that occurred since DMAP first calculated this measure was immunizations were added to Lines 4. This change was taken into account by using the same list – the prioritized list of April 1, 2009 – for all the years.

For each measurement period (calendar year), the rate is calculated in the following way:
Numerator (upper number): the total number of Line 4 services provided to OHP clients 11 years old and older
Divided by:
Denominator (lower number): the total number of member months for all clients 11 years old and older
divided by 12 to calculate "member years".

Many clients are not enrolled in OHP for all twelve months of the calendar year so this measure is based on the actual months that clients are enrolled in the measurement period - their combined member months in the calendar year. To calculate total combined member months, the number of months that each client, 11 years old and older, was enrolled in the measurement period is added together. This number is than divided by 12 to create a member year.

Numbers of services for health care claims/encounters are in the MMIS database. All data used for the calculations are pulled at least six months past the last day of the calendar year to take into account the amount of time needed by some medical claims/encounters to enter the MMIS database. Although not shown here as a Key Performance Measure, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

KPM #17	APPROPRIATE PRENATAL CARE FOR OREGON HEALTH PLAN (OHP) CLIENTS - Percentage of pregnant OHP clients who received an appropriate number of prenatal care visits while on OHP	2009
Goal	People are healthy	
Oregon Context	Health care access, Oregon Benchmark #40 - prenatal care	
Data Source	Medicaid Managed Information System (MMIS) EDS/HP database. Health Services Commission Prioritized List of Health Services April 1, 2009. Diagnosis and/CPT-HCPCS pairings on line 000 and line 001.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

This measure, proposed for 2009-2011, has proven to be inherently immeasurable because of nearly universal use of global and bundled coding when billing for prenatal, delivery, and postpartum services.

In order to avoid costly chart reviews, DMAP uses administrative data from its claim processing system to calculate measures. At this time, DMAP does not have access to electronic medical records or any other data sources that would provide meaningful data for this measure. Therefore, DMAP has put this measure on hold until an accurate measurement process is available.

2. ABOUT THE TARGETS

3. HOW WE ARE DOING

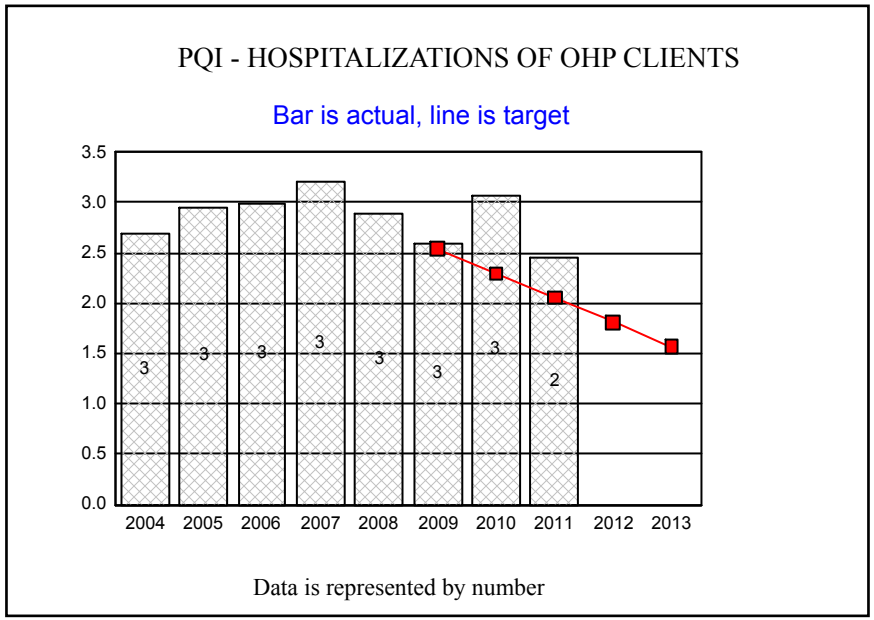
4. HOW WE COMPARE

5. FACTORS AFFECTING RESULTS

6. WHAT NEEDS TO BE DONE

7. ABOUT THE DATA

KPM #18	PREVENTIVE QUALITY INDICATOR (PQI) - HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients by condition	2010
Goal	People are healthy	
Oregon Context	Health Care Access	
Data Source	Data source is the Medicaid Managed Information System (MMIS) database. This measure is a national Agency for Healthcare Research and Quality (AHRQ) Quality Indicator. AHRQ updates the specifications periodically. Measurement years 2010 and 2011 were calculated using the version V4.4 software. The prior years used the software that was current at the time.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

DMAP's strategy is to increase access to and quality of preventive and primary care in order to reduce unnecessary hospital admissions. With high-quality, primary care, hospitalization for some illnesses may be avoided. In addition to quality of care, a higher PQI rate can indicate an access to primary care concern.

The Oregon Health Plan prioritizes preventive health care services. Evidence suggests that good preventive care can reduce the risk of hospitalization for some chronic and acute conditions. These conditions are called ambulatory care sensitive conditions. "Ambulatory care" means medical office or clinic based health services, and "sensitive" means the condition can be treated in this setting.

The Prevention Quality Indicator is a nationally specified measure and represents hospital admission rates for clients 18 years old and older for the following 12 ambulatory care sensitive conditions:

- Diabetes, short-term complications
- Diabetes, long-term complications
- Uncontrolled diabetes
- Lower extremity amputations among patients with diabetes
- Adult asthma
- Angina without procedure
- Chronic obstructive pulmonary disease
- Hypertension
- Congestive heart failure
- Dehydration
- Bacterial pneumonia
- Urinary infections

This measure was chosen because it makes use of a free software program and can be used by Care Coordination Organizations (CCOs) to calculate their organization's PQI rates using their own administrative data. In this way, the measure can become actionable by the entities that are contracted to manage the care of OHP clients. For example, besides an overall focus on prevention and chronic disease care, CCOs could focus on members hospitalized for one of these conditions during and after discharge from the hospital to ensure their condition is stabilized to prevent re-hospitalization.

Although not shown here as a Key Performance Measure, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific managed care plan, primary care management, fee for service and as they are established CCOs. Starting in 2012, CCOs are being contracted with to provide health services to OHP clients instead of managed care plans.

A CCO is a network of all types of health care providers (i.e. physical health, mental health, hospitals) who have agreed to work together for people who receive health care coverage under the Oregon Health Plan. These providers have joined together to form one jointly governed entity that will contract with the Oregon Health Authority to serve people on the Oregon Health Plan in their local communities. CCOs will have increased flexibility to pay for things like preventive care, chronic disease care, coordination of care and patient education.Research shows that 80 percent of health care costs are driven by 20 percent of patients, many with one or more chronic conditions such as heart disease, diabetes and serious mental illness. CCOs will have the ability to hire community based health workers to help people access care, manage their conditions, ensure they are taking appropriate medications, and avoid unnecessary acute or emergency care. In the future,CCO reimbursement will be linked to specific outcomes based on a set of proposed measures. The PQI

measure is included in this set of measures.

Working in conjunction with CCOs, are the newly recognized Patient-Centered Primary Care Homes. Coordinated Care Organizations are required to include recognized primary care homes in their networks of care to the extent possible. Expanding the availability of primary care homes will strengthen the primary care networks as CCOs emerge and thereby increase access to primary and preventive care. Patient-Centered Primary Care Homes are clinics that have been recognized for their commitment to a patient-centered approach to care. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Clinics improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions. Directly related to this measure, for example, clinics will help patients navigate the health care system to get the type of care they need in a safe and timely way and thereby decrease avoidable hospitalizations.

Another opportunity to improve coordination of care is Oregon's Medicaid Electronic Health Record (EHR) Incentive Program. This program makes available grants through the federal American Recovery and Reinvestment Act to Oregon hospitals and health care providers who serve Medicaid patients. The grants will help providers and hospitals implement electronic health records. The goal for the grants is to provide incentives for the move to confidential records that can be more easily shared among different types of providers and patients.

2. ABOUT THE TARGETS

Avoiding hospital admissions is preferable, and results in a low favorable direction for this measure. The PQI measure represents possibly unnecessary hospitalizations and may reflect a lack of primary care services. Low income populations have higher PQI rates than the general population. DMAP's 2015 target is the 2007 PQI rate for the population of Oregon. Next, we assigned yearly targets reflecting equally proportioned decreases projected to 2015. The table above shows these proportioned decreases out to 2013.

3. HOW WE ARE DOING

In 2011, the rate was the most favorable, lowest, since the data was first calculated for 2004. The 2011 rate is close but slightly higher (less favorable) than the target set for 2011.

4. HOW WE COMPARE

The national Agency for Healthcare Research and Quality has published a national observed rate of 1,825 per 100,000 population. The Oregon Health Care Quality Corporation (Q-Corp) has calculated an Oregon aggregate rate of 1,769 per 100,000 patients slightly lower (more favorable) than the national rate. Using type of health insurance as a subdivision, Q-Corp calculated a rate of 407 for 100,000 Oregon commercial plan patients and 6,442 for 100,000 Oregon Medicare patients. Older and disabled populations (Medicare) and low income populations (Medicaid) consistently have higher (less favorable) PQI rates than aggregate population rates and commercial plan rates comprised of members who tend to have higher incomes and levels of education. The 2011 calculated rate for this measure of 2,444 is lower (more favorable) than the rates for Oregon Medicare and higher (less favorable) than the national and Oregon aggregate rates and the Oregon commercial plan rates.

One difference between this measure and the AHRQ national rates and Q-Corp rates is that DMAP's rate uses 100,000 member years, each member year may represent one or several members, the AHRQ general population rate uses 100,000 people and the Q-Corp rate uses 100,000 patients. Another difference is that DMAP uses a calendar year while the calculations for Q-Corp were from July 2010 to June 2011.

5. FACTORS AFFECTING RESULTS

As mentioned previously, nationally low income populations, including those on Medicaid, consistently have higher (unfavorable) PQI rates than commercial health plan and general population PQI rates. Many of the PQI medical conditions are affected by long term tobacco use, obesity, and other social determinants of health which occurs disproportionately among low income people. These conditions are also influenced by aging and this explains the high rate for the Medicare population.

6. WHAT NEEDS TO BE DONE

This measure is included in the Care Coordinated Organizations core set of performance measures. Besides concentrating on prevention and chronic disease management through CCOs and PCPCHs, the agency can coach the CCOs to use this measure directly to decrease unnecessary hospitalizations. Often a member has more than one PQI condition hospitalization. As previously mentioned, CCOs could run this measure (in closer to) real time and develop a communication with hospitals that alerts the CCO when a member has been hospitalized for one of these conditions. The member then could be focused on during and after discharge from the hospital to ensure their condition is stabilized and to prevent re-hospitalization.

7. ABOUT THE DATA

Reporting cycle is calendar year.

Note: For each calendar year, the rate is calculated in the following way:

·Numerator (upper number): the total number of PQI ambulatory care hospital admissions for OHP clients 18 years old and older.

·Divided by:

Denominator (lower number): the total number of member years for all clients 18 years old and older

·Multiply resulting number by 100,000.

Many clients are not enrolled in OHP for all twelve months of the calendar year, so this measure is based on the actual months that clients are enrolled in the measurement period -- their combined member months in the calendar year. To calculate total combined member months, we add together the number of months that each client, 18 years older, was enrolled in the measurement period. This number is than divided by 12 to create a member year. Because hospital admissions are relatively rare, the numerator is quite a small number. However, the combined total number of member years of all adult clients is a very large number. So, in order to calculate a comprehensible rate, the number resulting from the numerator divided by the denominator is multiplied by 100,000 to create a rate approximately comparable to 100,000 people.

Rates are based on hospital admission claims and encounter data contained in the MMIS database. All rates are calculated at least six months past the last day of the calendar year to take into account the amount of time some medical claims and encounters need to enter the MMIS database. Although not shown here as a Key Performance Measure, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific care plan, primary care management, fee for service, and soon CCO. The State of Equity Report has 2009 rates separated by race and ethnicity categories.

DATA

2004

2005

	2006
	2007
	2008
	2009
	2010
	2011
	2012
	2013
Actual	
PQI Admissions	5,349
Member Years *	199,019
(x 100,000)	= .02688
	(x 100,000)
	5,486
	186,297
	=.02945
	(x 100,000)
	5,351
	179,389
	=.02983
	(x 100,000)
	5,521
	172,120
	=.03208
	(x 100,000)
	5,343
	184,345
	=.02898
(x 100,000)	
	5,173
	199,693
	=.02591
	(x 100,000)
	6,669
	217,061

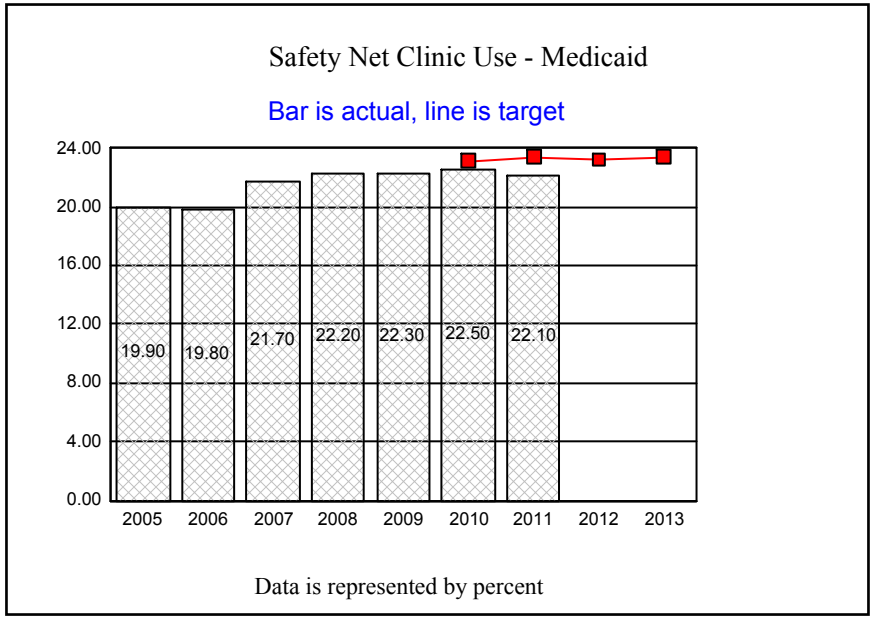
=.03724
(x 100,000)
6,414
262,422
=.02444
(x 100,000)

Actual

2,688
2,945
2,983
3,208
2,898
2,591
3,072
2,444

Target

KPM #19a	SAFETY NET CLINIC USE - MEDICAID - Oregonians on Medicaid served by safety net clinics as a percentage of total Oregonians on Medicaid	2010
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	Oregon Primary Care Association, Oregon Population Survey, 2008 American Community Survey, and Portland State University	
Owner	OHA – Office of Health Policy and Research, Satenik Hackenbruck 503-373-1931	



1. OUR STRATEGY

Safety net clinics provide health care services to vulnerable populations such as uninsured people, Medicaid and Medicare clients, many of whom face multiple barriers to health care not only due to income status. This has been a critical role especially in economically challenging times. Oregon Health Policy and Research (OHPR) monitors policy

implications and staffs the Safety Net Advisory Council. OHPR determines health professional shortage areas and areas of unmet need and makes that information available to communities. OHPR provides technical assistance to communities and sites interested in establishing or expanding sites. OHPR assists communities with workforce needs in underserved areas of the state.

2. ABOUT THE TARGETS

This key performance measure shows the proportion of total uninsured in Oregon served by safety net clinics. However, due to the lack of data for all types of safety net clinics, we are using Federally Qualified Health Centers (FQHC) as a proxy for all safety net clinics:

In 2002, FQHCs served 69,400 uninsured Oregonians. By 2010 that number had risen to 133,000, which is a 92 percent increase compared to 2002. At the same time the number of total uninsured in Oregon had increased by 30 percent from 490,700 to 636,000. This indicates that over time the proportion of uninsured people receiving care at FQHCs is increasing at a higher rate than the growth of uninsured population in general. Which is not surprising given the rapid growth of FQHC sites; the number of FQHC sites grew by 45 percent from 106 in 2002 to 154 in 2010.

Due to the implementation of state and federal health care reforms, the number of uninsured in Oregon is expected to decline. However, it's hard to predict what will happen to the number of uninsured seen by FQHCs. On one hand we have seen an upward trend in the past, due to the increased capacity of safety net, on the other hand, many of the current uninsured seen by FQHCs will gain insurance coverage as a result of the reform. In the end, we expect the number of uninsured served by FQHCs to decline at a higher rate than the overall number of uninsured, due to the fact that the uninsured seen by safety net clinics are more likely to gain insurance coverage compared to those not seen in safety net clinics. Often times, the challenge with insuring low income uninsured individuals is in finding them, thus those seen by safety net have an instant advantage of being found and enrolled. Thus, we expect the key performance measure to decrease slightly in 2012-2013.

As mentioned above, uninsured is not the only category of people relying on safety net clinics. An increasing number of communities are reporting Medicaid and Medicare related access problems. Safety net clinics report serving over 144,000 Medicaid and Medicare clients in 2010 and therefore represent an important component of primary care access for these populations. As a result, OHPR has two additional measures for the 2011-13 biennium: the percentages of Medicaid and Medicare patients served by safety net clinics. These additional measures will help to better understand the utilization of the safety net by various groups of people, and its implications for public policy.

3. HOW WE ARE DOING

Percentages served by the safety net have been consistently increasing since 2003. With the implementation of health care reform these percentages are expected to drop. Assuming that the purpose of the safety net is to provide care to a significant number of uninsured whatever the barriers they face then one would have to conclude that the safety net is doing its job. This is especially true given that the safety net providers also serve Medicaid and Medicare patients and are part of the capacity equation for these populations as well. Of some concern from a policy perspective is the fact that the safety net has served increasing numbers of uninsured without corresponding increases in revenue. Additionally, there are capacity needs in the current Medicare and Medicaid programs that will be strained as more baby boomers retire. While the safety net is a critical part of the state's health care access equation it is also vulnerable to the same workforce "pipeline", recruitment and retention challenges faced by the rest of the delivery system.

4. HOW WE COMPARE

There are no comparative data available in Oregon or for other states, although safety net roles and dynamics are believed to be similar in other states.

5. FACTORS AFFECTING RESULTS

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

6. WHAT NEEDS TO BE DONE

Targets need to be changed to absolute numbers rather than percentages or at least both need to be included to document the role of the safety net and to highlight capacity needs and challenges for serving the increasing number of individuals.

Understanding the shifting payer source for safety net providers will be important to understanding the role the safety net can and should play in an environment where many more people are covered. In that light one needs to understand the relative proportions of uninsured, Medicaid, and Medicare served by the safety net. Medicare access is increasingly problematic in Oregon and Fully Capitated Health Plans depend to a good extent on the safety net as part of their panel to assure access. Until fee-for service rates improve, the safety net is likely to remain a critical part of this access solution. Workforce shortages will also play a part in understanding both the contribution of the safety net and the challenges it faces. It is important to understand the role the safety net plays as a part of total health system capacity to provide care to both those who are uninsured (assuming there will always be some) and those who are covered by Medicare or Medicaid.

7. ABOUT THE DATA

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

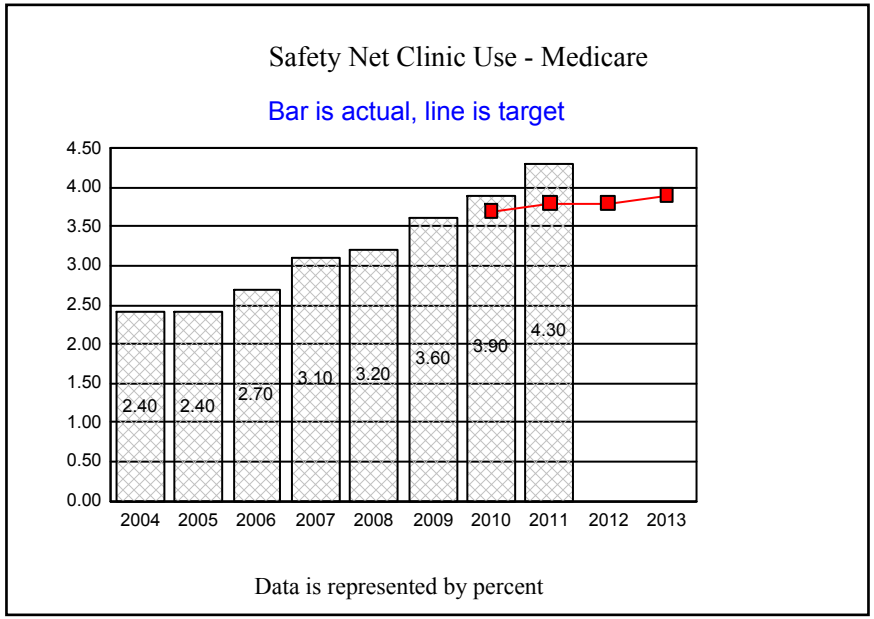
The Uniform Data System (UDS) collects data on all clinics in the U.S. receiving federal funds through section 330 of the Public Health Service (PHS) Act and administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). These clinics are known as Federally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

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

The Census Bureau's American Community Survey (ACS) is the largest nationwide survey producing comprehensive data on demographic, social, economic, and housing characteristics. The ACS surveys three million addresses per year, including roughly 25,000 Oregonians. More details about the methodology and data can be obtained at: http://cms.oregon.gov/oha/OHPR/RSCH/docs/uninsured/oregonuninsured_2010acs_finalreport.pdf

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

KPM #19b	SAFETY NET CLINIC USE - MEDICARE - Oregonians on Medicare served by safety net clinics as a percentage of total Oregonians on Medicare	2010
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	Oregon Primary Care Association, Oregon Population Survey, 2008 American Community Survey, and Portland State University	
Owner	OHA – Office of Health Policy and Research, Satenik Hackenbruck 503-373-1931	



1. OUR STRATEGY

Safety net clinics provide health care services to vulnerable populations such as uninsured people, Medicaid and Medicare clients, many of whom face multiple

barriers to health care not only due to income status. This has been a critical role especially in economically challenging times. Oregon Health Policy and Research (OHPR) monitors policy implications and staffs the Safety Net Advisory Council. OHPR determines health professional shortage areas and areas of unmet need and makes that information available to communities. OHPR provides technical assistance to communities and sites interested in establishing or expanding sites. OHPR assists communities with workforce needs in underserved areas of the state.

2. ABOUT THE TARGETS

This key performance measure shows the proportion of total uninsured in Oregon served by safety net clinics. However, due to the lack of data for all types of safety net clinics, we are using Federally Qualified Health Centers (FQHC) as a proxy for all safety net clinics:

In 2002, FQHCs served 69,400 uninsured Oregonians. By 2010 that number had risen to 133,000, which is a 92 percent increase compared to 2002. At the same time the number of total uninsured in Oregon had increased by 30 percent from 490,700 to 636,000. This indicates that over time the proportion of uninsured people receiving care at FQHCs is increasing at a higher rate than the growth of uninsured population in general. Which is not surprising given the rapid growth of FQHC sites; the number of FQHC sites grew by 45 percent from 106 in 2002 to 154 in 2010.

Due to the implementation of state and federal health care reforms, the number of uninsured in Oregon is expected to decline. However, it's hard to predict what will happen to the number of uninsured seen by FQHCs. On one hand we have seen an upward trend in the past, due to the increased capacity of safety net, on the other hand, many of the current uninsured seen by FQHCs will gain insurance coverage as a result of the reform. In the end, we expect the number of uninsured served by FQHCs to decline at a higher rate than the overall number of uninsured, due to the fact that the uninsured seen by safety net clinics are more likely to gain insurance coverage compared to those not seen in safety net clinics. Often times, the challenge with insuring low income uninsured individuals is in finding them, thus those seen by safety net have an instant advantage of being found and enrolled. Thus, we expect the key performance measure to decrease slightly in 2012-2013.

As mentioned above, uninsured is not the only category of people relying on safety net clinics. An increasing number of communities are reporting Medicaid and Medicare related access problems. Safety net clinics report serving over 144,000 Medicaid and Medicare clients in 2010 and therefore represent an important component of primary care access for these populations. As a result, OHPR has two additional measures for the 2011-13 biennium: the percentages of Medicaid and Medicare patients served by safety net clinics. These additional measures will help to better understand the utilization of the safety net by various groups of people, and its implications for public policy.

3. HOW WE ARE DOING

Percentages served by the safety net have been consistently increasing since 2003. With the implementation of health care reform these percentages are expected to drop. Assuming that the purpose of the safety net is to provide care to a significant number of uninsured whatever the barriers they face then one would have to conclude that the safety net is doing its job. This is especially true given that the safety net providers also serve Medicaid and Medicare patients and are part of the capacity equation for these populations as well. Of some concern from a policy perspective is the fact that the safety net has served increasing numbers of uninsured without corresponding increases in revenue. Additionally, there are capacity needs in the current Medicare and Medicaid programs that will be strained as more baby boomers retire. While the safety net is a critical part of the state's health care access equation it is also vulnerable to the same workforce "pipeline", recruitment and retention challenges faced by the rest of the delivery system.

4. HOW WE COMPARE

There are no comparative data available in Oregon or for other states, although safety net roles and dynamics are believed to be similar in other states.

5. FACTORS AFFECTING RESULTS

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

6. WHAT NEEDS TO BE DONE

Targets need to be changed to absolute numbers rather than percentages or at least both need to be included to document the role of the safety net and to highlight capacity needs and challenges for serving the increasing number of individuals.

Understanding the shifting payer source for safety net providers will be important to understanding the role the safety net can and should play in an environment where many more people are covered. In that light one needs to understand the relative proportions of uninsured, Medicaid, and Medicare served by the safety net. Medicare access is increasingly problematic in Oregon and Fully Capitated Health Plans depend to a good extent on the safety net as part of their panel to assure access. Until fee-for service rates improve, the safety net is likely to remain a critical part of this access solution. Workforce shortages will also play a part in understanding both the contribution of the safety net and the challenges it faces. It is important to understand the role the safety net plays as a part of total health system capacity to provide care to both those who are uninsured (assuming there will always be some) and those who are covered by Medicare or Medicaid.

7. ABOUT THE DATA

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

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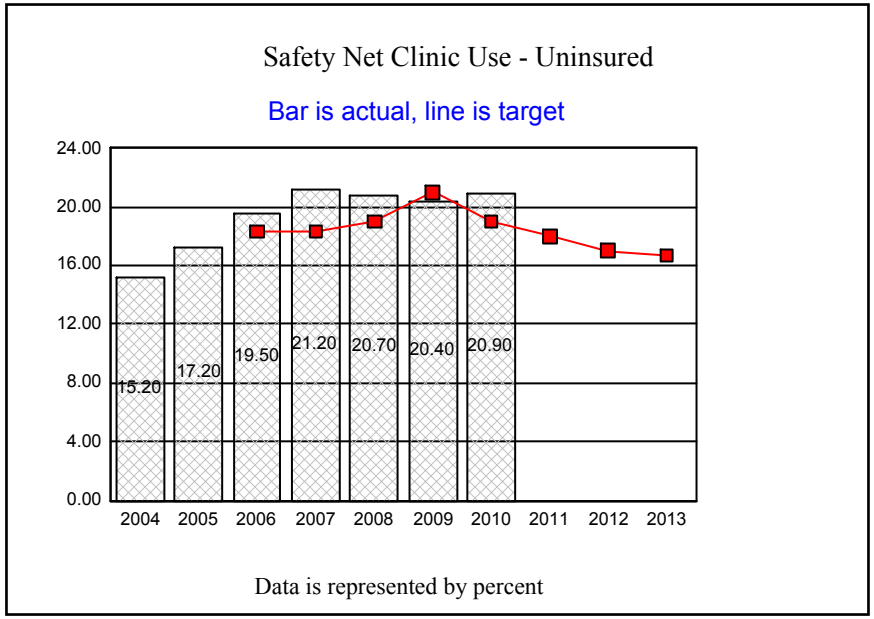
KPM #19c	SAFETY NET CLINIC USE - UNINSURED -Uninsured Oregonians served by safety net clinics as a percentage of total uninsured Oregonians	2002
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	Oregon Primary Care Association, Oregon Population Survey, 2008 American Community Survey, and Portland State University	
Owner	OHA – Office of Health Policy and Research, Satenik Hackenbruck 503-373-1931	



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4. HOW WE COMPARE

There are no comparative data available in Oregon or for other states, although safety net roles and dynamics are believed to be similar in other states.

5. FACTORS AFFECTING RESULTS

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6. WHAT NEEDS TO BE DONE

Targets need to be changed to absolute numbers rather than percentages or at least both need to be included to document the role of the safety net and to highlight capacity needs and challenges for serving the increasing number of individuals.

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7. ABOUT THE DATA

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

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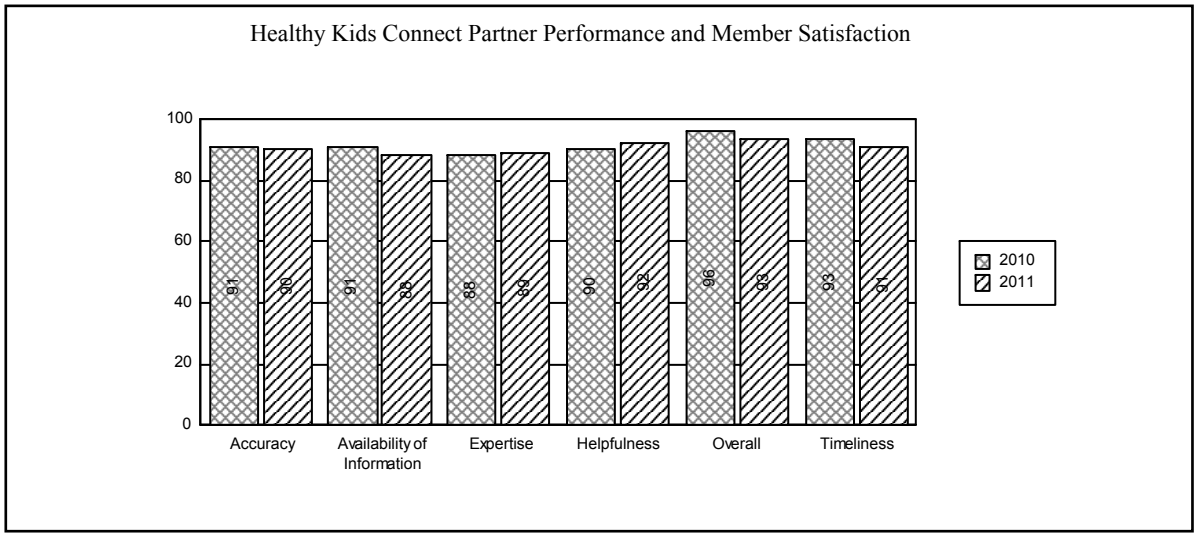
KPM #20	HEALTHY KIDS CONNECT PARTNER PERFORMANCE AND MEMBER SATISFACTION - The percentage of Healthy Kids Connect (HKC) and Healthy Kids ESI members who rate their experience with their contracted insurance carriers as "good" or "excellent".	2010
Goal	Improve collaboration and deliver the highest level of customer service possible.	
Oregon Context	Oregon Benchmark #55 - Health Insurance	
Data Source	HKC Customer Survey Database	
Owner	OHA , Office of Private Health Partnerships (OPHP), Eve Ford, Healthy Kids Connect Program Manager, 503-378-5613	



1. OUR STRATEGY

The agency surveys active Healthy KidsConnect (HKC) members using the statewide customer satisfaction survey created by the Oregon Progress Board and Customer Satisfaction Work Group. Active HKC members are surveyed monthly to gather data on their satisfaction level. This measure reports specifically on the HKC customer service levels.

2. ABOUT THE TARGETS

Targets are expressed as the percentage of responses that are good or excellent of the total responses. 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

HKC began surveying in October 2010 and it has exceeded the target in almost every category since that time.

4. HOW WE COMPARE

Data from comparable agencies and a methodology of how to make the comparison are not readily available. Our survey results show that HKC is performing at a high level of customer satisfaction that should match or surpass other agencies.

5. FACTORS AFFECTING RESULTS

The agency is bound by some State and Federal regulations that are outside of the Agency's control. These regulations affect eligibility determination, enrollment criteria, premium and subsidy amount, program design, and other elements that are a part of the member-agency interaction. The results of the customer service survey may be impacted by these elements that are outside the agency's control.

6. WHAT NEEDS TO BE DONE

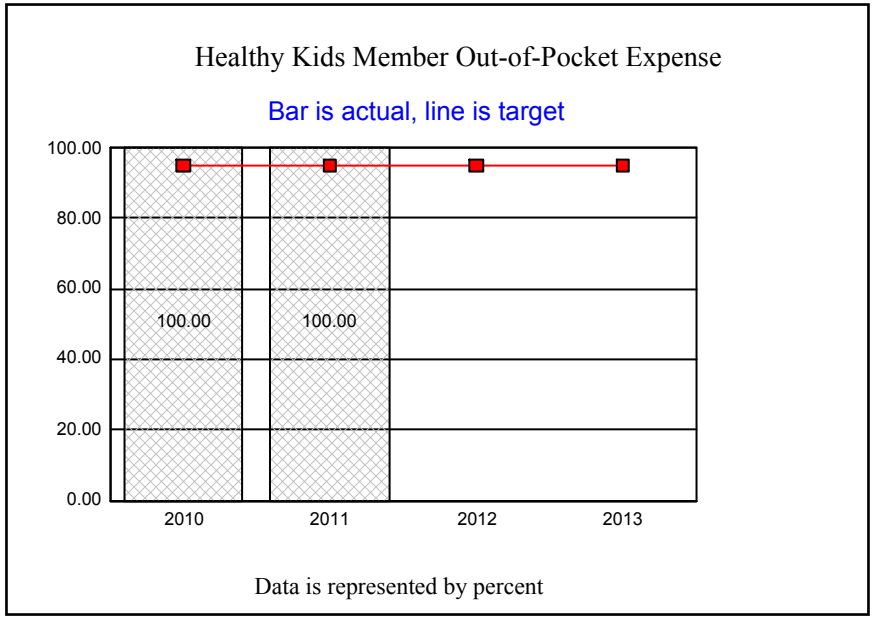
The agency is doing well based on these measures and needs to continue performing at this high level. HKC continues to target 95% to 100% for the upcoming biennium. Due to changes resulting from health care reform at the federal and State levels, it is unknown at this time what will happen to the HKC program. Significant changes are happening within the health insurance industry that will affect HKC. Staff numbers are shrinking as employees look for new jobs in anticipation of the OPHP office closing. Additionally, members will be transitioning to other programs administered by the OHA and the Health Insurance Exchange. We expect that these changes may have an impact either on service levels and member satisfaction levels once they are notified their subsidies will be ending. For these reasons we plan to hold the target at 90% for 2012-2013.

7. ABOUT THE DATA

Survey Name: HKC Customer Satisfaction Survey. Surveyor: Agency Staff. Date Conducted: Monthly, beginning October 2010. Population: Consumers Sampling Frame: All active cases that have been continuously enrolled for six months. Re-enrollees are not included. Sampling Procedure: Whole population. 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 HKC employees? 2. How do you rate the ability of HKC employees to provide services correctly the first time? 3. How do you rate the helpfulness of HKC employees? 4. How do you

rate the knowledge and expertise of HKC employees? 5. How do you rate the availability of information at HKC? 6. How do you rate the overall quality of service provided by HKC? This KPM is measured by State Fiscal Year (July - June).

KPM #21	HEALTHY KIDS MEMBER OUT OF POCKET EXPENSE - The percentage of Healthy Kids Connect (HKC) members who spend less than 5% of their annual family income for healthcare expenses.	2010
Goal	Access to healthcare	
Oregon Context	Oregon Benchmark #55 - Health Insurance	
Data Source	Insurance Carriers will track this information on their client databases and report to OPHP on any member that exceeds their 5% out of pocket maximum.	
Owner	OHA , Office of Private Health Partnerships (OPHP), Eve Ford, Healthy Kids Connect Program Manager, 503-378-5613	



1. OUR STRATEGY

The Centers for Medicare and Medicaid Services (CMS) and the Children's Health Insurance Plan (CHIP) State Plan consider Healthy KidsConnect CHIP coverage with benefits comparable to OHP Plus benefits offered through Healthy Kids. The State Plan requires that member out of pocket costs be limited to 5% of the family's annual income. Out of

pocket costs include copayments, coinsurance, deductibles and the member's monthly premium share.

2. ABOUT THE TARGETS

HKC carriers track member out of pocket costs and notify HKC when a member has reached their 5% out of pocket maximum.

This key performance measure was developed when the HKC program was newly implemented. Since this is a key requirement of the federal government it seemed important to measure success against the goal. While 100 percent of HKC members have spent less than 5 percent of their annual income on healthcare, OPHP does not believe this is representative of any action taken by the program. It is not measuring HKC's performance effectiveness, but rather just insurance plan utilization.

3. HOW WE ARE DOING

100 percent of HKC members have spent less than 5 percent of their annual income since the program was implemented.

4. HOW WE COMPARE

There are no other programs within the State that are subject to this requirement. HKC benefits are comparable to OHP Plus, but OHP Plus has no cost sharing; thus the reason HKC out of pocket costs are limited to keep them comparable.

5. FACTORS AFFECTING RESULTS

While this is a program performance measure, it is really just measuring plan utilization. In no way is it representative of HKC's performance.

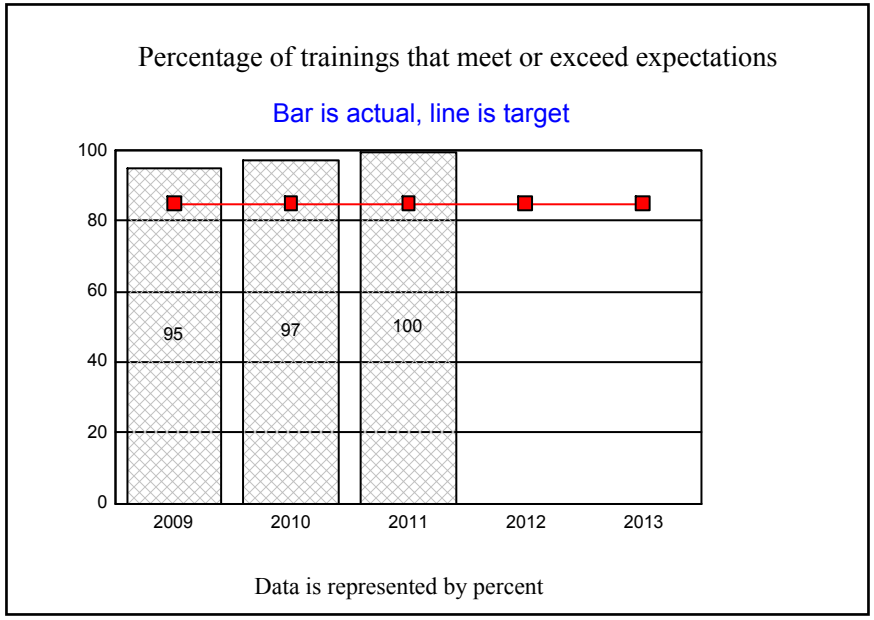
6. WHAT NEEDS TO BE DONE

Since this is just a measure of plan utilization and doesn't reflect HKC performance, we will be recommending to eliminate this KPM.

7. ABOUT THE DATA

HKC calculates the members' out of pocket limits based on 5% of the family's income. The member's monthly premium portion is deducted from this 5 percent cap and the net amount (which represents the maximum limit for other out of pocket costs related to co payments, coinsurance and deductibles) is sent to the HKC carrier for tracking purposes. The HKC insurance carriers track utilization data and member out of pocket spending. Data is submitted to HKC at the point a member exceeds the 5 percent out of pocket maximum. To date, no members have exceeded the limit.

KPM #22	OPHP TRAINING - Percentage of attendees rating the training received as 'meets or exceeds learning experience expectations'.	2009
Goal	TRAINING – To provide Oregon insurance producers, consumers, and the advocate community with timely, accurate, and well-designed and presented information on health insurance and state health insurance programs in Oregon.	
Oregon Context	Oregon Benchmark #55, Health Insurance. In ORS 735.702, the agency is directed to provide "a central source for information about resources for health care and health insurance."	
Data Source	A database of information is collected through a survey done at the conclusion of each training session. The survey asks attendees if the training given: 1) did not meet their learning experience expectation; 2) somewhat meets the expectation; 3) meets the expectation; or 4) exceeds the expectation. Surveys will also provide the opportunity to provide specific feedback on the training program.	
Owner	OHA – OPHP, Information Education & Outreach, Mark Jungvirt, 503-378-5461	



1. OUR STRATEGY

The purpose of Information, Education and Outreach (IEO) is to educate the public about OPHP programs and the health insurance system to make them better consumers. The

best way to do this is through intensive and informative trainings for insurance carriers, producers, employers, medical providers and other community partners who work with our target audience. These partners, in turn, are better able to link uninsured Oregonians 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) and Oregon Health Authority (OHA) staffs. The Family Health Insurance Assistance Program (FHIAP) is an alternative for many Oregonians who qualify for Oregon Health Plan (administered by OHA) but either chooses private insurance or can't get into OHP because of budget limits. FHIAP and HKC also serve people/families that are making the transition from public- to private-sector programs. There is a need for ongoing training about how all Oregon programs work together. During stakeholder trainings, IEO also reaches out to county health departments, safety net clinics, medical providers, state employment offices, employer human resource personnel, medical providers and advocacy groups that help people with applications.

2. ABOUT THE TARGETS

The goal is to have 85% of those who attend our trainings report that the training “meets or exceeds” their learning experience expectations, which means that we are providing our audience with the information that they need. The Goal will increase to 90% starting in 2012. 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 is dictated in part by program openings, and the OPHP budget, but the need for relevant and up to date information remains the same.

3. HOW WE ARE DOING

OPHP is above target for 2009, 1010 and 2011.

4. HOW WE COMPARE

There is no direct comparator to the work that OPHP does to train stakeholders.

5. FACTORS AFFECTING RESULTS

All factors are within the control of OPHP.

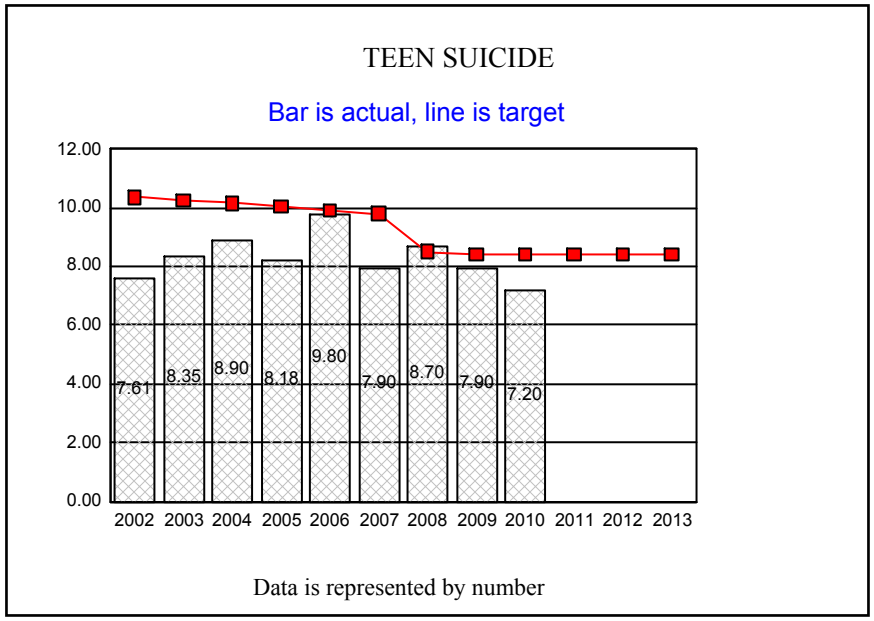
6. WHAT NEEDS TO BE DONE

OPHP will continue to provide free or low-cost education to newly licensed producers and producers who need continuing education, as well as key community partners. OPHP will do so in a manner that meets or exceeds their expectation. The agency is exploring other ways to deliver training, such as webinars and online classes.

7. ABOUT THE DATA

OPHP has a mechanism by which all data for this measure is electronically collected at the end of each training session. The data is then combined with data from other trainings and reported each year.

KPM #23	TEEN SUICIDE -The rate of suicides among adolescents per 100,000.	2002
Goal	People are safe. People are healthy.	
Oregon Context	Oregon Benchmark #45 - Preventable Death	
Data Source	Public Health Division, Center for Prevention & Health Promotion, Center for Public Health Practice (Death Certificates), Oregon Violent Death Reporting System (ORVDRS) and Portland State University, Population Research Center (Population Estimates)	
Owner	OHA - Public Health Division, Center for Prevention & Health Promotion, Injury Prevention & Epidemiology Program, Lisa Millet 971-673-1059	



1. OUR STRATEGY

The agency strategy has been to encourage local organizations and agencies to integrate best practices and evidence-based practices for suicide prevention 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. The program is moving to true primary prevention to prevent the onset of mental, emotional, and behavioral disorders among youth, building intra-agency and inter-agency collaboration, targets and funding with an emphasis on building and supporting nurturing environments. Projects include public health surveillance, development of interventions that will reduce risk factors and increase protective factors identified by data in individuals, families, communities and on the societal level, evaluate projects, and disseminate results broadly.

2. ABOUT THE TARGETS

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

·developing resources to fund primary prevention activities
·preventing child maltreatment
·increasing parenting skills
·increasing classroom management skills in primary school
·increasing life skills among youth, e.g., problem-solving, coping, anger management, emotional awareness and regulation.
·increasing nurturing environments and positive youth development
·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
·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 to recognize, assess, and manage suicidal thoughts and behaviors

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

With 3-year grant funding received by the Public Health Division from the Garrett Lee Smith Memorial Act (GLS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) in October 2009, youth suicide prevention activities have been implemented in 19 Oregon counties. Those counties have trained nearly 200 English and Spanish trainers in basic and advanced intervention skills, held over 400 trainings, implemented the comprehensive high

school-based program, RESPONSE in 90 schools, worked with local coalitions on youth suicide prevention, and reached a million Oregonians through public education campaigns. They have trained over 100 mental health practitioners to assess and manage suicide risk. The grant funded 5 counties to provide prevention and outreach to Latino communities and youth. The state has successfully worked to increase local capacity and build sustainability for youth suicide prevention in grant-funded counties. A consortium of 8 colleges and universities are implementing suicide prevention on campuses. The Native American Rehabilitation Association (NARA) received a third 3-year GLS grant; the Confederated Tribes of Umatilla Indians received a GLS grant in 2011. All 9 federally-recognized tribes in Oregon collaborate on a youth summer camp to provide adult mentors, increase youth leadership, and teach traditional practices to youth. School-Based Health Centers receive support to serve students on funded campuses to provide enhanced mental health services. Public Health is working with Addictions & Mental Health, NARA, the 9 tribes, the Commission on Children and Families, and many private organizations to increase skills, knowledge, and training. Data collected through Oregon's Violent Death Reporting System and the Injury Epidemiology Program help inform prevention priorities. The Health Division selected suicide prevention as a priority for the next 5 years; the program is moving towards true primary prevention to increase the prevalence of nurturing environments and to prevent mental, emotional, and behavioral disorders. This approach applied throughout state government will reduce not only suicide and mental illness, but also abuse and neglect, academic failure, crime, drug addiction, risky sexual behavior, poverty, and physical illness.

4. HOW WE COMPARE

Oregon's youth suicide rate (ages 10-24) ranks 24th among states. The state rate of 8.13 per 100,000 (2009 most recent national comparison data) is greater than the national rate of 7.34 per 100,000.

5. FACTORS AFFECTING RESULTS

A national, state, and local focus on funding prevention programs for specific, targeted risk behaviors among adolescents prohibits a coordinated and comprehensive approach to true primary prevention of mental, emotional, and behavioral disorders. Funding is dependent on special grants and foundation awards with no assurance they will be funded in the long term. There are not enough staff and resources to implement comprehensive efforts statewide. 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

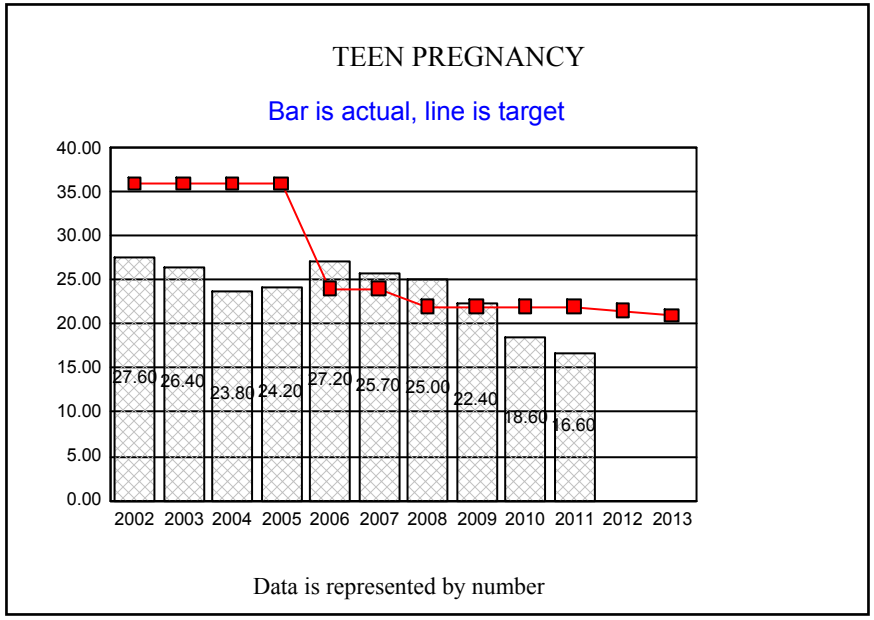
State prevention activities and funding need to be coordinated among agencies and programs to prevent child maltreatment and to provide evidence-based support and education for families, schools, and communities. Change focus to coordinate early primary prevention among state and community programs and agencies; decrease focus on risk behaviors in favor of promoting population-wide, evidence-based programs that increase and support nurturing environments. Increase implementation of a comprehensive school-based program, RESPONSE; continue to build capacity of intervention skills training among mental health professionals, healthcare providers, school staff and others who work with youth; provide bereavement support for parents and children; and assure sustainability of the efforts

made to date. Use national research, evaluation results from the GLS grant and data from ORVDRS and Injury to provide information on how to broaden those efforts.

7. ABOUT THE DATA

Reporting cycle – calendar year. The data are provided by the Oregon Violent Death Reporting System from the Center for Public Health Practice's death certificate database, medical examiner reports and local police agencies. The data include youth aged 10-24 years of age. Some suicides may be excluded as local medical examiners might 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 #24	TEEN PREGNANCY - The number of female Oregonians ages 15 - 17, per 1,000, who are pregnant.	2000
Goal	Helping people achieve optimum physical, mental and social well-being.	
Oregon Context	This performance measure links to the OHA Goal to “Improve the lifelong health of all Oregonians .” This measure also links to Oregon Benchmark #39 and two Title V Performance Measures; “Rate of birth (per 1000) for teenagers aged 15 through 17 years” and “percent of births that are intended.”	
Data Source	Oregon Center of Health Statistics and PSU Center for Population and Census estimates. Based on births and induced terminations. Population estimates provided by the Center for Population and Census.	
Owner	OHA - Public Health Division, Center for Prevention and Health Promotion, Adolescent Health Program, Bob Nystrom (971) 673-0243	



1. OUR STRATEGY

The Oregon Youth Sexual Health Plan (the plan) is the guiding document for teen pregnancy prevention activities. The plan emphasizes adults’ responsibility to

ensure availability of accurate information, skill-building opportunities, and quality health services for all youth. It also recognizes that youth must be centrally involved in defining their own needs and identifying programs and policies that support their health. The Oregon Youth Sexual Health Partnership (OYSHP) is a statewide public-private partnership charged with supporting and coordinating activities that promote youth sexual health and reduce the risk of early, unintended pregnancy and other negative outcomes.

The federal Personal Responsibility Education Program (PREP) grant, administered by the Office of Family Health, supports implementation of ¡Cuídate!, a Latino-focused evidence-based HIV prevention program in six Oregon counties. ¡Cuídate! addresses Oregon's significant disparity in Hispanic teen birth rates and teen pregnancy rates. Though the focus is on HIV Prevention, the behaviors ¡Cuídate! seeks to change are the same behaviors that lead to unplanned pregnancy. The Office of Family Health collaborates with other agencies in Oregon receiving federal teen pregnancy prevention funding.

2. ABOUT THE TARGETS

Teen pregnancy is closely linked to a number of other critical issues, including poverty, income disparity, high school completion, and overall child and family well-being. In Oregon, the estimated annual cost associated with teen pregnancy (ages 15-19) is $110 million (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011). Reducing teen pregnancy would reduce the risk of negative social, education, and health outcomes and lead to cost savings.

Oregon uses the 15-17 year-old group for its teen pregnancy KPM. Although teen pregnancy rates are often reported for 15-19 year olds, the 15-17 year old rate is of more concern as this group of teens is more vulnerable to the negative outcomes of pregnancy than older teens. 15-17 year olds are also able to access prevention education and services through school and other programs more readily than 18-19 year olds.

This target is based on a desired downward trend. Having a rate to 21 per 1,000 or lower by 2013 would put the state on a positive trajectory.

3. HOW WE ARE DOING

Preliminary data for 2011 shows the lowest teen pregnancy rate since data have been reported. The preliminary rate of 16.6 per 1,000 shows a significant decrease from 2010 to 2011. The teen pregnancy rate did not change from 2007 to 2008 (25.7 per 1,000 both years). Oregon had the first increase in teen pregnancy rates in 10 years in 2005 (from 23.8 to 24.2 per 1,000). There was another increase in 2006 to 27.2 per 1,000. Among 15-17 year-olds in Oregon, the pregnancy rate fell 27% between 2008 and 2010.

4. HOW WE COMPARE

The State's teen pregnancy rate has consistently been lower than the national rate. In 2008 (the most recent national data available), Oregon's 15-17 year old teen pregnancy rate was 25.7 per 1,000 and the national rate was 36.8 per 1,000.

5. FACTORS AFFECTING RESULTS

Teen pregnancy is tied to social, economic and educational factors. Sexual behaviors that may lead to teen pregnancy are influenced by poverty, discrimination, gender inequities, and gender role expectations. Barriers to reducing teen pregnancy include lack of access to medically accurate, age-appropriate sexuality education and reproductive health services. Facilitators to preventing teen pregnancy include providing reproductive health care and offering comprehensive sexuality education, as outlined in ORS 336.455. Oregon supports the provision or referral of reproductive health care to youth at School-Based Health Centers and provides comprehensive services at Title X and CCare supported family planning clinics throughout the state. Oregon has a strong comprehensive sexuality education law; decisions on how to provide that education are made at the local level. On April 1, 2012, Oregon ContraceptiveCare (CCare) increased the income eligibility for enrollment to 250% of the Federal Poverty Level (FPL). This change means that more Oregonians, inducing teens, will have access to family planning services through CCare.

6. WHAT NEEDS TO BE DONE

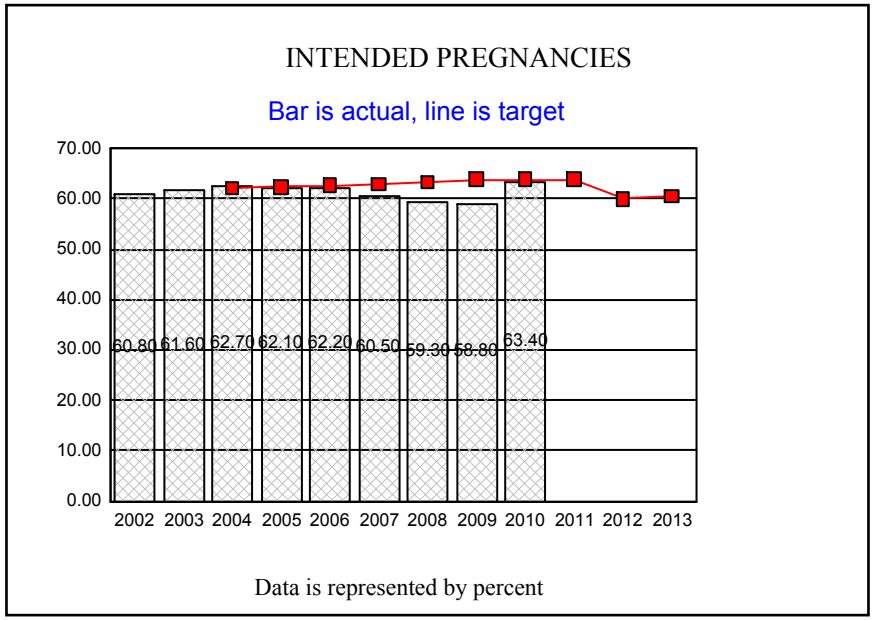
The Oregon Health Authority will continue to support communities in implementing activities that align with the Oregon Youth Sexual Health Plan. More work can be done in understanding and addressing racial and ethnic disparities in teen pregnancy rates.

7. ABOUT THE DATA

2011 data are preliminary.Reporting cycle - calendar year. The data are generally 1 ½ to 2 years behind. In Oregon, pregnancy numbers specific to racial/ethnic groups are reported only over a three-year cumulative period, rather than annually, due to the challenges of small numbers and reliability of race/ethnicity reporting. It is important to note that the Oregon-reported teen pregnancy rate reflects the number of births and abortions. National teen pregnancy rates often include miscarriages and still births in the pregnancy rate; therefore, comparing Oregon and National data is not always an exact comparison. Oregon data is available at: http://public.health.oregon.gov/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/TEENPREGNANCY/Pages/index.aspx.

National pregnancy data is available from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics at: http://www.cdc.gov/nchs/data/databriefs/db58.pdf.

KPM #25	INTENDED PREGNANCY - The percentage of births where mothers report that the pregnancy was intended.	2006
Goal	People are healthy.	
Oregon Context	Oregon Benchmark #39 - Teen pregnancy	
Data Source	OHA - Public Health Division, Office of Family Health, Pregnancy Risk Assessment Monitoring System (PRAMS) survey	
Owner	OHA - Public Health Division, Center for Prevention and Health Promotion, Reproductive Health Program, Bob Nystrom (971) 673-0243	



1. OUR STRATEGY

Through a network of approximately 170 county health department clinics, private providers, and other local agencies, the state Reproductive Health Program provides contraceptive services and supplies to enable all individuals to plan and space their pregnancies as desired.

2. ABOUT THE TARGETS

Modest targets have been set given limited program budget and the complex nature of pregnancy intent. The target is based on a desired upward trend.

3. HOW WE ARE DOING

Between 2002 and 2006, there was a slight increase in the percentage of births where mothers reported that the pregnancy was intended. In 2007, the percentage of intended births began to slowly decrease but then jumped to its highest rate of 63.4% in 2010. It should be noted that none of these changes have been statistically significant since tracking of the outcome began in 2002.

4. HOW WE COMPARE

As of 2008, the most recent year for which national data is available, Oregon ranked 14th (among the 29 states that participate in PRAMS) for rates of pregnancies that are intended, the highest being New York State at 70.4% and the lowest being Mississippi at 41.7%. The Healthy People 2020 objective related to intended pregnancy (Objective FP-1) sets the target of 56.0% of all pregnancies that are intended, which is significanly lower than the ambitious goal of 70% set for Healthy People 2010 (Objective 9-1). Oregon is currently meeting the new goal set by Healthy People 2020, and is similar to comparative states, such as Washington and Colorado, where rates in 2008 (the most recent year for which data is available) were 63.3% and 63.1%, respectively.

5. FACTORS AFFECTING RESULTS

One important obstacle to increasing intended pregnancy is the limited funding available for family planning programs. Oregon's Title X program—the federal grant program devoted to family planning and reproductive health care—has been flat-funded for several years, which translates to a decrease in funding when adjusted for inflation and the rising cost of providing medical care. Oregon also administers a Medicaid family planning waiver, OregonContraceptiveCare, and clients of that program have been adversely affected by eligibility changes to the waiver, including citizenship documentation requirements of the Federal Deficit Reduction Act, implemented in 2006. OregonContraceptiveCare has been unable to restore client volume to pre-2006 levels. Additionally, lack of support and funding for strategic outreach and marketing efforts to populations in need has contributed to the limited growth in client numbers.

Furthermore, pregnancy intent is influenced by an often complex mix of feelings about pregnancy, childbearing, intimate relationships and other issues. Given the importance of these factors, there is a limit to what state-level programs can do to increase the proportion of pregnancies that are intended. Comprehensive access to high-quality family planning services should be considered a necessary, but not sufficient, step toward achieving significant increases in intended pregnancy. It should be noted that recently enacted provisions of the Affordable Care Act (ACA) regarding coverage of women's preventative services, including

contraception, without cost sharing, should increase access to family planning services among those with insurance and thereby help to reduce unintended pregnancy rates.

6. WHAT NEEDS TO BE DONE

Current family planning activities should continue and every effort should be made to expand funding and reduce barriers to access to free or low-cost contraceptive services for low-income individuals. In particular, recent research has supported the use and promotion of long acting reversible contraceptives (LARCs), especially among youth in transition (e.g. adolescents, women in college, etc.), to reduce unintended pregnancies. Efforts around health system transformation in Oregon have also recognized the importance of providing access to high-quality family planning services. In fact, effective contraceptive use among women who do not desire pregnancy is a required core measure for years 1 and 2 for newly developed Coordinated Care Organizations (CCOs), although it is still too early to predict the impact this measure will have on service delivery.

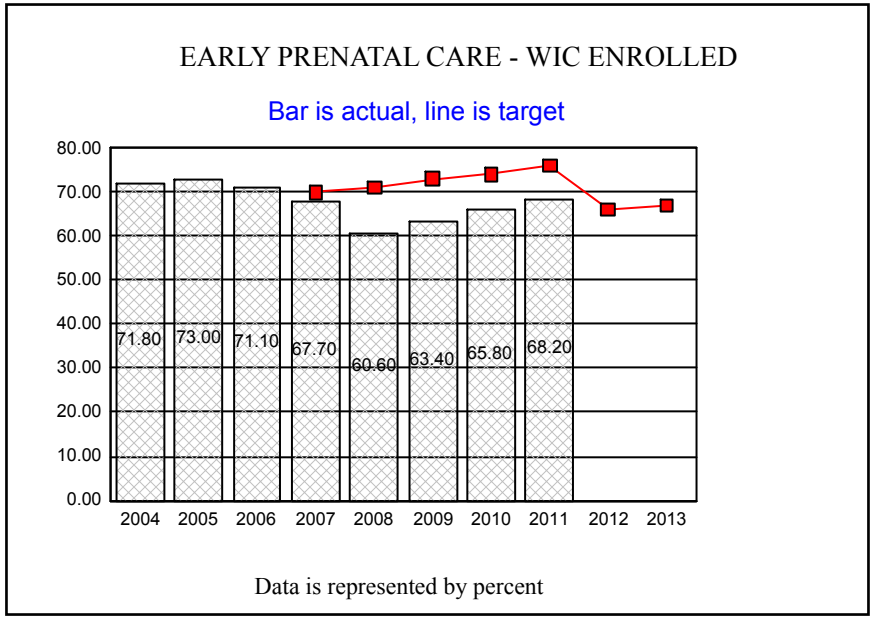
Research also suggests that pregnancy intention, specifically unwanted and ambivalent, may be associated with increased risk for both poor fetal and maternal health outcomes. Therefore, an increased focus on preconception care within the context of family planning visits will help women to plan and space healthy pregnancies. Specifically, more preconception and interconception care may lead to better long-term reproductive care planning (such as improving the effectiveness of contraceptive methods used). Providers should be educating women about optimal health and family planning methods, as well as increasing emphasis on postpartum care to minimize subsequent unintended pregnancies. Providers should also increase preventive counseling to women about the availability of emergency contraception (EC).

Finally, it is essential to support youth in making healthy, positive choices about sexual health. Medically accurate and evidence-based comprehensive sexuality education and skill-building programs should be supported and expanded for youth and families.

7. ABOUT THE DATA

Reporting cycle - calendar year: data are aggregated based on respondents' child's year of birth. (Oregon data is available at: http://www.oregon.gov/DHS/ph/pnh/prams/index.shtml). The 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 of women's feelings about pregnancy and childbearing can make pregnancy intent difficult to measure accurately. A weakness of the data is that it relies on women to accurately report how they felt about becoming pregnant almost a year before they actually complete the survey.

KPM #26a	EARLY PRENATAL CARE - The percentage of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women: a) WIC enrolled (low-income women)	2010
Goal	People are healthy	
Oregon Context	Prenatal care	
Data Source	OHA, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Birth Certificates)	
Owner	OHA - Public Health Division, Center for Prevention & Health Promotion, Cate Wilcox (971) 673-0299	



1. OUR STRATEGY

The goal of this measure is to increase access to early prenatal care for all women and reduce the disparity in access between low-income and the general population. The gap in access to prenatal care has been widening between low-income and all other births, even as prenatal care rates are stable for the whole

population. The PHD, Office of Family Health (OFH), promotes early prenatal care through the Oregon MothersCare Program, Family Planning, and the Preconception Health Initiative. Other state and community services and private health care providers also promote early access to prenatal care in coordination with PHD programs. This KPM will evaluate the effectiveness of the state and local system of services and programs that provide, promote, and coordinate prenatal care for all pregnant women, especially for low-income and underserved women.

Office of Family Health (OFH) is continuing to provide funding and technical support for Oregon MothersCare (OMC), a program that collaborates with the Division of Medical Assistance Programs (DMAP), the agency that administers the Oregon Health Plan (OHP), to assist pregnant women in entering early prenatal care. The OMC program has expanded from five sites serving fewer than 1,000 low-income women in 2000 to 29 sites that served 4,817 women in 2010 with 17,942 referrals to prenatal care and other services. OFH also supports SafeNet, the toll-free hotline for referrals to local prenatal services. In addition, DMAP expedites applications for OHP from pregnant women. Weekly, DMAP sends its contracted managed care plans a download of members from which the plan can identify pregnant women. Plans use this information to make timely contact and help arrange the first prenatal visit. DMAP places regular messages on the monthly medical card emphasizing the importance of initiating early prenatal care.

2. ABOUT THE TARGETS

The targets were developed for a different data source (survey) that yielded slightly higher rates. The present rates are 4 to 7 percentage points below these targets. The National Title V Performance Measure and the Healthy People 2010 target for early prenatal care is 90% of infants born to pregnant women, **of all income ranges**, initiating prenatal care in the first trimester.

3. HOW WE ARE DOING

There has been a decrease (from 14.5 percentage points to 12.2 percentage points) in the gap between early prenatal care for WIC and non-WIC women from 2004-2010. There has been a decrease in early prenatal care for non-WIC women (2004-2010). There has been a smaller decrease in early prenatal care for WIC women (2004-2010). Birth certificate changes that began in 2008 make analysis of trends over time difficult to interpret. Since most WIC-enrolled women are enrolled in Medicaid, there is a similar gap in early prenatal care for Medicaid and non-Medicaid enrolled women.

4. HOW WE COMPARE

The lives of low-income women have more complexity than non-low-income women's (e.g., transportation, high attention to basic living needs) giving them less time to focus on their own health care. Although this measure is for women entering prenatal care in the first 3 months of pregnancy, a comparison between OMC clients (where 85% of clients apply for OHP) and OHP clients in general illustrates the importance of supporting these women in accessing services. In 2010,

approximately 82% of women receiving services through OMC during their first trimester entered prenatal care during the first trimester or within 15 days of their OMC visit. This includes women who are low-income but ineligible for Oregon Health Plan (OHP) coverage. Among women who report OHP/Medicaid as their delivery payment source, the percent of first trimester care is consistenly slightly less than 70%. Although OHP applications from pregnant women are expedited, Oregon does not have Medicaid presumptive eligibility for pregnant women. Presumptive eligibility allows pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed. Nationally, thirty-one states have Medicaid presumptive eligibility. According to the National Academy for State Health Policy, "Early prenatal care plays a critical role in the health of pregnant women and their babies. Access to early prenatal care can lead to better birth outcomes, healthier babies, and reduced health care costs. Presumptive eligibility in Medicaid has become an important strategy for improving access to prenatal care for low-income pregnant women" (2008).

5. FACTORS AFFECTING RESULTS

When low-income women who are not already covered by Medicaid become pregnant, they must apply for OHP after they find out that they are pregnant. It is likely 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. Presumptive eligibility would allow pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed. The Prenatal Care Expansion Program provides OHP Plus coverage for prenatal services in 14 participating counties as of July 2011 to pregnant women who would otherwise be eligible for OHP except for their immigration status. These are women who would qualify for CAWEM coverage. While we do not know exactly the extent of this population, the Hispanic population is the largest community with potential immigration status barriers. The number of Hispanic births in Oregon has stayed relatively constant over the past five years (19.9% in 2005 to 20.2% in 2010).

6. WHAT NEEDS TO BE DONE

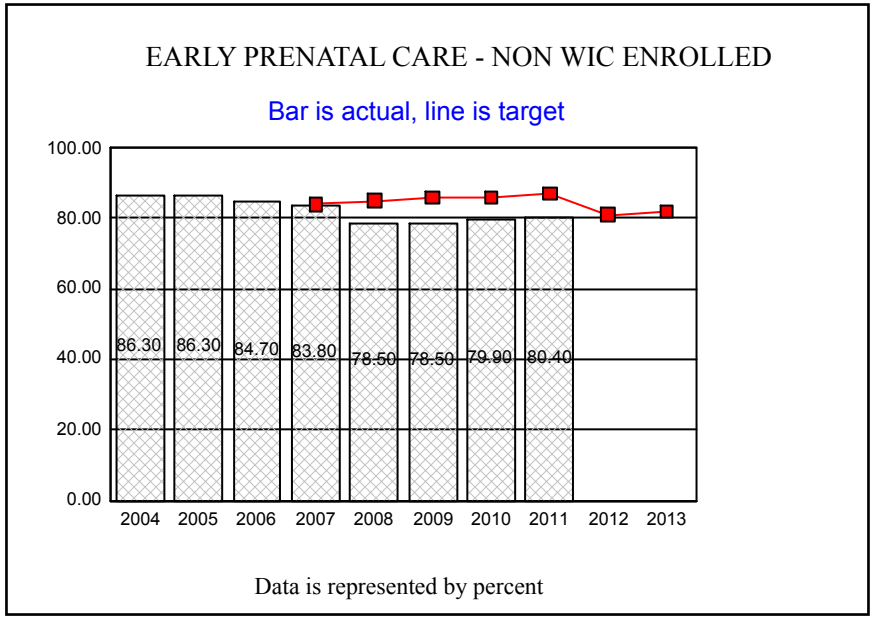
1) Presumptive eligibility should be considered as a policy option in the Coordinated Care Organization (CCO) structure.
2) Continue to fund PHD, DMAP and OHA initiatives.
3) Continue to work with partners to effectively communicate the importance of early prenatal care.
4) OFH and DMAP will continue to collaborate through the Oregon MothersCare program.

7. ABOUT THE DATA

OFH uses birth certificate record information to monitor trends in birth outcomes. For monitoring trends for disparity in access to early prenatal care from this data source, a proxy for low-income and non-low-income women is the number of women reporting that they were enrolled, or not enrolled, in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for one or more months during pregnancy. Eligibility for enrollment requires a family income of ≤185% Federal Poverty Level (FPL) and is the best available data for estimating low-income status in pregnancy.

The measure has two parts: a) Low-income women with first trimester care: the numerator is the number of live births whose mothers report prenatal care in the first 3 months and who report enrollment in WIC during pregnancy, and the denominator is all mothers who report enrollment in WIC during pregnancy; and b) Non-low-income women with first trimester care: the numerator is the number of live births whose mothers report prenatal care in the first 3 months and who report not being enrolled in WIC during pregnancy, and the denominator is all mothers who reported not enrolled in WIC during pregnancy.

KPM #26b	EARLY PRENATAL CARE - The percentage of low income women who initiated prenatal care in the first 3 months of pregnancy compared to non-low income women: b) Non WIC enrolled (non low-income women)	2010
Goal	People are healthy	
Oregon Context	Prenatal care	
Data Source	OHA, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Birth Certificates)	
Owner	OHA - Public Health Division, Center for Prevention & Health Promotion, Cate Wilcox (971) 673-0299	



1. OUR STRATEGY

The goal of this measure is to increase access to early prenatal care for all women and reduce the disparity in access between low-income and the general population. The gap in access to prenatal care has been widening between low-income and all other births, even as prenatal care rates are stable for the whole

population. The PHD, Office of Family Health (OFH), promotes early prenatal care through the Oregon MothersCare Program, Family Planning, and the Preconception Health Initiative. Other state and community services and private health care providers also promote early access to prenatal care in coordination with PHD programs. This KPM will evaluate the effectiveness of the state and local system of services and programs that provide, promote, and coordinate prenatal care for all pregnant women, especially for low-income and underserved women.

Office of Family Health (OFH) is continuing to provide funding and technical support for Oregon MothersCare (OMC), a program that collaborates with the Division of Medical Assistance Programs (DMAP), the agency that administers the Oregon Health Plan (OHP), to assist pregnant women in entering early prenatal care. The OMC program has expanded from five sites serving fewer than 1,000 low-income women in 2000 to 29 sites that served 4,817 women in 2010 with 17,942 referrals to prenatal care and other services. OFH also supports SafeNet, the toll-free hotline for referrals to local prenatal services. In addition, DMAP expedites applications for OHP from pregnant women. Weekly, DMAP sends its contracted managed care plans a download of members from which the plan can identify pregnant women. Plans use this information to make timely contact and help arrange the first prenatal visit. DMAP places regular messages on the monthly medical card emphasizing the importance of initiating early prenatal care.

2. ABOUT THE TARGETS

The targets were developed for a different data source (survey) that yielded slightly higher rates. The present rates are 4 to 7 percentage points below these targets. The National Title V Performance Measure and the Healthy People 2010 target for early prenatal care is 90% of infants born to pregnant women, **of all income ranges**, initiating prenatal care in the first trimester.

3. HOW WE ARE DOING

There has been a decrease (from 14.5 percentage points to 12.2 percentage points) in the gap between early prenatal care for WIC and non-WIC women from 2004-2010. There has been a decrease in early prenatal care for non-WIC women (2004-2010). There has been a smaller decrease in early prenatal care for WIC women (2004-2010). Birth certificate changes that began in 2008 make analysis of trends over time difficult to interpret. Since most WIC-enrolled women are enrolled in Medicaid, there is a similar gap in early prenatal care for Medicaid and non-Medicaid enrolled women.

4. HOW WE COMPARE

The lives of low-income women have more complexity than non-low-income women's (e.g., transportation, high attention to basic living needs) giving them less time to focus on their own health care. Although this measure is for women entering prenatal care in the first 3 months of pregnancy, a comparison between OMC clients (where 85% of clients apply for OHP) and OHP clients in general illustrates the importance of supporting these women in accessing services. In 2010, approximately 82% of women receiving services through OMC during their first trimester entered prenatal care during the first trimester or within 15 days of their

OMC visit. This includes women who are low-income but ineligible for Oregon Health Plan (OHP) coverage. Among women who report OHP/Medicaid as their delivery payment source, the percent of first trimester care is consistenly slightly less than 70%. Although OHP applications from pregnant women are expedited, Oregon does not have Medicaid presumptive eligibility for pregnant women. Presumptive eligibility allows pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed. Nationally, thirty-one states have Medicaid presumptive eligibility. According to the National Academy for State Health Policy, "Early prenatal care plays a critical role in the health of pregnant women and their babies. Access to early prenatal care can lead to better birth outcomes, healthier babies, and reduced health care costs. Presumptive eligibility in Medicaid has become an important strategy for improving access to prenatal care for low-income pregnant women" (2008).

5. FACTORS AFFECTING RESULTS

When low-income women who are not already covered by Medicaid become pregnant, they must apply for OHP after they find out that they are pregnant. It is likely 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. Presumptive eligibility would allow pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed. The Prenatal Care Expansion Program provides OHP Plus coverage for prenatal services in 14 participating counties as of July 2011 to pregnant women who would otherwise be eligible for OHP except for their immigration status. These are women who would qualify for CAWEM coverage. While we do not know exactly the extent of this population, the Hispanic population is the largest community with potential immigration status barriers. The number of Hispanic births in Oregon has stayed relatively constant over the past five years (19.9% in 2005 to 20.2% in 2010).

6. WHAT NEEDS TO BE DONE

1) Presumptive eligibility should be considered as a policy option in the Coordinated Care Organization (CCO) structure.
2) Continue to fund PHD, DMAP and OHA initiatives.
3) Continue to work with partners to effectively communicate the importance of early prenatal care.
4) OFH and DMAP will continue to collaborate through the Oregon MothersCare program.

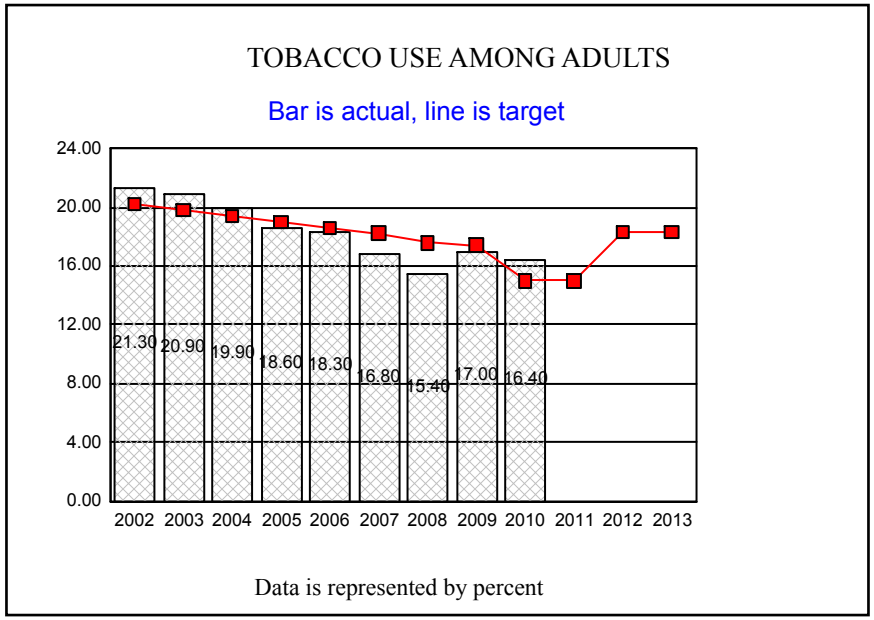
7. ABOUT THE DATA

OFH uses birth certificate record information to monitor trends in birth outcomes. For monitoring trends for disparity in access to early prenatal care from this data source, a proxy for low-income and non-low-income women is the number of women reporting that they were enrolled, or not enrolled, in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for one or more months during pregnancy. Eligibility for enrollment requires a family income of ≤185% Federal Poverty Level (FPL) and is the best available data for estimating low-income status in pregnancy.

The measure has two parts: a) Low-income women with first trimester care: the numerator is the number of live births whose mothers report prenatal care in the

first 3 months and who report enrollment in WIC during pregnancy, and the denominator is all mothers who report enrollment in WIC during pregnancy; and b) Non-low-income women with first trimester care: the numerator is the number of live births whose mothers report prenatal care in the first 3 months and who report not being enrolled in WIC during pregnancy, and the denominator is all mothers who reported not enrolled in WIC during pregnancy.

KPM #27a	TOBACCO USE - Tobacco use among adults.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks:#44 - Adult non-smokers#45 - Preventable death#50 - 8th grade substance abuse#53 - Tobacco abstinence during pregnancy	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	OHA - Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099.	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are

accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach to effectively decrease tobacco use.

2. ABOUT THE TARGETS

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

3. HOW WE ARE DOING

Among Oregon adults, the prevalence of smoking was 16.4% in 2010. The prevalence of smoking among 8th grade adolescents was 9.9% in 2009 (in 2010, these data were not collected). Finally, among women who had a live birth (pregnant women), the prevalence of smoking was 13.4% in 2009. Designated targets were not reached for any of the population groups, however, the data on tobacco use during pregnancy are now collected using a different method than when this measure was originally proposed (the change was enacted in January 2008). Although it was anticipated that the newly measured prevalence would be higher, the extent of the difference could not be determined, so the targets were kept static despite underlying change in the measurement.

4. HOW WE COMPARE

For adult smoking prevalence, the Healthy People 2010 target was 12%. This target remained unchanged in the revamped, updated Healthy People 2020. By dedicating substantial resources to tobacco prevention, Oregon may be able to meet this target by 2020, but current resources are likely insufficient to enable Oregon to reach this target.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended funding is $11.60 per capita, which

equates to $43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.2 billion lost to medical care and lost productivity annually in Oregon.

During the 2009-2011biennium, Oregon spent $3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennia, Oregon was funded at $2.10 per capita for tobacco prevention from all funding sources. For most of the 2001-2003 biennium, TPEP received approximately $2.87 per capita per year, although from April 2003 through the end of the biennium the program was shuttered when the Legislature redirected monies that had been allocated to TPEP. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented.

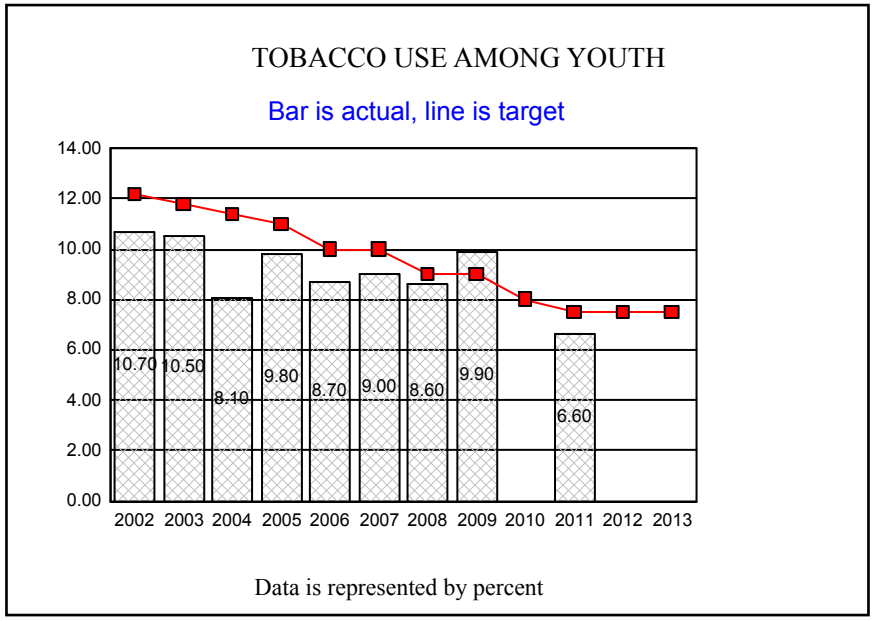
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. 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

Smoking prevalence among adult Oregonians is on an annual reporting cycle, computed once per calendar year. The estimate is derived from the Oregon Behavioral Risk Factor Surveillance System, a telephone-administered survey of adults that examines health related behaviors. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. Disadvantages associated with BRFSS include its reliance upon telephone landlines, which are increasingly less common among younger age groups, people with low income, and certain racial and ethnic populations. Estimates calculated in for 2011 and later will account for these factors, and thus will be higher than estimates calculated for 2010 and earlier.

KPM #27b	TOBACCO USE - Tobacco use among youth.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks: #45 - Preventable death#50 - 8th grade substance abuse	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	OHA - Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are

accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach to effectively decrease tobacco use.

2. ABOUT THE TARGETS

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

3. HOW WE ARE DOING

Among Oregon adults, the prevalence of smoking was 16.4% in 2010. The prevalence of smoking among 8th grade adolescents was 9.9% in 2009 (in 2010, these data were not collected). Finally, among women who had a live birth (pregnant women), the prevalence of smoking was 13.4% in 2009. Designated targets were not reached for any of the population groups, however, the data on tobacco use during pregnancy are now collected using a different method than when this measure was originally proposed (the change was enacted in January 2008). Although it was anticipated that the newly measured prevalence would be higher, the extent of the difference could not be determined, so the targets were kept static despite underlying change in the measurement.

4. HOW WE COMPARE

For adolescent smoking prevalence, the Healthy People 2010 target was 16%. This target remained unchanged in the revamped, updated Healthy People 2020. The Health Authority's measurement represents 8th graders, but the 11th grade-smoking rate was 14.9% in Oregon in 2009. If this trend continues, Oregon's 11th grade smoking rates will likely remain lower than Healthy People 2020's 16% target.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended funding is $11.60 per capita, which

equates to $43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.2 billion lost to medical care and lost productivity annually in Oregon.

During the 2009-2011biennium, Oregon spent $3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennia, Oregon was funded at $2.10 per capita for tobacco prevention from all funding sources. For most of the 2001-2003 biennium, TPEP received approximately $2.87 per capita per year, although from April 2003 through the end of the biennium the program was shuttered when the Legislature redirected monies that had been allocated to TPEP. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented.

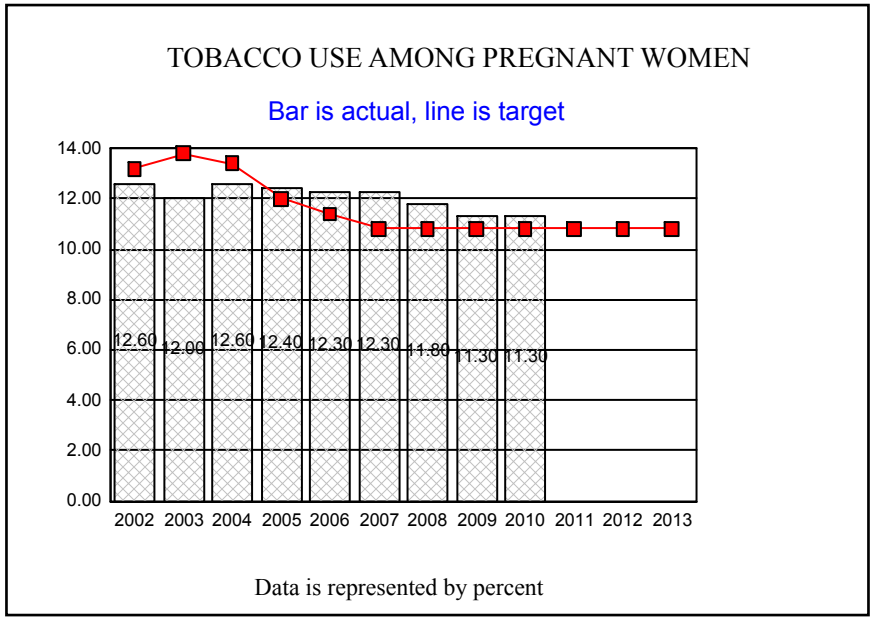
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. 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

Smoking prevalence among 8th graders in Oregon is now on a biennial reporting cycle, computed for odd years. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper survey administered to students at school. Data were not collected for 2010.

KPM #27c	TOBACCO USE - Tobacco use among pregnant women.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks#45 - Preventable Death#53b - Tobacco Abstinence During Pregnancy	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	OHA - Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

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

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

2. ABOUT THE TARGETS

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

3. HOW WE ARE DOING

Among Oregon adults, the prevalence of smoking was 16.4% in 2010. The prevalence of smoking among 8th grade adolescents was 9.9% in 2009 (in 2010, these data were not collected). Finally, among women who had a live birth (pregnant women), the prevalence of smoking was 13.4% in 2009. Designated targets were not reached for any of the population groups, however, the data on tobacco use during pregnancy are now collected using a different method than when this measure was originally proposed (the change was enacted in January 2008). Although it was anticipated that the newly measured prevalence would be higher, the extent of the difference could not be determined, so the targets were kept static despite underlying change in the measurement.

4. HOW WE COMPARE

Data on tobacco use during pregnancy are now collected using a different methodology than when this measure was originally proposed (the change was enacted in Oregon in January 2008). Although it was anticipated that the newly measured prevalence would be higher (and the data have indeed been higher), the extent of the difference could not be determined, so the targets remained static despite the underlying change in the measurement. National data isn't yet available using this new data collection methodology. It is therefore currently not possible to assess how Oregon's measure compares to the nation.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended funding is $11.60 per capita, which

equates to $43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.2 billion lost to medical care and lost productivity annually in Oregon.

During the 2009-2011biennium, Oregon spent $3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennia, Oregon was funded at $2.10 per capita for tobacco prevention from all funding sources. For most of the 2001-2003 biennium, TPEP received approximately $2.87 per capita per year, although from April 2003 through the end of the biennium the program was shuttered when the Legislature redirected monies that had been allocated to TPEP. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented.

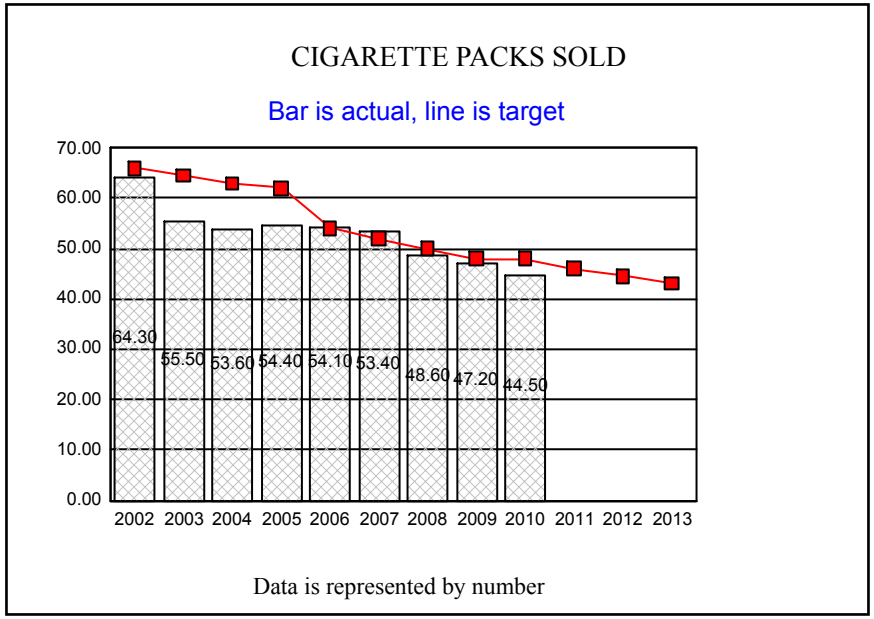
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. 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

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. One disadvantage is that the federal requirements for collecting data via the birth file changed in 2003, and in Oregon this change took effect in 2008.

KPM #28	CIGARETTE PACKS SOLD - Number of cigarette packs sold per capita.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks#44 - Adult Non-Smokers#45 - Preventable Death#50c - 8th Grade Substance Abuse (cigarettes)#53b - Tobacco Abstinence During Pregnancy	
Data Source	Oregon Department of Revenue (Cigarette Tax Receipts); Portland State University, Population Research Center (Population Estimates)	
Owner	OHA - 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 Oregonians. This goal is accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program,

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

2. ABOUT THE TARGETS

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

3. HOW WE ARE DOING

In 2010, 44.5 packs of cigarette packs were sold for every Oregon resident. This measure surpasses the target for 2010. Moreover, from 2008 onward, these data points have represented a welcome change compared with 2003-07, a period during which per capita cigarette packs sold stagnated.

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 2010, conversely, U.S. per capita sales of cigarette packs was 44.5 (2.8 packs per capita higher than Oregon). The current difference between Oregon and the U.S. represents a much steeper decline in per capita cigarette sales in Oregon, on average, than in the rest of the country.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, and to eliminate nonsmokers' exposure to secondhand smoke. For Oregon, the recommended funding is $11.60 per capita, which equates to $43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.2 billion lost to medical care and lost productivity annually in Oregon.

During the 2009-2011biennium, Oregon spent $3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennia, Oregon was funded at $2.10 per capita for tobacco prevention from all funding sources, and for most of the 2001-2003 biennium, the TPEP received approximately $2.87 per capita per year. TPEP also had to shutter its program from April 2003 through the end of the biennium when the Legislature redirected monies that had

been allocated to TPEP. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented.

6. WHAT NEEDS TO BE DONE

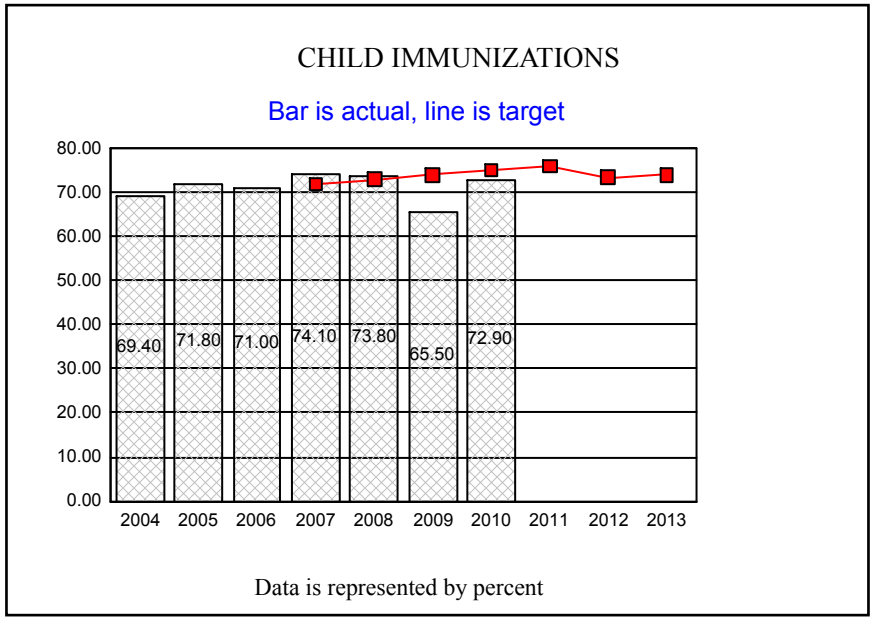
Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. Prior successes in Oregon and a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

7. ABOUT THE DATA

Average per capita cigarette consumption is estimated from tobacco tax revenue data. An economic consulting firm, Orzechowski and Walker, collects these data from states' revenue departments and issues monthly and annual summary reports. As the summary reports describe fiscal year pack sales, monthly reports are summed to determine calendar year sales for each state. The total number of cigarettes sold for each state is divided by the U.S. Census population estimate to determine per capita consumption.

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. Surveillance data collected by TPEP indicates that untaxed cigarettes represent a small fraction of the cigarettes Oregon smokers consume, however.

KPM #29	CHILD IMMUNIZATIONS - The percentage of 24-35 month old children who are adequately immunized.	2002
Goal	People are healthy.	
Oregon Context	Immunizations, Child mortality	
Data Source	Public Health Division, Office of Family Health (ALERT Registry)	
Owner	OHA - Public Health Division, Center for Public Health Practice, Immunization Program, Lorraine Duncan (971) 673-0283	



1. OUR STRATEGY

The Vaccines for Children program supplies vaccine and technical assistance to private and public providers who serve eligible children. The ALERT Immunization Information System (IIS) maintains a clinical database of all reported vaccine for provider reference and identifies all shots due. Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Education and training opportunities are held for

providers throughout the year to provide up-to-date information about vaccine efficacy, safety, reporting, as well as storage and handling.

2. ABOUT THE TARGETS

The goal is to increase immunization rates to meet the Healthy People 2010 objective of 90% coverage for vaccines included in the 4:3:1:3:3:1 series.Healthy People 2020 has a goal of 80% coverage for all vaccines in the series 4:3:1:3:3:1:4, which includes the Pneumococcal Conjugate Vaccine, and we will also track Oregon's progress in achieveing this goal.

3. HOW WE ARE DOING

Oregon two-year old immunization rates have seen incremental improvement since population-based data assessments began in 2004 through 2008. There was a decrease in rates in 2009, largely attributable to a vaccine shortage for the *Haemophilus Influenzae* type b vaccine. Rates recoveredin 2010, once the effect of the Hib vaccine shortage was mostly resolved. The rate is calculated for 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; three or more doses of hepatitis B; and one or more doses of varicella (4:3:1:3:3:1).

4. HOW WE COMPARE

This KPM reflects children 24-35 months olds with vaccines reported to the statewide immunization information system (IIS). A national comparison is difficult because national data is based on the National Immunization Survey (NIS), a phone survey of a limited sample of Oregon residents 19-35 months of age. However, the national NIS rate for the 4:3:1:3:3:1 series in 2010 was 74.9% (+/- 1.2%), with 69.3% (+/- 6.3%) for Oregon, 73.7% (+/- 5.4%) for Washington and 61.2% (+/- 6.7%) for Idaho.

5. FACTORS AFFECTING RESULTS

The percentage of Oregon two year olds who are adequately immunized has seen modest growth from 2004-2008. However, our 2009 rates saw a notable decline compared to 2008 (decrease from 73.8% to 65.5%) for coverage among 24-35 months old with the same vaccine series as assessed in previous years. The reason for this decline can be directly attributed to the national shortage of Hib vaccine that occurred from December 2007 through July 2009. Children included in the 2009 rate assessment were directly impacted by this vaccine shortage, as demonstrated by the fact that our up-to-date rate for the series excluding Hib continues to be at 73%. Furthermore, 2010 rates demonstrate that coverage has returned to where it was prior to the shortage, increasing from 65.5% to 72.9%, and specificlaly Hib rates have returned to pre-shortage levels.. The Immunization Program oversees the Vaccines for Children (VFC) program, a federally funded entitlement that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The success of VFC is based upon

partnership between the Oregon Immunization Program, public providers, and private providers. Ninety-five percent of Oregon's childhood immunizations are captured in the ALERT IIS, which is used to estimate immunization rates, while also providing a clinical record for providers to accurately assess the vaccine needs of individual children.

6. WHAT NEEDS TO BE DONE

To continue our success, OHA needs to:

· Continue to provide funding, vaccines, and consultation to all local health department;

· Increase private provider participation in the statewide ALERT IIS in order to improve providers' ability to identify under-immunized children;

· Continue to work with other OHA programs to identify referral and assessment opportunities;

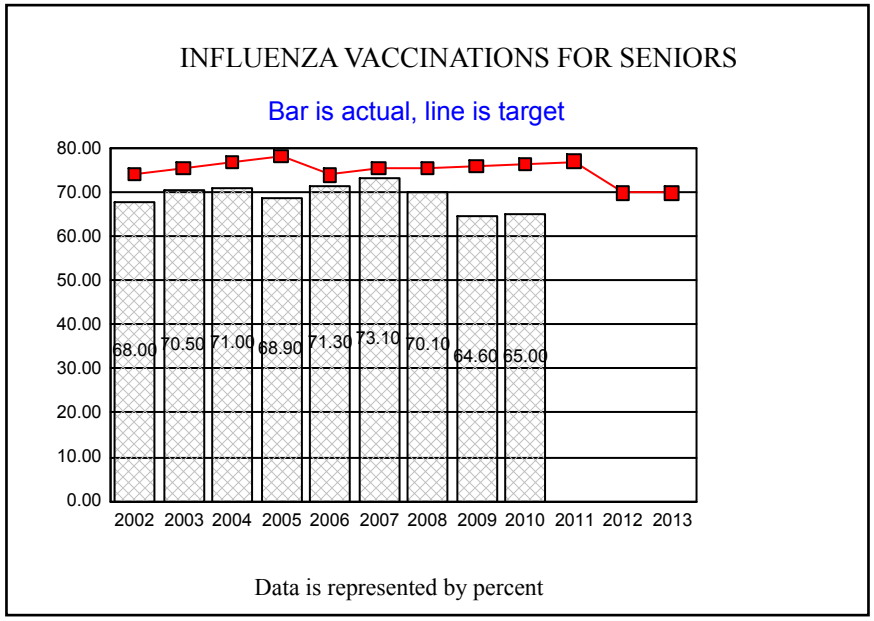
· Continue to work with internal and external partners to effectively communicate with consumers regarding vaccine safety and the importance of receiving vaccines according to the ACIP-recommended vaccine schedule; and

· Continue to work with the Centers for Disease Control (CDC), vaccine manufacturers, and providers to assure that appropriate strategies are in place for storage and handling of vaccines, as well as strategies specifically designed to respond to a vaccine shortage.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measures the statewide immunization rate for children 24 to 35 months of age. The data source is the ALERT immunization information system, our statewide IIS, that records reported immunization data from 100% of public providers and 93% of private providers. The immunizations assessed include 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, and 1 Varicella (4:3:1:3:3:1). Annual data are generally available in August. Rates for 2011 will be published in September 2012.

KPM #30	INFLUENZA VACCINATIONS FOR SENIORS - The percentage of adults aged 65 and over who receive an influenza vaccine.	2002
Goal	People are healthy	
Oregon Context	Oregon Benchmark #45 - Preventable Death	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS)	
Owner	OHA - Public Health Division, Center for Public Health Practice, Immunization Program, Lorraine Duncan (971) 673-0283	



1. OUR STRATEGY

Strategies include promoting adult immunizations through the DHS-funded Oregon Adult Immunization Coalition (OAIC), promotion of hospital standing orders, and technical support to public and private provider. 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 2020 objective of 90%.

3. HOW WE ARE DOING

In 2010, 65% of seniors in Oregon had received a flu vaccination rate in the past 12 months. This measure has shown little progress and has been below targets since its introduction in 2002. Data from 2011 will be available in Aug/Sep 2012.

4. HOW WE COMPARE

In 2010, 65% of seniors in Oregon had received a flu vaccination rate in the past 12 months. In comparison, other states range from 59.3% in Nevada to 72.4% in Massachusetts.

5. FACTORS AFFECTING RESULTS

rates are influenced by public perception of need and efficacy of the vaccine. Factors that negatively impact rates include: absence of policies in place that motivate health systems to routinely vaccinate all clients, limited funding for adult immunizations, and challenges around increasing provider use of the ALERT Immunization Information System (IIS) – the statewide immunization registry – that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB 2188 passed expanding ALERT IIS to a lifespan registry, and during the 2011 legislative session, HB 2371 passed stating that VFC and 317 providers need to report all administered doses to ALERT IIS; pharmacies are also required to report all administered vaccine to ALERT IIS. Over the next few years as the IIS collects and processes data, the IIS will contain more comprehensive immunization histories across the lifespan, which will help healthcare providers identify candidates for vaccine and potentially send out reminders to clients to seek out immunization every year.

6. WHAT NEEDS TO BE DONE

With the support of OAIC and depending on 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;
- Continue to support efforts to increase vaccination of health care workers;
- Assess adult population capture in the IIS to produce near real-time estimates of coverage, by county, throughout the flu season; 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.

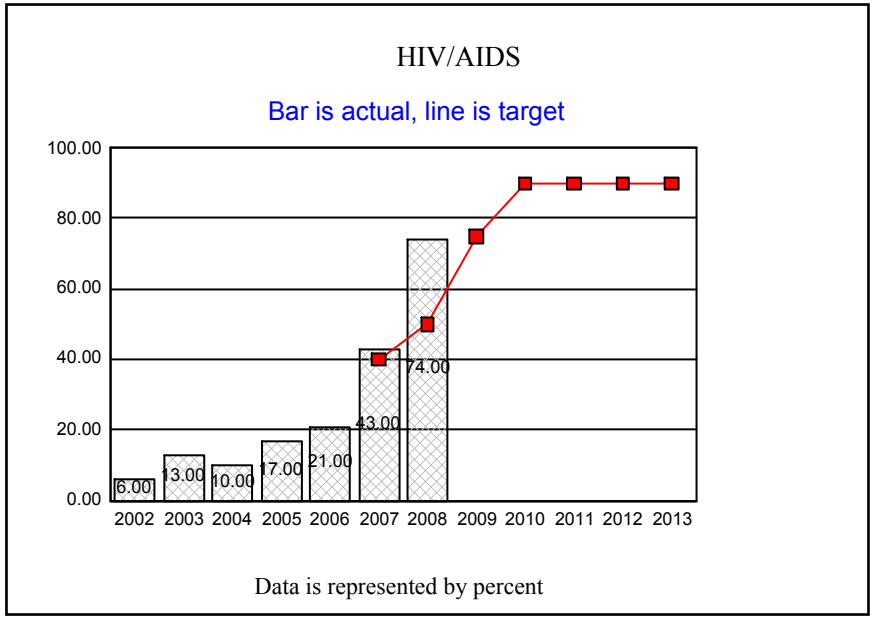
· Continue to partner with pharmacies, as these are commonly the vaccination venues for older adults

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 for the preceding 12 months. 2011 data were not yet available at the time of completing this analysis, however should be available within the month. Data using BRFSS and National Immmunization Survey data

This KPM was audited in 2008 and was certified as "verified" meaning that performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #31	HIV/AIDS - The percentage of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment.	2009
Goal	People are healthy	
Oregon Context	Oregon Benchmark #43 - HIV diagnosis, Communicable disease	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/AIDS Reporting Systems (HARS) database & PSU Census	
Owner	OHA - Public Health Division, Office of Disease Prevention & Epidemiology, HIV/STD/TB Program, DHS, Sean Schafer, MD, 971-673-0181	



1. OUR STRATEGY

The HIV Programs of Oregon's HIV/STD/TB (HST) Program in the Public Health Division aim to reduce new HIV infections. One important way to accomplish this is by finding and testing sex and needle partners of newly reported cases, treating and counseling them if infected and counseling about HIV avoidance if not infected.

Governmental partners include the Centers for Disease Control and Prevention and local health authorities. Non-governmental partners include clinical laboratories, health practitioners and health care facilities that report cases, and non-governmental HIV prevention agencies.

2. ABOUT THE TARGETS

During 2006, HST began redirecting some prevention resources to focus on direct interviews of people with newly reported cases of HIV to identify and test exposed partners. In all likelihood, interviewing 100% of all patients will never be achieved. Nevertheless, in pursuit of this, HST aims to interview at least 90% of case patients by 2010 and sustain that level during 2011.

3. HOW WE ARE DOING

During 2005, approximately 21% of newly reported cases had been interviewed. This had increased to 74% by 2008 because of redoubled efforts and resource allocation.

4. HOW WE COMPARE

Centers for Disease Control and Prevention recommends that all reported HIV cases be interviewed and offered partner notification services . No explicit industry standards exist for this measure. A 2001 national survey indicated that fewer than a third of newly reported HIV cases were being interviewed or offered partner notification services.

5. FACTORS AFFECTING RESULTS

A completed interview of a person with a newly diagnosed case of HIV infection requires efficient functioning of several public health systems . First, Oregon's HIV/AIDS case monitoring system must identify, in a timely way, all new cases by collecting reports from laboratories of all clinical tests that might be indicative of HIV infection and from health practitioners about newly recognized cases. State and local public health staff must compare these to previously reported cases , identifying the new cases and initiating case investigations. When a new case is confirmed, specially trained disease intervention specialists attempt to locate and interview the individual. In particular the interviewers try to collect locating information about sex and needle partners who may have been exposed, then locate these partners for testing and counseling. Some patients may not be successfully located and interviewed. This can happen when laboratory or practitioner reporting is delayed, public health staff are not timely at recognizing new cases or initiating case investigations , interviewers are unavailable or ineffective , or patients refuse to respond or cannot be located.

6. WHAT NEEDS TO BE DONE

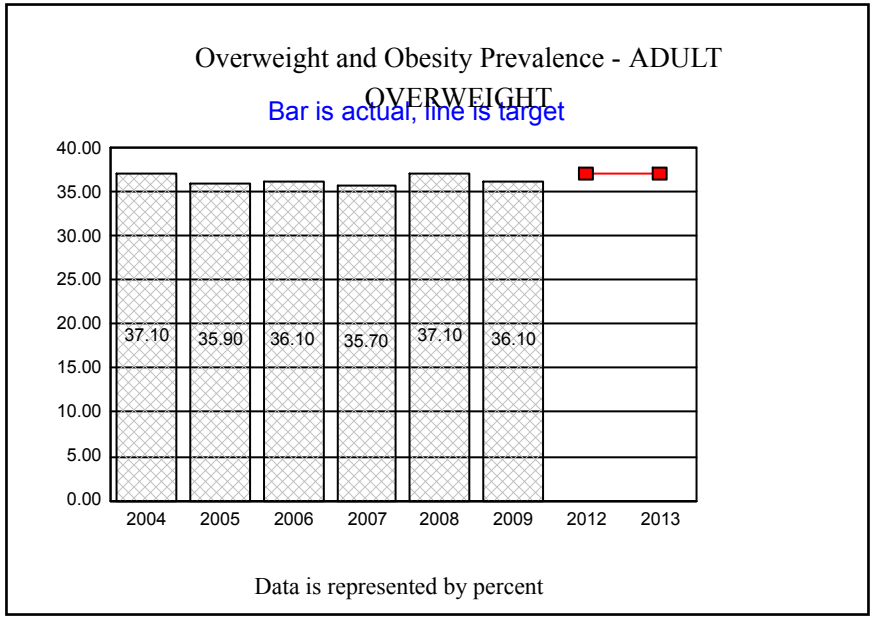
HST will compare the proportion of newly identified cases interviewed with the targets above . If the targets are not met, the program will examine the contributing public health systems such as timeliness of reporting by laboratories and health practitioners, interviewer performance, and methods used to locate and contact

patients looking for opportunities to increase interview performance. If targets are repeatedly met, the program will consider raising the target or proposing a new performance measure within the line of sight of reduction of new HIV cases.

7. ABOUT THE DATA

HST collects data from interviews of patients with reported cases of HIV, including number of partners contacted, in an existing public health database. These interviews are collected throughout the year, whenever a new case is reported. HST uses stored data to generate reports of numbers of cases interviewed biannually during the calendar year, or more often if needed. Estimates of the total number of reported cases per year that will serve as the denominator for this proportion will be estimated from the HIV/AIDS Reporting System (HARS), maintained by HST.

KPM #32a	OVERWEIGHT AND OBESITY PREVALENCE - ADULT OVERWEIGHT - The percentage of people who are overweight or obese among Oregonians.	2010
Goal	People are healthy	
Oregon Context	Oregon Benchmark - Preventable death	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS), Oregon Healthy Teens Survey (OHT)	
Owner	OHA, PHD, Health Promotion and Chronic Disease Prevention Section (HPCDP), Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

The Oregon Public Health Division does not currently receive funding dedicated to reducing overweight and obesity. Our strategy is to build a comprehensive, coordinated, statewide obesity prevention program/initiative.

2. ABOUT THE TARGETS

Over the past two decades, obesity has become a national and state health crisis. In Oregon, obesity contributes to the deaths of about 1,400 Oregonians each year, making it second only to tobacco as the state's leading cause of preventable death. Overweight and obesity are also major risk factors for chronic diseases such as diabetes, cancer, high blood pressure, high cholesterol, arthritis, heart disease and stroke. Nearly 73 percent of adult Oregonians with a history of heart attacks were overweight or obese in 2009. Since 1990, Oregon's adult obesity rate has increased 121 percent. If Oregon remains on this trajectory, children born today will not live as long as their parents or grandparents do.

In Oregon, medical costs related to obesity among adults were estimated to have reached $1.6 billion in 2006, with $339 million of that paid by Medicare and $333 million paid by Medicaid. In addition, obese persons are estimated to have annual medical costs that are $1,429 higher than non-obese persons.

3. HOW WE ARE DOING

Among Oregon adults, 36.1% were overweight and 24.1% were obese in 2009. Since 1990, the proportion of obese adults has increased 121 percent, and the proportion of overweight adults has increased 11 percent.

Among Oregon youth, 13.0% were overweight and 8.4% were obese in 2011. Since 2001, the proportion of overweight youth has decreased 13 percent, and the proportion of obese youth has increased 15 percent.

4. HOW WE COMPARE

Adults in Oregon were 10% less likely to be obese than their counterparts nationwide (2009: 24.1% Oregon vs. 26.9%), and had the same likelihood of being overweight (36.1% Oregon vs. 36.2%). National data on 8th youth do not exist for comparison with Oregon data.

5. FACTORS AFFECTING RESULTS

Poor nutrition and lack of physical activity are the main culprits behind overweight and obesity in Oregon. Only about a fourth of adult Oregonians eat the recommended amounts of five or more servings per day of fruits and vegetables. For 11th-graders, fruit and vegetable consumption was even lower: about 18 percent. Conversely, young people are still drinking a lot of sugary beverages: about 21 percent of eighth-graders report drinking an average of one or more soft drinks a day. Slightly more than half of adult Oregonians met minimum recommendations for physical activity in 2009, and more than one in four eighth-graders say they play video games, computer games or use the Internet — for non-school work — for three or more hours in an average school day. Only about 12 percent of Oregon 11th-graders participated in daily physical education in 2009.

6. WHAT NEEDS TO BE DONE

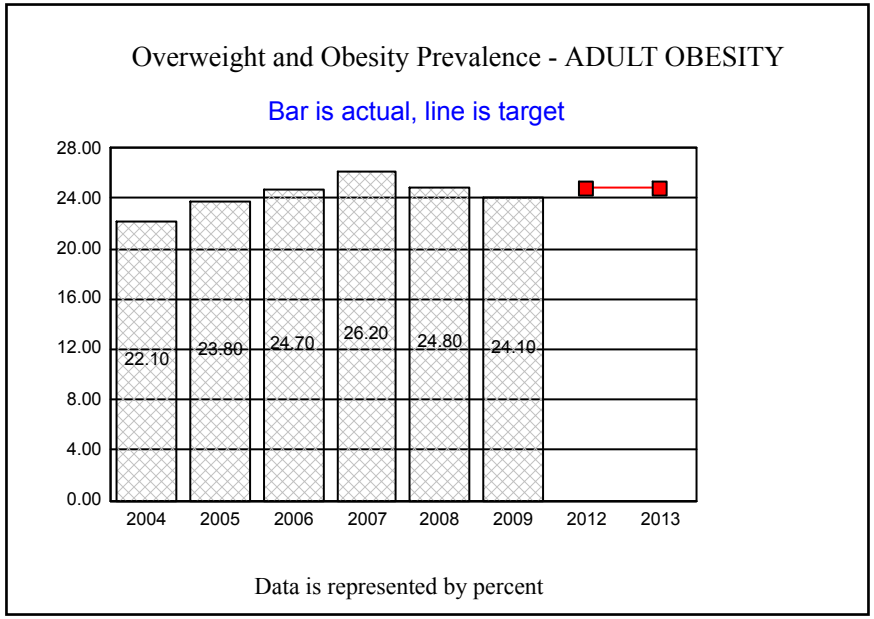
Comprehensive, collaborative statewide and community-based obesity prevention programs that include standards for physical activity and nutrition can make it easy for children and adults to access healthy foods and physical activities where they live, work, play and learn. Unless appropriate steps are taken to curb the obesity crisis in Oregon, the costs in Oregon lives and dollars will be too great for the state to sustain. Obesity is a preventable disease. It occurs in predisposed children and adults living in environments that promote eating too many calories and too little physical activity. Like other chronic diseases, prevention is the optimal approach and is our strategy to address this public health crisis.

7. ABOUT THE DATA

Among adults, body mass index (BMI) is calculated from the Oregon Behavioral Risk Factor Surveillance System, a telephone-administered survey that examines health related factors including height and weight. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. Disadvantages associated with BRFSS include its reliance upon telephone landlines, which are increasingly less common among younger age groups, people with low income, and certain racial and ethnic populations. Estimates calculated in 2011 and later will account for these factors, and thus will be higher than estimates calculated for 2010 and earlier. Another disadvantage is that respondents tend to give responses that skew their BMI slightly lower (either by over-reporting height or under-reporting weight), although over time this bias is assumed to be relatively constant.

BMI among 8th graders in Oregon is now collected biennially in odd years. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper or online survey administered to students during the school day.

KPM #32b	OVERWEIGHT AND OBESITY PREVALENCE - ADULT OBESITY - The percentage of people who are overweight or obese among Oregonians.	2010
Goal	People are healthy	
Oregon Context	Oregon Benchmark - Preventable death	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS), Oregon Healthy Teens Survey (OHT)	
Owner	OHA, PHD, Health Promotion and Chronic Disease Prevention Section (HPCDP), Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

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2. ABOUT THE TARGETS

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3. HOW WE ARE DOING

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Among Oregon youth, 13.0% were overweight and 8.4% were obese in 2011. Since 2001, the proportion of overweight youth has decreased 13 percent, and the proportion of obese youth has increased 15 percent.

4. HOW WE COMPARE

Adults in Oregon were 10% less likely to be obese than their counterparts nationwide (2009: 24.1% Oregon vs. 26.9%), and had the same likelihood of being overweight (36.1% Oregon vs. 36.2%). National data on 8th youth do not exist for comparison with Oregon data.

5. FACTORS AFFECTING RESULTS

Poor nutrition and lack of physical activity are the main culprits behind overweight and obesity in Oregon. Only about a fourth of adult Oregonians eat the recommended amounts of five or more servings per day of fruits and vegetables. For 11th-graders, fruit and vegetable consumption was even lower: about 18 percent. Conversely, young people are still drinking a lot of sugary beverages: about 21 percent of eighth-graders report drinking an average of one or more soft drinks a day. Slightly more than half of adult Oregonians met minimum recommendations for physical activity in 2009, and more than one in four eighth-graders say they play video games, computer games or use the Internet — for non-school work — for three or more hours in an average school day. Only about 12 percent of Oregon 11th-graders participated in daily physical education in 2009.

6. WHAT NEEDS TO BE DONE

Comprehensive, collaborative statewide and community-based obesity prevention programs that include standards for physical activity and nutrition can make it easy for children and adults to access healthy foods and physical activities where they live, work, play and learn. Unless appropriate steps are taken to curb the obesity crisis in Oregon, the costs in Oregon lives and dollars will be too great for the state to sustain. Obesity is a preventable disease. It occurs in predisposed children and adults living in environments that promote eating too many calories and too little physical activity. Like other chronic diseases, prevention is the optimal approach and is our strategy to address this public health crisis.

7. ABOUT THE DATA

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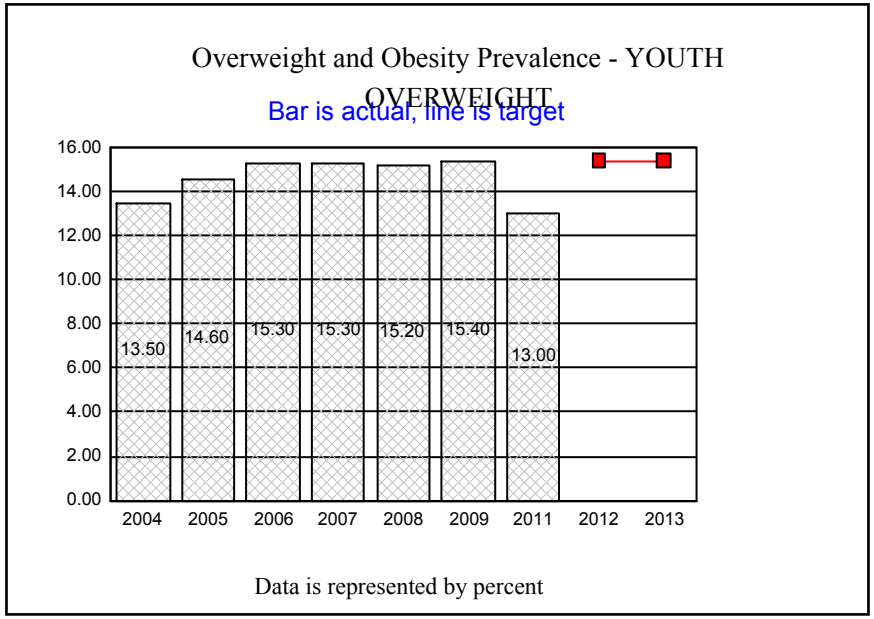
KPM #32c	OVERWEIGHT AND OBESITY PREVALENCE - YOUTH OVERWEIGHT - The percentage of people who are overweight or obese among Oregonians.	2010
Goal	People are healthy	
Oregon Context	Oregon Benchmark - Preventable death	
Data Source		
Owner	OHA, PHD, Health Promotion and Chronic Disease Prevention Section (HPCDP), Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

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2. ABOUT THE TARGETS

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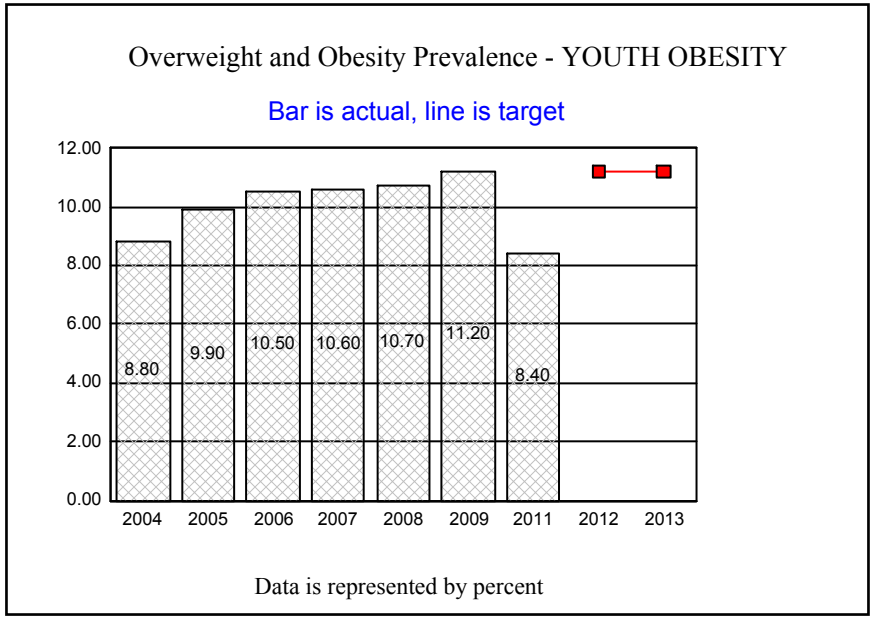
KPM #32d	OVERWEIGHT AND OBESITY PREVALENCE - YOUTH OBESITY - The percentage of people who are overweight or obese among Oregonians.	2010
Goal	People are healthy	
Oregon Context	Oregon Benchmark - Preventable death	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS), Oregon Healthy Teens Survey (OHT)	
Owner	OHA, PHD, Health Promotion and Chronic Disease Prevention Section (HPCDP), Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

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2. ABOUT THE TARGETS

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Among Oregon adults, 36.1% were overweight and 24.1% were obese in 2009. Since 1990, the proportion of obese adults has increased 121 percent, and the proportion of overweight adults has increased 11 percent.

Among Oregon youth, 13.0% were overweight and 8.4% were obese in 2011. Since 2001, the proportion of overweight youth has decreased 13 percent, and the proportion of obese youth has increased 15 percent.

4. HOW WE COMPARE

Adults in Oregon were 10% less likely to be obese than their counterparts nationwide (2009: 24.1% Oregon vs. 26.9%), and had the same likelihood of being overweight (36.1% Oregon vs. 36.2%). National data on 8th youth do not exist for comparison with Oregon data.

5. FACTORS AFFECTING RESULTS

Poor nutrition and lack of physical activity are the main culprits behind overweight and obesity in Oregon. Only about a fourth of adult Oregonians eat the recommended amounts of five or more servings per day of fruits and vegetables. For 11th-graders, fruit and vegetable consumption was even lower: about 18 percent. Conversely, young people are still drinking a lot of sugary beverages: about 21 percent of eighth-graders report drinking an average of one or more soft drinks a day. Slightly more than half of adult Oregonians met minimum recommendations for physical activity in 2009, and more than one in four eighth-graders say they play video games, computer games or use the Internet — for non-school work — for three or more hours in an average school day. Only about 12 percent of Oregon 11th-graders participated in daily physical education in 2009.

6. WHAT NEEDS TO BE DONE

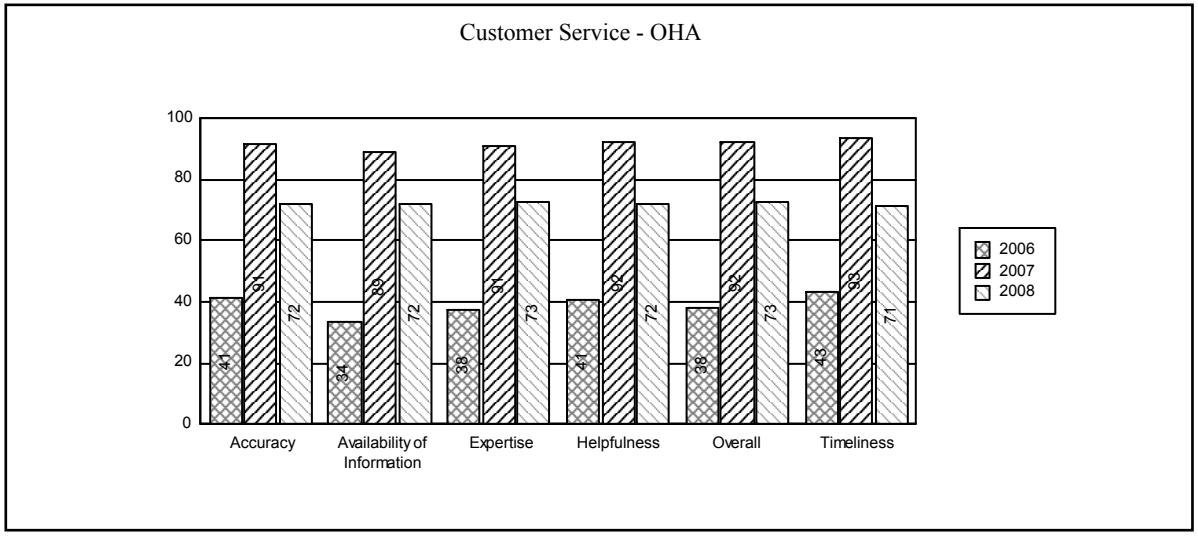
Comprehensive, collaborative statewide and community-based obesity prevention programs that include standards for physical activity and nutrition can make it easy for children and adults to access healthy foods and physical activities where they live, work, play and learn. Unless appropriate steps are taken to curb the obesity crisis in Oregon, the costs in Oregon lives and dollars will be too great for the state to sustain. Obesity is a preventable disease. It occurs in predisposed children and adults living in environments that promote eating too many calories and too little physical activity. Like other chronic diseases, prevention is the optimal approach and is our strategy to address this public health crisis.

7. ABOUT THE DATA

Among adults, body mass index (BMI) is calculated from the Oregon Behavioral Risk Factor Surveillance System, a telephone-administered survey that examines health related factors including height and weight. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. Disadvantages associated with BRFSS include its reliance upon telephone landlines, which are increasingly less common among younger age groups, people with low income, and certain racial and ethnic populations. Estimates calculated in 2011 and later will account for these factors, and thus will be higher than estimates calculated for 2010 and earlier. Another disadvantage is that respondents tend to give responses that skew their BMI slightly lower (either by over-reporting height or under-reporting weight), although over time this bias is assumed to be relatively constant.

BMI among 8th graders in Oregon is now collected biennially in odd years. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper or online survey administered to students during the school day.

KPM #33	CUSTOMER SERVICE (OHA) - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.	2006
Goal	OHA Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	
Oregon Context	OHA Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	
Data Source	CAHPS Survey	
Owner	OHA, Cathy Iles, Performance Management Coordinator, Director's Office, 503-602-1507	



1. OUR STRATEGY

OHA strives to be a world-class human and health services organizations. We are fundamentally changing the way we do business to provide more effective and efficient client services and improve accountability. The goal is to build a foundation for continuous improvement so we are always doing our best work by constantly measuring our performance and quickly resolving problems. Our transformation efforts are resulting in reduced red tape, reduced wait time for clients and improved customer service.

2. ABOUT THE TARGETS

2010 and 2011 targets were set based on 2008 results. Our methodology has varied greatly from year to year making it difficult to develop meaningful targets.

3. HOW WE ARE DOING

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

4. HOW WE COMPARE

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

5. FACTORS AFFECTING RESULTS

In 2008, we exceeded our target for overall customer service. This was the first year using results from the CAHPS survey, so we don't have data to compare to yet.

6. WHAT NEEDS TO BE DONE

As we've transitioned to DHS and OHA, we will revisit how we gather customer feedback. The CAHPS survey has been used for reporting DHS customer service, including Divisions that are now part of the Oregon Health Authority (AMH, DMAP, PHD). There are other organizations that have become part of OHA who have been reporting customer service using their own methodology (PEBB, OEBB, OPHP, OMIP). We will develop a plan for a comprehensive measurement of customer service that adequately represents DHS clients.

7. ABOUT THE DATA

Reporting cycle - fiscal year. The 2008 results are from the Consumer Assessment of Health Plans Survey (CAHPS). It was administered through the Division of Medical Assistance Programs (DMAP) over a 10-week period (October December 2007) using a mixed-mode (mail and telephone) five-wave protocol. This protocol consisted of a pre-notification letter, an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and reminder postcard to non-respondents. Phone follow-up was conducted for members who had not responded to the mailings. Respondents were surveyed in English and Spanish. The sampling plan for the adult and child surveys called for a random sample of 900 eligible members per plan in each age group. To be eligible, members had to have been enrolled in Oregon Health Plan for at least six months as of December 31, 2006. The final selected sample consisted of 13,962 adult OHP enrollees and 13,747 child OHP enrollees. For the customer service questions, we received approximately 10,600 responses. We will continue to use the CAHPS survey, which is a biennial survey, to report on customer service. This KPM was audited in summer 2010. It was certified as "verified" - procedures were documented and variances between the KPM results originally reported and subsequently recreated were all within allowable limits.

OREGON HEALTH AUTHORITY	III. USING PERFORMANCE DATA
Agency Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	

Contact: Cathy Iles, DHS/OHA Shared Services	**Contact Phone:** 503-602-1507
Alternate: John Britton	**Alternate Phone:** 503-945-6597

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

1. INCLUSIVITY	*** Staff :** · Staff are involved in the identification and refinement of Key Performance Measures. Feedback is sought to validate the measures. Over the next biennium, staff will become more involved in identifying, tracking and using performance metrics to make improvements to the work we do. These metrics should ultimately link to our KPMs or other high-level measures and inform us of our progress. *** Elected Officials:** · Elected officials provide input to the agency KPMs, targets and strategies. *** Stakeholders:** · Customer feedback is gathered to help guide strategies for effective service delivery. We continue to work closely with Legislative Fiscal Office and DAS Budget and Management to ensure we are making continuous improvements to our KPMs so they provide useful and relevant information for decision-making and management. *** Citizens:** Community forums related to budget development and priority-setting are a way to identify and validate priorities, expectations and performance areas.
2 MANAGING FOR RESULTS	As a result of Transformation efforts, there is an emphasis on using metrics to identify where improvements are needed, make changes, and track and report results to make sure improvements are sustained. The department has been training work units in the Lean Daily Management System® (LDMS®) which includes a component for developing metrics at the work unit level for the team's main processes. Key Performance Measures provide a high-level picture of our results, but the underlying metrics provide a more meaningful and actionable management tool.
3 STAFF TRAINING	Management and staff continue to receive training related to transformation and continuous improvement. Training in both online and classroom formats is available. The courses are introducing staff to the principles and concepts for thinking about work in terms of systems, processes and process improvement. A component of these trainings focus on metrics and how to effectively measure the results of our work. People are becoming more familiar with using data and information to inform our strategies and decision-making.

	Required courses for managers teach about creating a culture of continuous improvement to achieve results to become a world-class organization and sustain the transformation. Workshops help prepare managers to assist their work groups to establish and sustain LDMS® elements and practices, and improve their ability to guide work teams to constructively and practically select and use metrics to improve their work.
4 COMMUNICATING RESULTS	*** Staff :** · The annual performance report is posted online and used for information sharing. One goal of the Transformation Initiative is to make data and metrics more visible at all levels of the organization. As work units begin using the Lean Daily Management System® (LDMS®), they create visual display boards to post in their areas that include data and metrics about the team's work to provide current information about the results they are achieving and goals they are working toward. Work unit members meet in front of the display board regularly to review metrics, share information, set priorities and problem-solve when needed. *** Elected Officials:** · The annual performance report is posted online and included in the agency request document for purposes of sharing performance results, showing accountability, and informing the budget development process. KPMs are presented during the Ways & Means presentations to describe program results. *** Stakeholders:** · The annual performance report is posted online and used for information sharing. *** Citizens:** The annual performance report is posted online and used for information sharing.

OHA Proposed 2013-15 KPMs
Contact: Cathy Iles, cathy.f.iles@dhsoha.state.or.us, 503-602-1507
All measures will be analyzed by race/ethnicity where possible and appropriate so disparities can be identified and moving forward, reduced.

#	Short Title	Measure Description	Rationale								
			OHA Goals for Health Systems Transformation			Quality Improvement Focus Areas					
			Better Care / Access	Lower Cost	Better Health	Reducing preventable rehospitalizations	Addressing discrete health issues	Integrate primary care and behavioral health	Improving access to effective and timely	Improving perinatal and maternity care	Improving primary care for all populations
1	Initiation and engagement of alcohol and other drug dependence treatment - *Medicaid population*	Percentage of members with a new episode of alcohol or other drug dependence who received the following: a) initiation of AOD treatment within 14 days of diagnosis; and b) received two or more services within 30 days of initiation visit	√	√	√			√	√		
		a) initiation of AOD treatment within 14 days of diagnosis									
		b) received two or more services within 30 days of initiation visit									
2	Follow-up after hospitalization for mental illness - *Medicaid population*	Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge		√	√	√		√			
3	Mental and physical health assessment for children in DHS custody	Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days of initial custody date			√			√	√		
		a) mental health assessment									
		b) physical health assessment									
4	Follow-up care for children prescribed with ADHD medication - *Medicaid population*	Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication dispensed. Two rates: a) initiation, b) continuation and maintenance.			√			√	√		
		a) initiation									
		b) continuation and maintenance									

OHA Proposed 2013-15 KPMs
Contact: Cathy Iles, cathy.f.iles@dhsoha.state.or.us, 503-602-1507
All measures will be analyzed by race/ethnicity where possible and appropriate so disparities can be identified and moving forward, reduced.

#	Short Title	Measure Description	Rationale								
			OHA Goals for Health Systems Transformation			Quality Improvement Focus Areas					
			Better Care / Access	Lower Cost	Better Health	Reducing preventable rehospitalizations	Addressing discrete health issues	Integrate primary care and behavioral health	Improving access to effective and timely	Improving perinatal and maternity care	Improving primary care for all populations
5	30 day substance use (illicit drugs and alcohol) among 6th, 8th and 11th graders - *Population*	Percentage of 6th, 8th and 11th graders who have used illicit drugs or alcohol in the past 30 days			√			√			
		Alcohol use: a) 6th graders b) 8th graders c) 11th graders									
		Illicit drug use: a) 6th graders b) 8th graders c) 11th graders									
6	Prenatal care - *Population and Medicaid population*	Percentage of women who initiated prenatal care in the first 3 months of pregnancy or within 42 days of enrollment	√	√	√				√	√	
		a) Population									
		b) Medicaid population									
7	Primary care sensitive hospital admissions/inpatient stays - *Medicaid*	Percentage of admissions (for 12 diasnoses) that are more appropriately treated in an outpatient		√	√	√					
8	Patient Centered Primary Care Home (PCPCH) enrollment - *Medicaid*	Number of members enrolled in patient-centered primary care homes (PCPCH) by tier							√		√
9	Access to care - *Medicaid population*	Percentage of members who responded "always" or "usually" to getting care quickly (composite for adult and child)	√		√				√		
10	Member experience of care - *Medicaid population*	Composite measurement areas for adults and children: getting care needed; getting care quickly; how well doctors communicate; health plan information and customer service	√						√		

OHA Proposed 2013-15 KPMs
Contact: Cathy Iles, cathy.f.iles@dhsoha.state.or.us, 503-602-1507
All measures will be analyzed by race/ethnicity where possible and appropriate so disparities can be identified and moving forward, reduced.

#	Short Title	Measure Description	Rationale								
			OHA Goals for Health Systems Transformation			Quality Improvement Focus Areas					
			Better Care / Access	Lower Cost	Better Health	Reducing preventable rehospitalizations	Addressing discrete health issues	Integrate primary care and behavioral health	Improving access to effective and timely	Improving perinatal and maternity care	Improving primary care for all populations
11	Member health status - *Medicaid population*	Percentage of CAHPS survey respondents with a positive self-reported rating of overall health			√		√				√
12	Rate of tobacco use - *Population and Medicaid population*	Population: Tobacco use. Medicaid: Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days			√						√
		a) Population (adult)									
		b) Medicaid population									
13	Rate of obesity - *Population and Medicaid population*	Percentage of people who are obese among Oregonians			√						√
		a) Population (adult)									
		b) Medicaid population									
14	All cause readmissions - *Medicaid population*	Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older		√		√					
15	Effective contraceptive use - *Population and Medicaid population*	Percentage of reproductive age women who do not desire pregnancy using an effective method of contraception			√						√
		a) Population									
		b) Medicaid population									
16	Flu shots - ages 50-64 - *Population and Medicaid population*	Percentage of adults ages 50-64 who receive a flu vaccine			√						√
		a) Population									
		b) Medicaid population									
17	Child immunization rates - *Population and Medicaid population*	Percentage of 24-35 month old children who are adequately immunized			√						√

OHA Proposed 2013-15 KPMs
Contact: Cathy Iles, cathy.f.iles@dhsoha.state.or.us, 503-602-1507
All measures will be analyzed by race/ethnicity where possible and appropriate so disparities can be identified and moving forward, reduced.

#	Short Title	Measure Description	Rationale								
			OHA Goals for Health Systems Transformation			Quality Improvement Focus Areas					
			Better Care / Access	Lower Cost	Better Health	Reducing preventable rehospitalizations	Addressing discrete health issues	Integrate primary care and behavioral health	Improving access to effective and timely	Improving perinatal and maternity care	Improving primary care for all populations
		a) Population									
		b) Medicaid population									
18	OHA customer satisfaction	Percentage of OHA customers rating their satisfaction as "good" or "excellent"									

Please comment below on any specific features you would recommend for the State's Program for Real Property and Equipment Financings.

Please return this survey to: **Jack Kenny, Finance Manager**
Department of Administrative Services
155 Cottage Street NE, U10
Salem, OR 97301-3965

If you have any questions, please call Jack Kenny, at (503) 378-3107

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES
PROGRAM FOR REAL PROPERTY AND EQUIPMENT FINANCING

ARTICLE XI-Q BOND FINANCING REQUEST

Please return your response to this Survey by May 15, 2012

AGENCY: Oregon Health Authority (OHA)

DIVISION: Addictions and Mental Health (AMH), Oregon State Hospital Replacement Project (OSHRP)

CONTACT PERSON: Jodie Jones

TITLE: Administrator, Oregon State Hospital Replacement Project (OSHRP)

ADDRESS: 2575 Bittern Street NE (2nd Floor), Salem OR 97301

TELEPHONE: 503-945-9425

ALTERNATE CONTACT: Dawn Bass

EQUIPMENT ACQUISITION FINANCING

Please specify the equipment items, which you expect to acquire using Article XI-Q Bonds or capital leases over the next biennium, beginning July 1, 2013. Please indicate the type of equipment and when funds are needed to acquire the equipment. Please note: Financing agreements are defined at ORS 286.085(4) and include any agreement to finance real or personal property that is or will be owned and operated by the state. This includes lease purchase agreements, installment sales agreements, and similar financing arrangements. Do not include operating leases on this form.

EQUIPMENT TYPE

Please list by type, amount needed, and when you will need the funds in the spaces provided (brand names are not required.)

Description of Equipment/Personal Property	Dollar Value of Financed Asset	Purchased or Developed *In-House	Date to be Placed in Service/Useful Life	2013-15 Budget Proposal (Yes or No)	Financing Method (e.g. XI-Q Bonds, Capital Lease, etc)

*For assets to be developed in house, please provide details on project cash flow or refer to Policy Option Package where that detail is provided.

REAL PROPERTY ACQUISITION OR RESTORATION FINANCING

Please specify the real property and/or construction projects which you expect to finance through any form of bonds or other financing agreements over the next biennium beginning July 1, 2013. Please indicate the estimated amount needed for each project and when those funds will be required.

REAL PROPERTY AND/OR CONSTRUCTION PROJECTS

Real property acquisitions, restoration and/or construction projects.	Project Cost Estimate	2013-15 Budget Proposal (Yes or No)
OHA is requesting the remaining $29 million, which was originally anticipated for 2011-13, within the $458.1 million budget estimate reported to the Interim Ways and Means Committee in October 2007. OHA shifted the construction schedule and delayed this request to be added to the 2013-15 legislative session. This will move the Junction City site construction end date to late fall of 2014, which OHA believes will still leave adequate time to move patients from the Portland facility scheduled to close in March 2015.	$29,001,530	Yes
OHA is requesting an increase for 2013-15 to complete construction of the Junction City hospital. An important aspect of the new hospital in Junction City is the additional 100,000 square feet that is needed to provide the minimum of 20 hours per week of patient treatment activities, as well as accommodate the additional staffing needs. The minimum standard of 20 hours of active patient treatment has become the accepted measure for modern psychiatric facilities, and is set forth in the hospital's Continuous Improvement Plan. This is a critical part of the improved care for patients and creates a climate of recovery and provides patients the needed skills to make successful transitions back to their own communities.	$50,400,000	Yes

Please comment below on any specific features you would recommend for the State's Program for Real Property and Equipment Financings.

Please return this survey to: **Jack Kenny, Finance Manager**
Department of Administrative Services
155 Cottage Street NE, U10
Salem, OR 97301-3965

If you have any questions, please call Jack Kenny, at (503) 378-3107

STATE OF OREGON

DEPARTMENT OF ADMINISTRATIVE SERVICES
PROGRAM FOR REAL PROPERTY AND EQUIPMENT FINANCING

ARTICLE XI-Q BOND FINANCING REQUEST

Please return your response to this Survey by May 15, 2012

AGENCY: **Department of Human Services**

DIVISION: **n/a (Enterprise Initiative)**

CONTACT PERSON: **Kathryn Naugle Wilk**

TITLE: **IT Director of Business Engagement**

ADDRESS: **500 Summer Street NE, Salem, OR 97301**

TELEPHONE: **503-910-4184**

ALTERNATE CONTACT: **Trina Lee, DHS Modernization Director**

EQUIPMENT ACQUISITION FINANCING

Please specify the equipment items, which you expect to acquire using Article XI-Q Bonds or capital leases over the next biennium, beginning July 1, 2013. Please indicate the type of equipment and when funds are needed to acquire the equipment. Please note: Financing agreements are defined at ORS 286.085(4) and include any agreement to finance real or personal property that is or will be owned and operated by the state. This includes lease purchase agreements, installment sales agreements, and similar financing arrangements. Do not include operating leases on this form.

EQUIPMENT TYPE

Please list by type, amount needed, and when you will need the funds in the spaces provided (brand names are not required.)

Description of Equipment/Personal Property	Dollar Value of Financed Asset	Purchased or Developed *In-House	Date to be Placed in Service/Useful Life	2013-15 Budget Proposal (Yes or No)	Financing Method (e.g. XI-Q Bonds, Capital Lease, etc)
DHS Modernization: modifying business processes and service delivery, automation of manual business processes, replacement of aging legacy systems, creation of true case management system and data warehouse.	$50,000,000 TF $14,000,000 COP	Combination of Purchased and In-House development	Phased implementation started in 2009 continuing through 2017	Yes	COP/Federal Funds

EQUIPMENT ACQUISITION FINANCING

*For assets to be developed in house, please provide details on project cash flow or refer to Policy Option Package where that detail is provided.

REAL PROPERTY ACQUISITION OR RESTORATION FINANCING

Please specify the real property and/or construction projects which you expect to finance through any form of bonds or other financing agreements over the next biennium beginning July 1, 2013. Please indicate the estimated amount needed for each project and when those funds will be required.

REAL PROPERTY AND/OR CONSTRUCTION PROJECTS

Real property acquisitions, restoration and/or construction projects.	Project Cost Estimate	2013-15 Budget Proposal (Yes or No)

INFORMATION TECHNOLOGY PROJECTS IN 2013-15

(THAT EQUAL OR EXCEED $150,000)

Agency Name:	OHA OFFICE OF HEALTH INFORMATION TECHNOLOGY			
Project Name:	**HEALTH INFORMATION EXCHANGE (HIE) PROJECT**			
Mandated Project?	☐ Yes ☒ No		By: Oregon Legislature, federal government, Other (identify it)	Office of the National Coordinator for Health IT
Budget?	☒ Base ☐ POP		Which agency or state plans or goals does it align with and/or support?	Health Information Exchange in support of Oregon Health Transformation
Project Purpose	☐ Routine Lifecycle Replacement ☒ Upgrade/Enhance Existing System ☐ New System			
Project Status	☐ Concept Stage ☐ Planning Stage ☐ Ready to Implement ☒ Continuation of Existing Project			
SDC Involvement	☒ None ☐ Minor ☐ Active ☐ Participating Partner			
Estimate SDC Costs	**$** ***No costs expected*** ☐ Preliminary Estimate ☐ Project Design Estimate			

Project Description:

The American Recovery and Reinvestment Act (ARRA) (Pub. L. 111-5) authorized the Office of the National Coordinator for Health IT (ONC) to provide seed money to states for health information exchange through Cooperative Agreements in 2010. In addition, ONC provides federal workgroups and regulation to advance not only the information technology standards for HIE, but also funding, governance and policy strategies. States chose to participate in the ONC Cooperative Agreements for four years ending in 2013. Ubiquitous and trusted HIE is new and rapidly evolving in the United States. HIE is expected to continue beyond the current ONC Cooperative Agreement, however, sustainable funding has not be secured. This report is based solely on the committed funds from ONC for HIE that end September 30, 2013.

Oregon is developing the CareAccord program to provide a trusted means to exchange health information the state. The HIE Project vendor is Harris Corporation who serves as a system integrator to build ubiquitous and trusted HIE services in support of health system transformation. The HIE Project has built Direct secure messaging. Planned efforts to complete the ONC Cooperative Agreement include piloting and implementing a connection between HIE and public health systems, POLST registry, and CCOs.

Cost Summary							
Total estimated cost by fund (13-15):	General Fund	Lottery Funds	Other Funds	Non-Limited	Federal Funds	Non-Limited	Total Funds
	$78,676	$	$	$	$245,075 ONC	$	$323,751
Total estimated cost by fund (all biennia):	$	$	$	$	$	$	$

Estimated Cost by category (13-15):	Personal Services	Services & Supplies	Capital Outlay	Special Payments	Debt Service
	$	$	$	$	$

INFORMATION TECHNOLOGY PROJECTS IN 2013-15

Estimated Cost by category (all biennia):	$	$	$	$	$

		Positions: Internal	8
Expected Start Date:		Contractor	0
Expected Completion Date:		FTE:	5.0

Agency Request X Governor's Recommended _____ Legislatively Adopted Budget Page _____

INFORMATION TECHNOLOGY PROJECTS IN 2013-15

(THAT EQUAL OR EXCEED $150,000)

Agency Name:	DHS / OHA		
Project Name:	**COMPUTER & NETWORK INFRASTRUCTURE INVESTMENTS**		
Mandated Project?	☐ Yes ☒ No		
Budget?	☐ Base ☒ POP	Which agency or state plans or goals does it align with and/or support?	
Project Purpose	☒ Routine Lifecycle Replacement ☐ Upgrade/Enhance Existing System ☐ New System		
Project Status	☐ Concept Stage ☐ Planning Stage ☒ Ready to Implement ☐ Continuation of Existing Project		
SDC Involvement	☒ None ☐ Minor ☐ Active ☐ Participating Partner		
Estimate SDC Costs	**$ 0** ☐ Preliminary Estimate ☐ Project Design Estimate		

Project Description: DHS and OHA will have up to 66% of active computers over 5 year of age which is beyond industry standard lifecycle. The SDC has also not upgraded DHS network infrastructure in over 9 years in many buildings including the Barbara Roberts and Portland State Office Buildings. Both the Network and outdated computers cause inefficient work processes due to how slow DHS systems operate on these computers and systems. In addition, as modern systems such as HIX and Eligibility Modernization are implemented, a further strain on the performance of DHS and OHA IT systems will occur. Worst case scenario is that some computers will not support these modern applications. Older computers will also not support Windows 7 and Windows XP support will be soon phased out by Microsoft. Due to DHS and OHA's reliance on IT systems to provide services and ensure safety of clients, modernizing the IT tools and Infrastructure is critical to the long term success of DHS and OHA in achieving program outcomes and ensuring safety of Oregonians.

Cost Summary							
Total estimated cost by fund (13-15):	General Fund	Lottery Funds	Other Funds	Non-Limited	Federal Funds	Non-Limited	Total Funds
	$1,737,806	$	$ 2,366,211	$	$ 1,737,806	$	$ 5,841,823
Total estimated cost by fund (all biennia):	$	$	$	$	$	$	$

Estimated Cost by category (13-15):	Personal Services	Services & Supplies	Capital Outlay	Special Payments	Debt Service
	$ 1,655,359	$ 3,185,824	$ 1,000,640	$	$
Estimated Cost by category (all biennia):	$	$	$	$	$

Expected Start Date:	July 1, 2013	Positions: Internal	12
Expected Completion Date:	June 30, 2015	Contractor	0
		FTE:	10.56

_____Agency Request X Governor's Recommended _____ Legislatively Adopted Budget Page _____

INFORMATION TECHNOLOGY PROJECTS IN 2013-15

(THAT EQUAL OR EXCEED $150,000)

Agency Name:	OREGON HEALTH AUTHORITY – OFFICE OF INFORMATION SERVICES			
Project Name:	MAPIR – MHIT PROJECT			
Mandated Project?	☐ Yes ☒ No		By: Oregon Legislature, federal government, Other (identify it)	Centers for Medicare and Medicaid Services (CMS)
Budget?	☒ Base ☐ POP		Which agency or state plans or goals does it align with and/or support?	Health System Transformation Medicaid Health Information Technology
Project Purpose	☐ Routine Lifecycle Replacement	☒ Upgrade/Enhance Existing System	☐ New System	
Project Status	☐ Concept Stage	☐ Planning Stage	☐ Ready to Implement	☒ Continuation of Existing Project
SDC Involvement	☒ None	☐ Minor	☐ Active	☐ Participating Partner
Estimate SDC Costs	**$ *No costs expected***	☐ Preliminary Estimate	☐ Project Design Estimate	

Project Description:

The American Recovery and Reinvestment Act (ARRA) (Pub. L. 111-5) authorized the Centers for Medicare and Medicaid Services (CMS) to incentivize providers to adopt and meaningfully use electronic health record (EHR) systems. CMS created the EHR Incentive Program (42 CFR Part 495.338) for specific Medicare and Medicaid hospitals and providers. CMS administers the Medicare EHR Incentive Program and states choose to administer the Medicaid EHR Incentive Program starting in 2011. The program rules evolve over ten years with CMS releasing new regulations at various programmatic phases; these regulations impact the information systems supporting the program.

Oregon has chosen to administer the Medicaid EHR Incentive Program to support health system transformation in the state. Oregon is a part of a 13 state collaborative that implemented MAPIR, a modification to the MMIS system, to manage the incentive payments made to eligible professionals and hospitals. Oregon implemented MAPIR in 2011. The changing CMS regulations require frequent design, development and implementation activities at both the MAPIR collaborative level and local Oregon implementation.

Cost Summary							
Total estimated cost by fund (13-15):	General Fund	Lottery Funds	Other Funds	Non-Limited	Federal Funds	Non-Limited	Total Funds
	$209,897	$	$	$	$1,889,071	$	$2,098,967
Total estimated cost by fund (all biennia):	$944,535	$	$	$	$8,500,816	$	$9,445,352
Estimated Cost by	Personal Services	Services & Supplies	Capital Outlay	Special Payments	Debt Service		

category (13-15):	$	$	$	$	$
Estimated Cost by category (all biennia):	$	$	$	$	$

		Positions: Internal	5.0
Expected Start Date:	Continuation of enhancements in 2013-15	Contractor	Unknown
Expected Completion Date:	During 2013-15 biennium	FTE:	5.0

_____ Agency Request X Governor's Recommended _____ Legislatively Adopted Budget Page _____

INFORMATION TECHNOLOGY PROJECTS IN 2013-15

(THAT EQUAL OR EXCEED $150,000)

Agency Name:	OHA			
Project Name:	**FEDERAL RULE 5010 - MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)**			
Mandated Project?	☒ Yes ☐ No		By: Legislature, Federal Gov, Other (identify it)	Federal Rule 5010
Budget?	☒ Base ☐ POP		Which agency or state plans or goals does it align with and/or support?	▪ Assisting people to become Independent, Healthy and Safe ▪ KPM 43 – Customer Service: accuracy, availability of information
Project Purpose	☐ Routine Lifecycle Replacement	☒ Upgrade/Enhance Existing System	☐ New System	
Project Status	☐ Concept Stage	☐ Planning Stage	☐ Ready to Implement	☒ Continuation of Existing Project
SDC Involvement	☐ None	☒ Minor	☐ Active	☐ Participating Partner
Estimate SDC Costs	**$ 25,000**	☒ Preliminary Estimate	☐ Project Design Estimate	

Project Description: Federal DHHS published two final rules on January 16, 2009 under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). These rules impart changes to *Title45 –Public Welfare*, *Code of Federal Regulations*, and *Part 162 – Administrative Requirements*. These two rules apply to all HIPAA covered entities, including health plans, health care clearing houses, and certain health care providers. The first rule deals with updating the Electronic Transaction Standards, Stage 1 of the Project. The second rule deals with updating the Medical Code sets, Stage 2 of the Project. Stage 1 is underway, and is scheduled to complete by Jan 2012. Stage 2 is scheduled to start Oct 2011 and complete Oct 2013.

Cost Summary							
Total estimated cost by fund (13-15):	General Fund	Lottery Funds	Other Funds	Non-Limited	Federal Funds	Non-Limited	Total Funds
	$ 1.134.153	$	$	$	$ 3,402.460	$	$ 4,536,613
Total estimated cost by fund (all biennia):	$ 2,030,866	$	$	$	$ 12,552,291	$	**$** 14,583,154

Estimated Cost by category (13-15):	Personal Services	Services & Supplies	Capital Outlay	Special Payments	Debt Service
	$ 413,157	$ 5,761,892	$ -0-	$	$
Estimated Cost by category (all biennia):	$ 1,087,641	$ 10,440,248	$ 2,992,629	$	$

		Positions: Internal	1 FT, 12 PT
Expected Start Date:	9/01/2010	Contractor	10
Expected Completion Date:	12/02/2013	FTE:	9

_____Agency Request X Governor's Recommended _____ Legislatively Adopted Budget Page _____

INFORMATION TECHNOLOGY PROJECTS IN 2013-15

(THAT EQUAL OR EXCEED $150,000)

Agency Name:	OHA			
Project Name:	**FEDERAL RULE ICD-10 - MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)**			
Mandated Project?	☒ Yes ☐ No		By: Legislature, Federal Gov, Other (identify it)	Federal Rule ICD-10
Budget?	☒ Base ☐ POP		Which agency or state plans or goals does it align with and/or support?	▪ Assisting people to become Independent, Healthy and Safe ▪ KPM 43 – Customer Service: accuracy, availability of information
Project Purpose	☐ Routine Lifecycle Replacement	☒ Upgrade/Enhance Existing System	☐ New System	
Project Status	☐ Concept Stage	☐ Planning Stage	☐ Ready to Implement	☒ Continuation of Existing Project
SDC Involvement	☒ None	☐ Minor	☐ Active	☐ Participating Partner
Estimate SDC Costs	**$ -0-**	☒ Preliminary Estimate	☐ Project Design Estimate	

Project Description: Federal DHHS published two final rules on January 16, 2009 under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). These rules impart changes to *Title 45 –Public Welfare, Code of Federal Regulations*, and *Part 162 – Administrative Requirements*. These two rules apply to all HIPAA covered entities, including health plans, health care clearing houses, and certain health care providers. The first rule deals with updating the Electronic Transaction Standards, Stage 1 of the Project. The second rule deals with updating the Medical Code sets, Stage 2 of the Project. Stage 2 is scheduled to start OCT 2011 and complete DEC 2013.

Cost Summary							
Total estimated cost by fund (13-15):	General Fund	Lottery Funds	Other Funds	Non-Limited	Federal Funds	Non-Limited	Total Funds
	$ 1,20,424	$	$	$	$ 10,709,098	$	$ 11,913,522
Total estimated cost by fund (all biennia):	$ 1,370,397	$	$	$	$ 12,133,569	$	**$** 13,503,966

Estimated Cost by category (13-15):	Personal Services	Services & Supplies	Capital Outlay	Special Payments	Debt Service
	$ 1,146,672	$ 10,325,269	$ 405,000	$	$
Estimated Cost by category (all biennia):	$ 1,991,706	$ 11,512,260	$	$	$

		Positions: Internal	7
Expected Start Date:	4/18/2011	Contractor	16
Expected Completion Date:	12/02/2014	FTE:	9

_____Agency Request X Governor's Recommended _____ Legislatively Adopted Budget Page _____

INFORMATION TECHNOLOGY PROJECTS IN 2013-15

(THAT EQUAL OR EXCEED $150,000)

Agency Name:	OHA			
Project Name:	**DISASTER RECOVERY - MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)**			
Mandated Project?	☒ Yes ☐ No		By: Legislature, Federal Government, Other (identify it)	CMS
Budget?	☒ Base ☐ POP		Which agency or state plans or goals does it align with and/or support?	▪ Assisting people to become Independent, Healthy and Safe ▪ KPM 43 – Customer Service: accuracy, availability of information, expertise, helpfulness, timeliness - **Continuation of "emergent Medicaid operations"** ▪ **Medicaid Certification**
Project Purpose	☐ Routine Lifecycle Replacement ☒ Upgrade/Enhance Existing System ☐ New System			
Project Status	☐ Concept Stage ☐ Planning Stage ☐ Ready to Implement ☒ Continuation of Existing Project			
SDC Involvement	☐ None ☒ Minor ☐ Active ☒ Participating Partner			
Estimate SDC Costs	**Minimal** ☒ Preliminary I_APD Estimate ☐ Project Design Estimate			

Project Description: Create a stop-gap disaster recovery solution sufficient for CMS to qualify MMIS for certification and an enhanced 25% operating cost match (this includes a technical solution with accompanying business impact assessment, business continuity plan and emergency response plan) to be followed by a Cost Benefit Analysis and the selection, implementation and testing of a long-term solution

Cost Summary							
Total estimated cost by fund (11-13):	General Fund	Lottery Funds	Other Funds	Non-Limited	Federal Funds	Non-Limited	Total Funds
	$454,217	$	$	$	$3,120,324	$	**$ 3,574,541**
Total estimated cost by fund (all biennia):	$503,655	$		$	$3,535,808	$	**$ 4,039,463**

Estimated Cost by category (11-13):	Personal Services	Services & Supplies	Capital Outlay	Special Payments	Debt Service (DS)
	$1,304,482	$2,270,058		$	
Estimated Cost by category (all biennia):	$1,645,906	$2,393,557		$	

*** Staff costs charged to the project which will offset general fund salaries is $395,725 for a net cost to the State of $132,597.**	
Expected Start Date:	June 2011
Expected Completion Date:	2013

Positions: Internal	4
Contractors	HP and SunGard (work order contracts)
FTE:	4

_____Agency Request X Governor's Recommended _____ Legislatively Adopted Budget Page _____

Oregon Health Authority
AUDIT RESPONSE REPORT

1. DAS: State Cell Phone Plans, audit # 2009-18, (dated 08/26/09)

- DHS, ODOT, and DOC:
  - obtain from vendors cell phone billing and usage reports that identify cost saving opportunities and share those formats and analyses with other agencies as opportunities arise;
  - regularly review cell phone bills and vendor reports to identify zero use phones and usage patterns that indicate a line should be terminated or a plan should be adjusted;
  - update cell phone inventories now and immediately turn off all phones unaccounted for; and
  - update inventories periodically in the future, including accounting for phone returns and line terminations for separating employees.

The department implemented improved procedures on wireless communication device (WCD) usage, many of which reflect the recommendations in the audit report and have generated savings.

The process of identifying the local WCD coordinators began in January 2009. A pilot program for the (primary vendor) districts began in June 2009. Initial pilot training on the new local review process occurred on July 21, 2009. WCD coordinators are in place and have been trained. As new coordinators are added, training is provided by the Statewide WCD Coordinator. Webinar coordinator training is being prepared and will be presented twice a year starting with the second quarter of 2012. Training covers all vendors.

The department began working with WCD vendors in February 2009 to start the process of creating sub-accounts and bundling minutes. The department worked closely with vendors to create the appropriate sub-accounts, establish local coordinator access and receive ordering system training. The use of sub-accounts for each District is an example of how invoices are broken out for each Local WCD Coordinator for review.

Sub-accounts also facilitate roll up to one account allowing the agency to take advantage of volume discounts. Vendors provide other methods to achieve the same goal. Invoices from all vendors are sent to Local WCD Coordinators for review. The department also worked with the vendors to reduce expenses by bundling minutes into a shared pool of minutes. These efforts are ongoing.

DHS Policy DHS-020-006 and procedures DHS-020-006-01 and 02 provide overarching roles and responsibilities for wireless communication devices (WCD); however, they do not discuss inventory process or procedure. Local WCD coordinators have been assigned the responsibility of ordering, inventorying and monitoring the wireless devices and usage for their districts. WCD coordinators are responsible for examination of rate plans, zero use, and possible inappropriate use.

Existing department-wide policies and procedures were initially modified in August 2009 to provide better guidance on roles and responsibilities for all parties involved in the WCD process. This should improve communications between WCD administrators, Financial Services, and WCD users. It should also result in a reduction in duplication of work and improved oversight of this process. However, the processes have continued to change since the last policy update.

In support of the policy changes, the WCD order form was updated to improve the methods to track devices, justify business need, clarify plan needs, and identify supervisor responsibilities. It also clearly identifies if a phone is required for emergency preparedness or used as an office check out WCD, which will be indicated in the DHS Master WCD Inventory List. This updated form was posted on the DHS Form Server July 31, 2009.

Earlier in 2009, the central WCD coordinator began developing a new Master Inventory that includes vendor driven information and information collected internally.

A basic information sheet for new WCD users has been created. This sheet contains important information such as: contact numbers, policy information, plan specifics and basic user instructions. A "WCD Quick

Facts" document has been completed and posted to DHS forms server. Form use will be included in upcoming WCD coordinator training.

The WCD Rapid Process Improvement process has been completed. WCD coordinators continue to monitor rate plans, usage and under-utilized devices.

Smart phone billing is currently received electronically from all carriers. Bills are received monthly/quarterly. Electronic billing data allows the agency to query the "minutes used" and "data used" columns for zero values. Smart phone bills are received centrally. The Sprint smart phone account (approximately 1,600 users) is a bundled plan. If users exceed the voice minutes allowed by the plan, bundled minutes from underutilized plans provide coverage. The agency is working with AT&T and Verizon to evaluate the cost-effectiveness of shifting the remaining smart phone users (approximately 300 users) to bundled plans. All smart phone users have unlimited data plans.

Smart phones are provided at little or no cost to the agency. Additionally, agency accounts are eligible for upgrade/replacement at no cost within the first year. Smart phone accounts are suspended/terminated by matching employee data (OR#) against lines of service when an employ ends state service. This is accomplished through the use of a Mobile Device Management (MDM) software platform. As the agency completes its transition to Apple iOS devices, all state issued smart phones will be managed in this way.

Dedicated cell phone billing is received electronically from all carriers. Bills are received monthly/quarterly. Electronic billing data allows the agency to query the "minutes used" and "data used" columns for zero values. Dedicated cell phone bills are received and processed by local Wireless Communication Device (WCD) coordinators at the field office level. All accounts have a bundled minute option for a nominal cost. Bundled plans are selected by the local WCD coordinator. Local WCD coordinators are responsible for reviewing carrier's cellular invoices for usage accuracy. If users exceed the voice minutes allowed under their selected plan, bundled minutes from underutilized plans provide overage coverage. The plan to implement a semi-annual review of local WCD coordinator's records by the

state-wide WCD coordinator has not been implemented due to limited resources. The Office of Information Services (OIS) will develop a plan to spot check the Local WCD coordinators to assure they are actively reviewing their invoices.

Cell phone ordering and inventory, (as compared to smart phones), is currently the responsibility of the local WCD coordinators. Cell phones are ordered in a decentralized way to provide accountability at the office level. A centralized cellular device inventory is not currently maintained. The agencies are in the process of matching employee data (OR#) against lines of service. This will enable the suspension/termination of service when an employee ends state service. Devices are managed by the WCD coordinators and accounted for at the time of issue via the Employee Property Tracking process. When employment ends, the device is returned.

The department also shared the methods for our quarterly review with Department of Administrative Services, so that they can share this information with other agencies.

2. Oregon Health Plan: Timely Eligibility Determinations Conducted on Clients, audit #2009-21, (dated 09/17/09)

- After the department completes urgent and complex projects such as the client transfer, it also considers a final review to identify any errors.

  The Department of Human Services agrees with the audit recommendation to require a post-implementation review when the department is working on a project such as the FHIAP to OHP Standard transfer. One critical outcome of this review would be a final reconciliation of records between the two agencies involved.

3. DAS: Agencies Should Explore Opportunities to Earn Purchase Card Rebates, audit # 2010-12, (dated January 2010)

- The four agencies that missed the rebate periodically explore available strategies and analyze the associated costs and benefits of obtaining purchase card rebates. We also recommend these four agencies consider the specific strategies listed in the report. We also recommend that DHS selectively expand its existing pilot efforts to units and/or programs where it would be cost-effective to do so and consider exploring options for electronic payment and interim rebate reports.

  DHS and OHA continue to explore available strategies and analyze the associated costs and benefits of obtaining purchase card rebates. Here are the items DHS and OHA have been working on since January 2010:

  - *The Oregon State Hospital and Public Health have switched to weekly payment processing, allowing DHS and OHA to take further advantage of the rebates.*
  - *We worked with DAS to start making payments to our bank by ACH instead of warrant. This will reduce the time it takes the payment to reach our bank.*
  - *We worked with DAS to receive the interim rebate reports to help us analyze the spending trends.*

  DHS and OHA have improved payment cycle time and received increased rebates since these steps have been implemented.

4. DHS: Human Services, Department of: Purchase Card Controls, Management Letter #100-2010-03-02 (dated 03/17/10)

- Review the design and operation of its controls over purchase card use to assure that those controls align with the level of risk that management is willing to tolerate.

The department updated its SPOTS policies and procedures that strengthen the procurement controls and enhance SPOTS usage monitoring. This new policy and procedure has been incorporated into ongoing training for all card holders and their supervisors. Card holders that do not attend their required refresher training have their cards suspended.

The new manager training addresses manager responsibilities to ensure proper use of the cards, including security, card limits, documentation and monthly review and tracking. This training will be required for all department managers responsible for reviewing SPOTS usage.

The department's Internal Audit and Consulting unit also completed an audit on the department's SPOTS card use. The department has adopted the recommendations of the audit and continues to improve the SPOTS controls.

DHS and OHA continue to require refresher training for all cardholders and their supervisors every two years. Cardholders that fail to complete this required training have their cards suspended.

The Office of Financial Services (OFS) revised its SPOTS training sessions during 2012 placing a greater emphasis on purchasing rules, policies, and procedures.

- Establish controls over the administration of stored value cards that are consistent with the level of risk that management is willing to tolerate.

  The department updated and strengthened the controls in its revised SPOTS policies and procedures. This new policy will strengthen the procurement controls and stored-value card tracking.

The SPOTS coordinator monitors stored value card purchases on a monthly basis. The manager or designee authorizing stored value card purchases are regularly asked specific questions to ensure compliance with policy.

5. DHS: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2009, audit # 2010-19, (dated March 2010)

- Department management seek adequate assurance for the accuracy of all financial information they report. Management should have a documented understanding of the controls involved in transactions, whether automated or manual, to ensure the integrity of the information. When necessary, such as for significant financial systems operated by service providers, department management should obtain independent assurance over the reliability and accuracy of the information. This may be accomplished, in part, by ensuring contracts for significant services require internal control reviews and that the reviews are performed periodically as determined necessary.

  The department implemented a new Medicaid Management Information System (MMIS) in December 2008. This system replaced the department's former legacy system used to track, pay and report on a majority of the state's Medicaid eligible services. Operation of the MMIS is a joint effort between the Department of Human Services, who is responsible for the system, and our service provider, who has been contracted to implement it. Both the department and our service provider have experience designing and maintaining large information management systems. Under the current Operations and Maintenance contract, our service provider maintains control over the source code and is responsible for security of the code. Only our service provider's staff have update access for programming changes, implementing change orders, and correcting system defects. The department remains responsible for physical security of the system, for controlling user access, for updating reference tables and identifying errors in data entry and in output.

Over the course of the audit, the department provided a considerable number of documents outlining system operations and controls at both the department and our service provider. However, the department acknowledges that further work is needed to adequately document, communicate and review MMIS internal controls and processes.

The decision to implement the new MMIS in December 2008 was the only practical option available at that time and continues to be a wise financial decision for the state. The federal government, which had been paying 90 percent of the development costs, refused to pay for additional development. Comparisons to other states showed that Oregon was at a greater state of readiness than other states that had gone live with the same system. Although the quality assurance contractor expressed the reservations referenced in the finding, they also expressed their understanding of the department's legitimate reasons for not delaying implementation further.

The decision to go live was supported by a formal readiness assessment process that weighted outstanding issues against funding pressures, staff morale and the likelihood of full stabilization without being in a production environment. The decision was also supported by manual workarounds to ensure that the business processes functioned properly as the system was stabilized.

External audits of the Medicaid Management Information System have been completed by both the Oregon Secretary of State Audits Division (June 2011) and the Department of Health and Human Services Office of Inspector General (April 2011). The department has implemented many of the recommendations from these audits and is actively working on those recommendations not yet implemented. The system on-site Certification Review was also conducted by the Centers for Medicare and Medicaid Services (CMS) in January, 2011. In addition, in August 2011, the department entered into an agreement with a contractor to perform a series of SOC 1, Type 2 service organization control audits covering periods between July 1, 2010 and June 30, 2013. The first of these reports covering the period July 1, 2010 through June 30, 2011, was completed in June 2012.

- Department management ensure accounting personnel have the requisite knowledge, skills, and abilities to accurately perform their assigned duties and ensure the resulting accounting records are in accordance with GAAP. Management should emphasize the importance of understanding GAAP to personnel who are responsible for recording transactions, calculating year-end accruals, and making adjustments that cross fiscal years. Management should also create a better awareness of the differences between budgetary accounting and GAAP, and when each is applicable.

  The Department of Human Services (DHS) recognizes that staff skills need to improve. DHS's financial situation presents the most complex accounting and financial management questions in Oregon government. Because of this, DHS financial staff should be the best. The department is committed to achieve excellence not only in producing the annual financial statements, but in improving management and federal financial reporting.

  The complexity occurs because DHS keeps accounting records for three different purposes – the statewide financial report, budgetary reporting, and federal reporting. Each of these operate on different time periods, closing deadlines, and accrual rules. Thus, all staff making entries must be cognizant of the effect of their entry on all three reporting processes.

  Although the finding itself is a broad statement about staff skills, it is based largely on errors in the precise area where the three reports differ – accruals, prior period adjustments, and other year-end transactions. The errors themselves largely affected statewide financial reporting, not budgetary or federal reporting. They were immaterial to the statewide financial report and, in some cases, had they been entered correctly, would not have changed the statewide financial report. Nonetheless, many were errors and DHS is responsible to ensure staff has the ability and resources to record them correctly.

  Due to efforts made in response to a prior audit finding, DHS believes the performance of its Statewide Financial Reporting Team has improved in the last two years. The team developed and documented a detailed process for estimating year-end accruals based on actual accruals in the prior year adjusted for

known variations from prior period activity. This estimation is necessary because state policy requires that financial statement accruals be completed by mid-August – 45 days before the accrual period ends.

Further, to improve performance and strengthen staff knowledge, skills and abilities, the Office of Financial Services has taken the following actions:

- *Errors identified from the FY09 audit were documented and reviewed by staff.*
- *Statewide Financial Reporting (SFR) team staff attended various trainings in FY 10 including the annual GAAP update training held by GASB.*
- *The SFR team created an internal and external year-end task list for year-end closing activities. The internal task list was used by the SFR team to ensure that all of the necessary year-end activities were completed. During the FY 10 close period the SFR unit scheduled weekly meetings to review tasks, update and add to the task list and to problem solve issues. The external year-end task list was sent to OFS staff for the purposes of clarifying each unit's role in the year-end process and providing written guidance on required year-end tasks. SFR team members met with various staff and provided verbal guidance on GAAP required tasks including accruals, prior period adjustments, transferring completed assets, and appropriate backdating of payments and Balanced Transfers. These efforts resulted in reduced errors in FY 10 related to prior period adjustments, improved documentation of entries, and increased staff understanding of their entries related to GAAP requirements. The Lean Daily Management System adopted by DHS has also resulted in improved verbal communication of GAAP throughout DHS's fiscal units.*
- *Development of the batch release checklist was completed in April 2010. In-person and V-Con training for batch releasers was completed on August 17, 2010. The purpose of the checklist is to set expectations and provide guidance on what to review prior to releasing a batch. The checklist is to be used as a reference guide and is not required to be completed with each batch.*
- *Policy discussion on accrual recording level began in May, 2010. Accrual procedure has been updated and will be reviewed yearly for modification.*

We believe that ensuring that accounting personnel have the requisite knowledge, skills and abilities to accurately perform their accounting duties in this complex environment is an on-going process. During the last year we have taken steps to develop a more robust succession plan including more opportunities for cross-training and job developmentals and rotations. We continue to use Lean methodologies to document and improve our processes. We have formed an internal training committee with the goal of increasing training on the unique aspects of accounting in DHS/OHA.

- Department management obtain independent assurance over the reliability and accuracy of the system's controls.

  External audits of the Medicaid Management Information System have been completed by both the Oregon Secretary of State Audits Division (June 2011) and the Department of Health and Human Services Office of Inspector General (April 2011). The department has implemented many of the recommendations from these audits and is actively working on those recommendations not yet implemented. The system on-site Certification Review was also conducted by the Centers for Medicare and Medicaid Services (CMS) in January, 2011. In addition, in August 2011, the department entered into an agreement with a contractor to perform a series of SOC 1, Type 2 service organization control audits covering periods between July 1, 2010 and June 30, 2013. The first of these reports covering the period July 1, 2010 through June 30, 2011, was completed in June 2012. (Please refer to finding 09-01 response for further detail.)

- Department management strengthen controls to ensure that all rates are correct and adequately supported. Further, department management should determine the amount of Medicaid funds applied toward the incorrect or unsupported rates and ensure any unallowable amounts are credited back to the federal program.

  Of the four rates found to be inadequately supported, three occurred solely because their determination methodology was not promulgated in Administrative Rule. The rate methodology for most of the Medicaid program is outlined in Oregon Administrative Rule 410-120-1340. However, the rate methodology for the Durable Medical Equipment (DME) program has not been promulgated in rule.

The department's rates for these items is currently set by policy. The department reviewed the policy and determined that the payments to the providers was accurate based upon the existing policy.

The remaining inadequately supported rate involved services provided by a Seniors and People with Disabilities (SPD) Community Developmental Disability Program (CDDP) provider. This determination of this rate was not adequately documented. The federal amount of questioned costs for these services was $3,464.

The rate found to be incorrect was for a physician administered drug which is priced using Medicare Average Sales Price (ASP) fee schedule. The ASP fee schedule was manually entered into the old claims payment system with a data entry error of two cents and carried over into the new MMIS data conversion. Based on the department's research, the rate was incorrect for a one quarter period (October 1, 2008 to December 31, 2008) before it was corrected. This data entry error caused 30 claims to process incorrectly during the time period at a cost of $28.24 Total Funds.

The department reviewed the Administrative Rule and determined that the rule should reside in OAR 410-122-0186 and not 410-120-1340 as the prior response indicated. The department originally planned to include the payment method for DME in OAR 410-122-0186 and file it with the Secretary of State on October 15, 2010, with an effective date of January 1, 2011. Unfortunately, the department did not revise the rule as planned. Since October 2010, the department has been working with stakeholders to develop a payment methodology that is consistent with Medicare. The Division of Medical Assistance Programs (DMAP) filed OAR 410-122-0186 on July 29, 2011, to be effective August 1, 2011. This OAR contains the payment methods in effect for Date of Service August 1, 2011 and after.

For the remaining inadequately supported rate, SPD limited the staff authorized to complete the assessment tool used to determine payment rates. Only staff in the Restructuring Budgets, Assessments and Rates Unit within SPD may implement the tools that determine these rates, unless otherwise authorized. This allows for

greater standardization and permits SPD to retain better records of the client assessment and subsequent rate calculations. Prior to the 2009-2011 Biennium, assessment tools could be completed by CDDP or Regional Crisis Diversion staff.

The process that resulted in the use of the one incorrect rate has been discontinued. Beginning July 2009, the process for entering rates into the MMIS system changed from a manual data entry function to an automated download process. The rates are downloaded directly from the Centers for Medicare and Medicaid Services (CMS) website containing the ASP fee table. This file is loaded into a test environment where rates are reviewed by the department's Business Service Unit and Policy Unit. Once this review takes place and the file has been approved, our MMIS service provider is instructed to move the test table into production. An additional review is done during this move in order to assure the file transferred accurately.

DMAP performed a system mass adjustment process (SMAP) to our MMIS for that specific physician administered drug code. A total of 32 claims were found to be incorrect and a SMAP was performed August 5, 2011. The CMS-64 will reflect a prior period adjustment on the quarter ending September 30, 2011.

SPD also made adjustments of $15,157.81 to federal funds for the periods affected by the unsupported client rate change identified in the original finding. The first of these adjustments for $3,464 was made in March 2011, and the second for $12,693.81 was requested in August 2011. The CMS-64 will reflect a prior period adjustment for the second adjustment on the quarter ending September 30, 2011.

- Department management strengthen controls over the eligibility process to ensure that applications are complete, income determinations are accurate, and information entered into the department's systems is accurate. Further, department management should determine the total amount of CHIP funds paid on behalf of ineligible clients and ensure it is properly credited back to the federal program.

Children, Adults and Families (CAF) Self Sufficiency Programs (SSP) continues to proactively strengthen controls over the eligibility process. Income budgeting, signatures, third party liability, placement into correct medical programs and documentation issues are being addressed.

Streamlining eligibility:
In October 2009, the department streamlined the Children's Health Insurance Program (CHIP) eligibility process.

- *The CHIP countable income calculation used for the initial eligibility decision was reduced from a three-month income average to a two-month average.*
- *The un-insurance requirement was modified to make it less restrictive and easier to verify.*
- *Decreased the CHIP un-insurance waiting period from six to two months.*
- *The CHIP resource limit was eliminated.*
- *Increased the CHIP income limit to 201% of the Federal Poverty Level.*

In May 2010, the department revised OAR 461-115-0705 (Required Verification) providing the new policy that verification is required for any income a client has received as of the date of request. All other income is anticipated unless questionable.

In July 2010, the department revised OAR 461-115- 0071. This rule was revised to require only one signature per application, and now aligns with all SSP Programs.

SSPAT CHIP reviews 2009:
The Self Sufficiency Program Accuracy Team (SSPAT) conducted a special project of CHIP reviews consisting of ten branches between April and June 2009. The primary areas of review were budgeting, available third party resources, effective dates and correct program decisions. Trend information was shared with Program Managers, Line Managers and eligibility workers at the ten branch offices and with the medical training team. Following the project, SSPAT staff developed a CHIP training PowerPoint, which was distributed statewide for local and district use starting in February 2010. The PowerPoint covers

date of request, effective date, private major medical insurance, pursuing assets, income, combining Oregon Health Plan (OHP) households, and changing household members.

Application changes:
In July 2009, DHS implemented the Oregon Health Plan On-Line Application (OHP 7210W). The on-line application is submitted electronically into the imaging system and has an electronic signature.

For all medical programs, staff are trained that an individual does not need to complete a new Oregon Health Plan Application (7210) or Application for all Programs (415F) as long as the client is currently receiving DHS program benefits at the time they make the request for medical benefits. DHS staff review the application currently on file and "pend" for any verification that is needed to determine ongoing medical benefits. The August 2009 On Target newsletter included an article on when an application is needed for medical benefits.

Oregon Health Authority has hired a consulting firm to review the OHP 7210. The purpose is to make the application more user friendly.

Medical Quality Control:
CAF SSP Medical Quality Control (MEQC) completed a review of CHIP cases as part of the federal Payment Error Rate Measurement (PERM) and Quality Control (QC) process.

- *Each QC CHIP error was reported to field offices. Eligibility workers and branches were required to take appropriate action to correct errors.*
- *QC CHIP errors are discussed at the monthly statewide Quality Assurance (QA) Panel meetings. This is a statewide discussion of root causes of errors with a focus on prevention. Participants include field staff, Program Integrity, policy, and training.*

In 2010, QC conducted a CHIP review project in collaboration with SSPAT. Cases were sampled from offices with the highest number of CHIP cases. The review focused on error prone eligibility elements identified through the PERM and QC reviews: Earned income and private health insurance.

- *A total of 300 cases were sampled for the project.*
- *Error findings were reported to branch offices as they were identified. Corrective action was required for all discrepancies.*
- *Review project concluded in June 2010.*
- *A Statewide error summary will be provided to field leadership.*

Third Party Liability:
In 2010, DHS is implementing a new on-line interactive medical application. The new on-line medical application will have the capability to accept multiple signatures. (With the July 2010 rule change, two signatures are no longer required. Only one signature per household is required.) This new interactive application will also bring to the attention of the case manager if the individual has third party liability.

The Health Insurance Group (HIG) routinely works MMIS report TPL-0689-M, which identifies clients who have had active third party liability (TPL) for the past six months. When they are reviewing the TPL they also check to see if the client is receiving CHIP medical. For individuals who are receiving CHIP medical coverage and have TPL, the case is referred to OHP Statewide Processing Center. The OHP Statewide Processing Center eligibility staff review the case to see if the individual is eligible for Medicaid. If there is not Medicaid eligibility, the medical case is closed.

SSP Training:
SSP training staff developed and delivered Healthy KidsConnect training, practice opportunities and learning assessments for SSP and Seniors and People with Disabilities (SPD) eligibility and support staff. Training for SSP and SPD staff who determines eligibility is focused on new eligibility requirements; case coding; and the role of the Office of Private Health Partnerships (OPHP). SSP trainers provided Healthy KidsConnect classroom training for approximately 950 eligibility staff in 55 sessions

delivered across the state. Also, approximately 425 eligibility staff participated in one of the 17 Healthy KidsConnect NetLink sessions on-line. SSP trainers developed presentations, talking points, pre- and post-testing materials to support local Healthy KidsConnect training for SSP and SPD reception and support staff. Two Healthy KidsConnect focused skill challenges also helped SSP managers assess and support policy knowledge in local unit meetings.

Areas added to the curriculum Fall 2009

- *Screening OHP application for all medical programs.*
- *Presumptive medical process.*

In addition, in October 2010, a Skills Challenge regarding placing a client in the correct medical program will go out to all branch offices.

Self Sufficiency Modernization (SSM) efforts:
CAF SSP program staff are working in partnership with Office of Information Services staff to modernize CAF SSP eligibility systems.

- *The first phase of the new web-based application is the on-line OHP 7210W. The 7210W is a version of the OHP 7210 submitted electronically by the user into the SSP imaging system. A later version of an interview style on-line medical application is being developed for expected implementation in 2011.*
- *In addition to updating some legacy computer systems, a more intuitive user interface will be implemented. Applicant information will be entered on a common data interface screen and the data will be used to populate other screens or systems, reducing data entry errors and improving the accuracy of the client data.*
- *New imaging technology will streamline the eligibility determination process and allow workers instant access to documents, including income documentation. Use of imaging technology will reduce the amount of paper documents that can potentially be misplaced or misfiled and increase the accuracy of the information used to determine eligibility.*

- *The department plans to automate the medical program eligibility decision process using a web-based computer system.*
- *An additional component is a medical benefit calculator for eligibility workers. Eligibility workers will enter client information for each applicant, including income, household composition and other eligibility factors. The benefit calculator will review the eligibility factors for each medical category, including countable income, and assist the eligibility worker in making an eligibility determination. Income calculations will be automated. The new income calculation functionality will improve the accuracy of earned income calculations.*
- *The modernization efforts will continue to be implemented in phases, continuing throughout 2011.*

In June 2010, the department determined the amount of CHIP funds paid on behalf of the ineligible clients identified in the finding and credited the federal program.

On November 1, 2010, the department eliminated the two-month income average for OHP (including Standard) and Healthy KidsConnect (HKC) and implemented budget month income. The client reports what they have received during the budget month and what they anticipate the rest of the month. This new rule streamlines and simplifies the eligibility determination process for eligibility workers and clients. The rule changed from using two-month average to one-month.

With the budgeting change there is ongoing training, Informational Transmittals, On Target Newsletter, and QC Reviews. This will help staff in placing the client in the correct medical program.

The department continues to educate staff on when the two-months can be waived. Office of Healthy Kids sent out a "cheat sheet" for staff explaining when the two-months period can be waived. Office of Healthy Kids is also working with the federal government to see if the State can eliminate the two-months wait period.

The department is using more imaging technology. This allows workers instant access to documents and with the use of imaging, this will reduce the amount of paper documents that can potentially be misplaced or misfiled and increase the accuracy of the information used to determine eligibility.

As of July 15, 2010, the department implemented policy requiring only one signature per household. Policy Transmittal was sent to eligibility workers and the Family Services Manual was updated.

- Department management identify and correct all system coding to ensure compliance with federal eligibility requirements. In addition, department management should ensure follow-up and resolution occurs if a client coded as ineligible in the system remains on the monthly report. Further, department management should determine the total amount of TANF funds paid on behalf of ineligible clients and ensure it is properly credited back to the federal program.

  The department discovered during the audit that some family support services that meet the TANF requirements if provided to an eligible client were programmed in the department's financial system to be funded by TANF regardless of the client's eligibility for TANF. This apparently resulted from a misunderstanding of TANF requirements that occurred in the 2007-2009 budget process. The services were incorrectly charged beginning in November 2007.

  An analyst in the Federal Compliance Unit is responsible for monitoring the monthly report of clients who have or are approaching services exceeding the $25,350 annual limit. The analyst is responsible for ending the clients' TANF eligibility. Each month the analyst would verify the clients on the previous month's report had been made ineligible. However, the analyst and management did not research why some clients continued to show on the monthly report.

  The department will ensure that the funding for the services, which were programmed to charge federal TANF funds incorrectly, has been corrected. The payments were reprocessed to ensure the federal funds are reimbursed based on the clients' eligibility. The department determined, documented and made appropriate

funding adjustment to the federal program. The documentation and adjustments include the clients who had exceeded the $25,350 limit to ensure all payments funded by TANF beyond the clients' eligibility have been credited back to the federal program.

The department has implemented a monthly Federal Funding Program Update meeting. Representatives from budget, financial services, federal compliance and program policy are represented at this update meeting. The current expenditures of the federal funds are monitored and discussed. Proposed changes to use of federal funds will be discussed and decisions are made jointly by department fiscal and program management.

The department corrected the funding for the services, which were programmed to charge federal TANF funds incorrectly, in May 2010. In July 2010, the department made adjustments for the 2007-09 biennium and a portion of the 2009-11 biennium to credit funds back to the TANF federal program. In October 2010, (the next quarterly TANF report), an additional adjustment was made for the remainder of the 2009-11 biennium. In total, these adjustments equaled approximately $6.27 million. We provided the accounting detail regarding the manual adjustment mentioned above to the Region X Office of Administration for Children and Families (ACF). The adjustments were based on the total payments for the service that was incorrectly coded to use TANF funds by using the eligibility of the client. The documentation and adjustments included the clients who had exceeded the $25,350 limit to ensure all payments funded by TANF beyond the clients' eligibility have been credited back to the federal program.

The department will continue to monitor the monthly $25,350 report to ensure that any clients reported on previous reports receive the necessary adjustment to payments. Any client that remains on the report more than two months will be completely analyzed, any problems identified will be corrected and documentation of actions taken will be attached to the monthly $25,350 report. Procedures have been created for this process.

October 2010, Central Office modified the $25,350 report to include a breakdown per case, per monthly payment. This ensures a more timely and accurate determination of ineligibility when a client exceeds the $25,350 limit.

As previously noted, the department did create procedures to improve the monitoring and analysis of $25,350 report. The finding 10-13 Oregon Department of Human Services Eligibility – System coding issues, found that the procedures were being completed accurately, however, services were still being claimed to TANF-EA after the eligibility was appropriately denied. As discussed in the 10-13 Oregon Department of Human Services Eligibility – System coding issues finding, Children, Adults and Families federal compliance, contracts, budget and OR-Kids business analyst staff have completed detailed service definitions, which include appropriate budget and funding sources (federal or state general fund). This work was done with the knowledge of past audit findings and with particular attention to the appropriate use of federal funds. In addition to the detailed service definitions, the OR-Kids financial batch processing should monitor the amount claimed within the 365 days and when the $25,350 amount is achieved the system should automatically end claiming and send a notice to the Federal Revenue Specialist to close TANF eligibility.

The OR-Kids system was implemented on August 29, 2011. The OR-Kids system has not been accepted at this time due to significant issues which have not been completely corrected. The OR-Kids Project Team and DHS Executive Team are working with the vendor to determine how and when these issues can be resolved. All eligibility, TANF, Title IV-E and Title XIX, have been significantly impacted by the issues mentioned above.

Also impacted by the implementation of the OR-Kids system is the ability to complete adequate queries of the data maintained in OR-Kids. In June 2012, we began working with the Office of Information Services to design reports for Central and Field Offices to use. An Eligibility Report is still in the design stages and is proposed to be available in September 2012. The Eligibility Report will be the mechanism by which the Federal Revenue Specialists will track all their workload including TANF eligibility determinations.

Due to the issues described above and the estimated schedule for accepting the OR-Kids system, the federal compliance unit will be completing the analysis of prior payments and complete a manual adjustment by March 31, 2013.

- Department management ensure that eligibility re-determinations are conducted timely and that all eligibility criteria are substantiated. Further, department management should determine the total amount of TANF funds paid on behalf of ineligible clients and ensure it is properly credited back to the federal program.

  Child Welfare (Emergency Assistance Re-determinations)
  Procedures established in September 2008, requiring the completion of annual re-determinations for Child Welfare related TANF Emergency Assistance, have resulted in improved compliance. The monthly report used to notify Child Welfare Federal Revenue Specialists (FRS) when re-determinations are due is the same report used by the Federal Compliance Unit analyst to monitor ongoing compliance. Unfortunately, this report can be difficult to understand due to conflicting eligibility history data on Child Welfare's legacy system. The department took or is taking the following actions:
  - *Child Welfare sent an Action Request instead of a Policy Transmittal. CW-AR-10-008 was sent to Federal Revenue Specialists and the Supervisors on December 15, 2010.*
  - *Provide refresher training to individual FRS' (identified from the Federal Compliance Unit analyst's monitoring of the re-determination report) who are not completing the annual re-determinations timely. A monthly report is provided to all Federal Revenue Specialists in the field offices via e-mail to notify them when an annual re-determination is due. The monthly e-mail reminds the Federal Revenue Specialists of timelines and re-determination procedures.*
  - *Continue to analyze and fine tune to monthly report to increase its completeness, accuracy and usability. The monthly report has been enhanced as much as the current system will allow. Unfortunately, due to the complexity of the current Child Welfare IIS/FACIS system some cases are not included on the monthly re-determination report.*

The department sent an e-mail to the Child Welfare FRS to remind them of the requirement to complete TANF re-determinations annually. Refresher training was provided to individual FRS' (identified from the Federal Compliance Unit analyst's monitoring of the re-determination report) who are not completing the annual re-determinations timely.

The department will also continue to analyze and fine tune the monthly TANF re-determination report to increase the accuracy and usability of the report to ensure all re-determinations are being reported and completed timely.

Self Sufficiency (Pre-TANF Eligibility)
The Transition, Referral, and Client Self-Sufficiency (TRACS) narrative system is used to maintain a chronological, legal record of program eligibility and client case plan activity. Information narrated by case workers in TRACS includes specific financial and non-financial information related to eligibility for the Pre-TANF and TANF cash assistance programs, and the final program eligibility determination. The TRACS narrative for the identified Pre-TANF case did not contain clear, detailed information regarding eligibility based on deprivation. The department will take the following actions:

- *Send a Policy Transmittal to Self Sufficiency field staff - reminder of TANF financial and non-financial eligibility requirements and TRACS narration to support the eligibility decision.*
- *Review and update training materials related to TANF non-financial and financial eligibility factors and TRACS narration.*

In addition, the Operations Improvement Committee, Self Sufficiency Program Managers and others continue to discuss outcomes regarding narration of information in the TRACS system. Included are minimum standards of narration related to financial and non-financial program eligibility, case plan activity, confidentiality and sensitivity of health-related information, and payments in the form of benefits or support services made to families.

To support the intent of TRACS to provide a chronological, legal record of actions taken, the use of standardized narration guidelines and other tools are being explored to assist in capturing the minimum necessary information needed. The SSP TANF Program Analysts and Training Unit Staff meet monthly to discuss SSP policy and training related issues. These meetings provide an opportunity to discuss the application of policy and review training materials for accuracy and clarity, and gave the opportunity to discuss specific policy related to the eligibility for the Pre-TANF program and basic needs and support service payments.

The three incorrect payments identified and issued on the Pre-TANF case, were properly credited back to federal funds by the Office of Financial Services, in June 2010. The department will determine the total amount of TANF funds paid on behalf of the child welfare ineligible client and credit it back to the federal program.

The department continues to send monthly e-mails to the Child Welfare Federal Revenue Specialists to remind them of the requirement to complete TANF re-determinations annually. The department determined that the monthly TANF re-determination could not be fine-tuned anymore. The report is negatively affected by the current legacy systems Individual Eligibility screen. The Individual Eligibility screen is used to document eligibility for three (3) federal programs (TANF-EA, Title IV-E and SSI). Anytime a Title IV-E specialist changes the individual eligibility code it starts the clock for the calculation of when the TANF-EA re-determination is due. It is not possible to change that functionality in the legacy system; however this issue will be corrected with the implementation of the new OR-Kids system on August 29, 2011. Each federal eligibility program, TANF-EA, Title IV-E and Title XIX, will have its own unique eligibility screen. The update to the TANF-EA policy and procedure manual was delayed because the entire policy and procedure manual had to be updated with the implementation of OR-Kids. The scheduled completion date is December 31, 2011.

The OR-Kids system was implemented on August 29, 2011. The OR-Kids system has not been accepted at this time due to significant issues which have not been completely corrected. The OR-Kids Project Team

and DHS Executive Team are working with the vendor to determine how and when these issues can be resolved. All eligibility, TANF, Title IV-E and Title XIX, have been significantly impacted by the issues mentioned above.

The Policy Analyst responsible for TANF-EA was on loan to the OR-Kids project for 10 months (September 2012 – June 2012) at which time she took a permanent position with the project. A replacement was finally hired on November 15, 2012. The new completion date for the update to the TANF-EA policy and procedure manual is July 31, 2013.

- Department management ensure that verification of IEVS required screens are documented when determining client eligibility.

  This finding occurred because the department no longer enters into its case management narration system, for every case, separate specific statements that each Income and Eligibility Verification System (IEVS) screen has been checked.

  The TANF program policy requires Self Sufficiency workers to verify and document eligibility. Staff are also required to use the information from the IEVS screens as well as other documentary evidence (oral or written) in determining and verifying financial and non-financial eligibility. This is consistent with federal guidance. The three cases identified in this audit included information in the Transition, Referral, and Client Self-Sufficiency (TRACS) narrative system indicating they were eligible.

  While the department agrees that verification of financial and non-financial requirements must be adequately documented when determining client eligibility, the department disagrees that the use of IEVS related screens must be independently documented for every client. States are required to participate in the IEVS. Oregon participates as required through regular use of IEVS screens by eligibility workers and cross matching of data across other agencies including: Unemployment Compensation match with Oregon Employment Department (OED); wage match with OED; Social Security Administration income match and

SSN verification. Discrepancy reports are now created monthly for use by eligibility staff. The three cases identified in this audit did not appear in the discrepancy reports.

The IEVS requirement is that States use the information obtained through IEVS. Section 1137 (a)(4)(C) of the Social Security Act provides that "the use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients." There is not a federal requirement for documenting each time IEVS screens are viewed for every case. ACF policy instruction: TANF-ACF-PI-2007-08 provides that eligibility decisions, including denials or closures, cannot be made solely based upon the results of IEVS checks. Consequently, Self Sufficiency staff are required to validate the data obtained through a variety of resources using the source with the most reliability for the given scenario.

Recently, the Office of Self Sufficiency has been working to achieve a more streamlined environment. This is in response to the need for increased efficiency given the high number of intakes and resulting higher than budgeted caseloads. This needed efficiency also comes as a result of staffing related to the TANF program field administration being approximately 40 percent of need.

One of the recent efficiency improvements involved discontinued use of narrative templates. Self Sufficiency workers are still required to document their eligibility decisions, including decisions based on both financial and non-financial requirements. However, staff are instructed to report how they verified pertinent eligibility information about a client.

While the department's TANF program participates in IEVS as required, the department recognizes improvements could be made to better utilize data from some of our federal partner agencies.

The department will review current policies and guidance to staff regarding verification and documentation of eligibility. The department will also continue to work with federal partners to improve the State's systematic approach to meeting the IEVS requirement.

The department continues to research the requirement to utilize information contained in IEVS screens to support program eligibility related decisions and the options for narration of findings. In addition, DHS is reviewing existing Interagency Agreements with the respective IEVS agencies for language related to information sharing, limitations of information usage, and general information sharing guidelines.

Communication of narration guidelines is messaged to Office of Self-sufficiency Programs (OSSP), Self Sufficiency Program (SSP) staff through existing TRACS and program training. It is also communicated to Districts through feedback by the Accuracy Unit staff of case record reviews.

On July 29, 2010, Self Sufficiency Program Managers, program accuracy, OSSP training and OSSP Field Services met to discuss narration guidelines. OSSP Field Services sent a reminder of the TRACS narration guidelines to all staff on August 19, 2010. The monthly accuracy newsletter, "On Target", for August also included the narration guidelines. The guidelines specify financial eligibility is an aspect that must be addressed in the narrative. Examples of what must be narrated are: "Income - earned, unearned, excluded, calculation, pay stubs/verification used, self employment, results of screen checks, if no income how they are meeting basic needs; NC1/NC2 calculations; resources; pursuing assets; good cause; categorical eligibility."

The OSSP continues to reinforce the TRACS narration guidelines with SSP eligibility workers and staff. In addition, SSP revised training curriculum as needed. Benefit certification periods are six to 12 months in length and SSP serves thousands of families. Because of this, OSSP anticipated this additional attention would yield improvement with applications and re-determinations completed beginning September 2010.

The department continued to reinforce the narrative guidelines with field managers in the Fall of 2010. The department also contacted the Self-Sufficiency Training Unit to ensure the TRACS narrative guidelines are taught in eligibility training, including TANF. On September 13, 2010, OSSP issued a policy transmittal reminding staff that when determining eligibility in the TANF and Pre-TANF program, staff must ensure TRACS narration includes all financial and non-financial eligibility factors. The policy transmittal reminded staff that, "In addition to information obtained from the DHS 415F [Application for Services] and intake interview, case workers can view records from other agencies, such as the Department of Motor Vehicles and Oregon Employment Department, regarding potential income and resources. Eligibility narration must also include income or resources obtained from these records, if applicable." The OSSP Field Services Narrative Guidelines were also included in this policy transmittal. Local line managers and lead workers also reviewed (as is the expectation) this transmittal with the staff who determine eligibility.

The department once again reinforced the narrative guidelines with field managers and staff in the Spring of 2012. Narration of financial eligibility continued to be the main area that needed reinforcement. For this reason, the monthly accuracy newsletter, "On Target", for April included a reminder of the narration guidelines and the expectation of checking screens and of narrating the results of screen checks in the TRACS system. The April article also included examples of how the results of screen checks can be narrated. The department also issued another Informational Memorandum transmittal in April 2012 reinforcing the narration expectations as they apply to financial eligibility and verifying information through the various IEVS screens available to field staff. A new Multiple Program Worker Guide #23 - All Program Narration Guidelines was added to the Family Services Manual effective May1, 2012. The new worker guide outlines expectations of narration of financial information. In November 2012, uploaded financial narration information was once again included in "On Target."

- That training be provided to personnel on the use of the electronic time keeping system and applicable work charge codes for the relevant grants, and that all payroll adjustments be based on corrections to actual time and effort charges and not to overcome funding deficiencies. Shared staff should document their actual time and effort at least monthly, and more frequently if they experience constant daily variations as to which

grants they work on. Time that cannot be subdivided between grants should be allocated based on an acceptable cost allocation methodology as discussed in OMB Circular A-87.

Within the Health Promotion and Chronic Disease Prevention (HPCDP) Section there are several "shared" staff who are budgeted in all the HPCDP Chronic Disease grants or cooperative agreements that are included in the CDC Investigations and Technical Assistance Program. These budgets are approved by the CDC. These staff are typically responsible for the management and administrative functions across all the Chronic Disease grants and provide support to all the grants all the time. The charges to any of these grants for shared staff time are approved and allowable expenditures under each grant.

A recent CDC Request for Applications specifically encouraged a shared approach to leveraging resources for chronic disease programs. Our methodology for managing the costs of shared staff across all the grants was based on our interpretation of this guidance from the CDC. We have initiated conversations with CDC about these audit findings. They agree that states, like Oregon, who have acted on their direction to integrate programs and leverage resources across multiple grants are in a difficult situation when it comes to time/activity reporting. The CDC Chronic Disease and Health Promotion Center has agreed to work with Oregon to find a mutually acceptable way to monitor personnel expenses for shared staff whose work crosses multiple grants and cannot be easily dissected to individual grants, while still remaining in compliance with OMB Circular A-87.

The department agrees that a mistake was made in the second instance described above. The employees in the Office of Disease Prevention & Epidemiology who work on multiple grants or cooperative agreements included in the CDC Investigations and Technical Assistance Program are required to do time and activity reporting. They must meet this requirement by over-riding the default coding on the monthly electronic timesheet with the coding for the grants/activities where they worked during the month. Management does not shift payroll costs for employees from one grant to another disproportionately, without regard for which grant the individual actually worked on. The payroll adjustment that was made did not reflect actual grant

activity for the month of May 2009. Rather, adjustments to time/activity reporting needed to have been done over several earlier months to reflect actual time spent on the Cancer Prevention and Control grant.

Per the recommendation above, training was provided in February 2010, for those HPCDP staff whose time is paid from multiple grants. The training included use of the electronic time keeping system and guidance on how to apply charge codes for relevant grants to reflect actual time and effort. Managers and staff on a monthly basis review and project time and effort during the month. Shared staff then document their actual time and effort during the month. Over the past several months, managers have reviewed and see close consistency between projected and actual time spent on various grant activities. Thus, this method of documenting time and effort appears to be a good solution for HPCDP.

The CDC Chronic Disease and Health Promotion Center has undergone multiple major reorganizations over the last several months. However, we have had discussions with the project officers for our various grants and they are supportive of the steps we have taken to assure that time reporting does reflect time and effort.

- Department management implement a procedure to completely review and detect whether assistance payments agree with the signed adoption agreements and to get any amended assistance agreements filed in the case files. We further recommend that the department management work with the designated federal agency to determine the appropriate way to resolve any potential overpayments.

  The department's Adoption Program completed a review of the reduction period cases identified in the audit to confirm the following:
  - *Payments opened during the reduction period of February through October, 2003, were established in line with the reduced foster care rate and pursuant to a properly negotiated Adoption Assistance agreement.*
  - *There was equitable management of payments for new cases opened during the reduction period.*

- *All payments for new cases opened during the reduction period were increased at the same time as longer-standing Adoption Assistance cases.*

Part of this file review also addressed the question of whether there was a signed agreement in the file that recorded the changes in payments, both decreases and increases, from the reduction period. While new agreements were sent to all families to correctly document the changes, not all families returned them and the adoption program did not track this at the time, nor did they file returned agreements directly into subsidy case records.

The absence of a signed agreement supporting the current payment is contrary to federal requirements. The manual review found that in a small number of subsidies, there were no signed agreements and incorrect payments continued until they were identified as a result of the audits and corrective action plan (a period of more than six years). As a result of the review, eight cases were determined to be under-payments in the total amount of $5,539. A total of 23 cases were determined to be overpayments in the total amount of $71,693. Most of these were for children placed out of state with more complicated subsidy structures.

Adoption Program management has initiated contact with the Administration for Children and Families Children's Bureau, Region X Child Welfare Program Office regarding how to best resolve the issue. At this point we estimate approximately $28,000 in federal Title IV-E funds are within the total overpayment amount.

Parents of all children with under and overpayments will receive a corrected Adoption Assistance Agreement with an explanatory letter appropriate for their circumstance. The agreements are retroactive to November 1, 2003. The department will reimburse parents of children with underpayments for the total difference DHS owes on each agreement.

The department manually reviewed all agreements affected by the reduction in 2003 and implemented new matching agreements on all but 19 active cases. The department developed and implemented a new

procedure that involves a second level of review which is conducted on every Adoption Assistance Agreement to ensure that the amount on the agreement and the amount authorized match. The department worked with the designated federal agency and determined there was no overpayment because there is no Federal requirement that Adoption Assistance Agreements reflect the amount of actual adoption assistance payments. This is confirmed in a letter from the Administration for Children and Families. Based on discussions with federal agency, no further actions are required. (See Statewide Single Audit Findings 07-42, 08-28 and 10-23.)

- The agency provide additional training for the one district on transferring case files. We also recommend the agency communicate to all CAF Self Sufficiency branch offices the importance of following established business procedures for transferring case files.

  Children, Adults and Families (CAF) District 8 initiated a work group comprised of transfer clerks from each branch office and two Line Managers, all within District 8. The "case transfer workgroup" meets monthly and has developed a District-wide case transfer process and database, as their mechanism for tracking incoming and outgoing case files. The process and database are used for case file transfers within the district, or to another branch office in the state. The workgroup identifies and provides solutions to management of case file transfer issues that may arise.

  The department has communicated the expectation of following established transfer procedures at various CAF statewide meetings including: Self Sufficiency Program Managers (April 14, 2010) and the Self Sufficiency Line Manager quarterly meetings (April 20-22, 2010). District Managers have also been engaged in the discussion (July 7, 2010). Case File transfer procedures (FSM MP-WG # 21) are located in the Family Services Manual (MP-WG # 21) and the Field Business Procedure Manual (XVI. Case Files, A. Interoffice Transfer of Case Files).

- Department develop and implement a system to track actual personnel compensation for those individuals working on multiple Federal grants but whose time is not allocated using another time effort and reporting

method. We recommend that those allocations based on actual amounts be reflected in the accounting system and properly allocated to the federal grants.

The DHS cost allocation unit has provided training for the staff affected to ensure appropriate time codes are used to reflect multiple program areas these staff now work on. Codes and basic instructions were communicated to staff on December 16, 2009, for Self Sufficiency Program Accuracy Team (SSPAT) and December 17, 2009, for Quality Control (QC). These instructions directed staff to begin using these codes immediately. Follow-up training was also conducted for both affected areas.

The questioned costs identified in this audit were corrected through an adjustment to the SNAP administrative grant. Furthermore, July 2009 through December 2009, administrative costs for these staff were reviewed and similarly adjusted.

- Department management apply the correct estimated clearance pattern to all applicable vocational rehabilitation expenditures and implement a review process to ensure federal draws are calculated correctly and drawn in compliance with established estimated clearance patterns. Additionally, the department should determine the effect of the errors for the year and assess whether interest is owed to the federal program for vocational rehabilitation federal funds drawn too soon during state fiscal year 2009.

  This was the first year that the vocational rehabilitation program was required to calculate a clearance pattern under the Cash Management Improvement Act (CMIA).

  All of the formula related errors have been corrected and desk procedures on the check clearance pattern were updated for the OVRS draw process.

  We have developed and implemented a review process to ensure federal draws are correctly calculated and drawn in compliance with established check clearance patterns.

Based on the audit recommendation the department analyzed how the original draws were calculated and compared them to the appropriate CMIA estimated check clearance pattern and determined no interest was due to the federal government. The OVRS CMIA for FY 2009 was independently reviewed again to verify that no interest was due. This CMIA report was submitted to the Department of Administrative Services for inclusion into the state CMIA Report.

- Department management comply with federal requirements and ensure eligibility is determined or eligibility extensions are filed within 60 days of an individual's application for services.

  The Office of Vocational Rehabilitation Services (OVRS) statewide field services managers sent out a statewide communication, on March 22, 2010, to promptly address the agency expectations for all vocational rehabilitation counselors to perform the eligibility determination process within a 60-day time frame or file for an eligibility extension as appropriate. This statewide correspondence will also serve to help reduce the misperception that eligibility determinations are due within a "two-month period" when the specific requirement is within 60 days.

  The eligibility process, including these standardized time frames, became a focus in the new counselor training module being conducted regionally throughout the state during 2010. OVRS administration staff developed a worksheet to assist vocational rehabilitation counselors to better identify and track the salient elements required when completing an eligibility determination, i.e., the number of documented disabilities, and corresponding functional limitations when determining eligibility, and due dates. This new worksheet was distributed during the new counselor trainings.

  All VR counselors who failed to meet the eligibility requirements at the time of the Secretary of State audit were sent a personalized letter by OVRS field services managers addressing the performance expectations of eligibility determination compliance time frames.

OVRS administration engaged the branch managers, during the April & May 2010 Statewide Branch Managers' Meeting, in a discussion regarding strategies for achieving compliance on the timeliness of eligibility determinations for services. One such strategy regarded the redirection of the flow of work when the vocational rehabilitation counselor of record is unexpectedly absent due to illness or other unanticipated reasons. Branch managers also reviewed case movement from application through eligibility by generating the "Activity Due Report" in the ORCA case management system. This duty was performed every two weeks for each counselor during the first six months of this corrective action implementation.

OVRS conducted administrative file reviews to monitor compliance and identify the need for technical assistance. Client files were randomly reviewed for quality control by the program technician in the region to evaluate the circumstances pertaining to a client's eligibility status. Notifications of the deficiencies in a staff member's performance are being reported to the local branch manager. The branch manager has been conducting one-on-one discussions with counselors if a deficiency occurs during a random review of the files. To enhance statewide performance, OVRS field services managers have been reading and responding to the case file review sheets being submitted to the administration office on a monthly basis.

The Secretary of State Audits Division completed a federal compliance audit in December 2010 and no finding was noted for eligibility determinations during this review period.

In 2011, OVRS administration and the State Rehabilitation Council significantly expanded the OVRS policy manual to address the recommendations from the Secretary of State Audit Division. All OVRS field staff members were required to attend a mandatory training on these policy changes. There was a specific training module dedicated to both presumed eligibility and eligibility determinations and compliance time frames. The branch managers were trained on the new policy manual in Salem on March 9 & 10, 2011. The regional staff trainings were conducted as follows: Clackamas & East Portland branches on March 29 & 30, 2011; Salem branches on April 5 & 6, 2011; Linn-Benton-Lincoln & Lane branches on April 13 & 14, 2011; Central & North Portland branches on April 20 & 21, 2011; Roseburg & Medford branches on April 26 & 27, 2011; Washington County branch on May 3 & 4, 2011; Bend & Eastern Oregon branches on May

11 & 12, 2011; and in a make-up session for any staff missing their original training site was held in Salem on June 15 & 16, 2011.

Additionally, a mandatory online exam was required of all OVRS field staff on each of the new policy training sections to include eligibility determinations. The online six-part examination required an average of three hours to complete with a deadline for completion by July 15, 2011.

6. DHS: Office of Vocational Rehabilitation Services: Save on Vocational Costs to Serve More Clients, audit #2010-31 (September 2010)

- Oregon's Office of Vocational Rehabilitation Services (OVRS) should take several actions that can help discontinue Order of Selection by serving more clients with its current state and federal resources. In order to save costs OVRS should:
  - Ensure counselors work with clients to approve realistic employment plans by better identifying impediments to future employment and discontinuing payments when clients show an inability to achieve the employment goal.
  - Ensure counselors adhere to the employment plan and only approve expenses directed toward employment impediments and employment goal achievement.
  - Consider using a fee schedule to ensure a reasonable cost to the program for commonly purchased services.
  - Monitor counselor spending approvals to ensure the most prudent decisions are made.
  - Establish realistic budgets for counselors and branch offices that are based on client types, economic conditions and other related factors.
  - Consider reviewing and revising the client contribution policy.
  - Continue with the addition of client maintenance system controls such as the current effort to link authorizations and payments to plan services.

The Office of Vocational Rehabilitation Services (OVRS) designated a Program Improvement Manager who acted as a Project Manager to assist the OVRS Executive Team to develop a plan for program improvement in case management, quality assurance, accountability and cost containment. The Program Improvement Plan is complete and being implemented. A Gantt chart of all program improvement activities to be implemented has been developed and monthly reviews to track the benchmarks identified within the overall plan are being conducted.

OVRS has established a goal to reduce the average cost per case served by 20% from comparable FFY 2008 levels by FFY 2012. This will be accomplished through the implementation of the Program Improvement Plan and close monitoring of program expenditures while simultaneously maintaining the quality of employment outcomes.

OVRS already has the following spending guidelines and controls in place for counselors:

- *Spending authority limitations are presently incorporated in ORCA, the program's case management system. The spending authority for counselors is $5,000 per authorization, $20,000 for branch managers, and $50,000 for field services managers. ORCA will not permit the issuance of payment documents beyond one's authority.*
- *All four-year school plans must be reviewed and approved by a field service manager and the agency administrator.*
- *All vehicle purchases must be reviewed and approved by the administrator. Vehicle purchase is currently an exception to policy and will only be considered when other modes of transportation are not feasible.*
- *New counselors' authorizations for services must be reviewed by their managers during their first six months of employment (trial service).*

In addition, in 2008 OVRS began exploring a shift to performance-based contracted services as a strategy to increase the quality of services for the dollars spent. Accordingly, during 2009 OVRS established minimum qualifications for job developers and provided them with training on how to

perform job development using practical marketing and sales techniques appropriate for securing jobs for clients with any level of an employment barrier. OVRS job placement contracts now emphasize performance-based outcomes in three categories: job development, job placement, and job retention. The full implementation to the performance-based methodology was initiated on January 2, 2010. Data analysis regarding the job placement and job retention outcomes and cost analysis has been incorporated as a portion of the Program Improvement Plan.

In addition to performance-based contracts for its job development service providers, OVRS collaborated with Alliance Enterprises, the creator of the program's case management system, in a pilot to develop a report card that gives managers and administrators more information about the performance of vendors. The report card will provide information on the effectiveness of individual vendor success rates across a number of disability and demographic variables. In addition to supporting better program oversight and administration at the management level, this information will help counselors and participants to make informed choices and assist the program to identify best practices. It will also serve as an objective foundation to discontinue issuing contracts to ineffective vendors.

OVRS took the following additional actions relating to cost containment:

- *OVRS reviewed current spending approval levels and methodologies. The review included consideration of setting budgets for counselors and branch offices that are based on client types, economic conditions and other related factors such as prior budget management, average costs and rehabilitation rates. The review also looked at improving ways to efficiently monitor and analyze spending patterns and ultimately set a process for routine reviews of spending approval levels.*
- *OVRS reviewed staff spending authority levels. It was determined that the most effective method is to distribute partial funding into counselor caseloads (in the ORCA case management system) every six months so that central office can monitor ongoing spending patterns throughout the year.*
- *OVRS asked the State Rehabilitation Council (SRC) to partner with them in a review of the current participation contribution policy. OVRS developed the consumer's contribution policy with the SRC, and any change in the existing policy would require their approval. OVRS engaged the SRC in a*

discussion about the level of the participant's contribution as a percentage of income as well as the income threshold for contributing to the cost of services. The SRC moved to maintain current client contribution levels.

- *OVRS is exploring options for a standardized fee schedule. The State's workers compensation's fee schedule was reviewed. It is a complex system that requires medical coding. It is not a practical option for OVRS. The program will continue to explore other options.*
- *OVRS reviewed and revised its Medical Restoration policy in order to provide more effective guidance on medical fees.*

The OVRS Administrator and the new Program Improvement Manager have set concrete timelines for completion of these additional action items as part of the Program Improvement Plan.

- In order to help client success rates OVRS should:
  - Ensure counselors develop and adhere to milestones within employment plans and take quick, appropriate actions if those milestones are not met.
  - Establish higher rehabilitation goals for counselors and take constructive actions when those goals are not met.
  - Ensure counselors establish clear client expectations.
  - Ensure counselors address any prior issues when clients return.

OVRS has implemented a new case management data monitoring system to identify individual case management issues and program-wide reporting on open cases. This system will strengthen monitoring consumer compliance to the mutually agreed benchmarks incorporated within the employment plans.

In support of more consistent practice, better counselor decision-making, and stronger management oversight, OVRS has taken the following steps focusing on improved case management.

OVRS revised the case closure policy to provide more specific guidance for counselors regarding conditions under which an individual's case file can be closed. After consulting with the Rehabilitation Services Administration (RSA), the OVRS Executive Team and State Rehabilitation Council Policy Committee approved the new policy in August 2010. The State Rehabilitation Council Executive Committee approved this policy in September 2010. Training for all staff was completed.

Over the last two years, training has been provided to counseling staff on how to identify and intervene when participant motivational issues impede engagement in the process and hinder progress with plan services. As a best practice, counselors are being asked to routinely use this methodology when a participant has failed to make sufficient progress toward plan benchmarks.

OVRS has enhanced its automated case management system so that services identified in a client's case plan are linked to services being authorized as the plan is implemented. This automation means that an individual counselor cannot pay for services that are not detailed in the plan or extend services without amending the plan. This enhancement was made available when the newest version of the Oregon Rehabilitation Case Automation System (ORCA) was implemented winter 2010.

Finally, in conjunction with the Spring 2011 ORCA update, OVRS provided training on informed choice to emphasize the application of best clinical practices in the areas of vocational goal selection, establishment of benchmarks to assess and track the client's progress, selection of vendor(s), and specific goods and services. This clinical training will also help counselors provide better occupational guidance to clients. These efforts are expected to result in client plans better aligning with realistic employment goals.

- In order to better assist counselors in performing their duties OVRS should:
  - Complete the drafting of its policy manual.
  - Develop better data monitoring to identify program-wide and individual case management issues, including better reporting on open cases.
  - Conduct regular performance evaluations that incorporate case closure.

- Explore cost-effective training solutions such as those provided for free by vocational rehabilitation Technical Assistance and Continuing Education centers.

OVRS completed a significantly expanded revision of the program's policy manual in May *2011, to address the increased need for consistency in client expenditures across the state. Regional trainings will be conducted on the new policy manual beginning May of 2011.*

As a consequence of the Order of Selection, in January 2009, OVRS re-trained all current staff on the eligibility determination process to ensure statewide consistency in establishing the consumer's disability-related functional limitations impacting employment. Eligibility became the focus of recent file reviews conducted by the program's field technicians. Results from those reviews were shared with managers who work with any staff who need additional support and/or who had deficiencies in this area.

In February 2009, the program revised its new counselor training to more narrowly focus on case management and critical case questioning. In March 2009, this class was conducted regionally across the state and was attended by new counseling staff and counselors who would benefit from refresher training.

The program offered this training again in September and December 2010, and will continue to offer it on a regularly scheduled basis. The program will provide training on plan development including appropriately ensuring clear client expectations and appropriate follow-up on any prior problems when clients return. Training will be prioritized for new counselors and counselors in need of additional training. On a go-forward basis, OVRS will continue to provide training, as well as utilize regional resources, to improve counselors' skills to provide effective and cost appropriate services and to promote better counselor decision-making.

Every 12 months, OVRS conducts a branch-wide review to include a random sampling of cases from each counselor. These branch-wide quality assurance reviews are conducted by the regional program technicians and results are provided to each branch manager. The agency will continue to perform file reviews and

identify branch level and statewide trends to develop trainings and to coach staff. In addition, OVRS will take the following actions:

- *Under an existing Oregon Administrative Rule, a person may be eligible for VR services if he/she is in the U.S. for other than a temporary purpose and legally entitled to hold employment in this country. On September 1, 2010, OVRS notified all managers that effective immediately OVRS will now require all prospective applicants to supply valid documentation of their legal status to work and proof of identity prior to initiating an application. An application will not be accepted until documentation is obtained and a copy placed in the client's file. Temporary guidelines have been provided to managers throughout the state. Revision on this associated policy will start immediately. Additionally, OVRS is, on its own, randomly auditing 500 files to ensure compliance.*
- *OVRS Central Office Administration has involved DHS Human Resources in implementing a monitoring system on a quarterly basis to track position descriptions, performance feedback, and employee development plans. Of the 204 field positions at the end of last quarter (through October 31, 2012), the HR report shows 187 current position descriptions, 170 with written performance feedback, and 178 with current employee development plans. OVR has five new hires on trial service who have not reached six months of employment to warrant a written performance evaluation and twelve vacant positions; thus, a total of 187 active employees are being tracked for performance reviews during the third quarter of 2012. OVRS administration intends to have the remaining 17 performance evaluations completed by December 31, 2012.*

7. DHS: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2010, audit # 2011- 06, (dated March 2011)

- We recommend the Department remove conflicting access rights where it can. In those instances where the conflict remains, DHS should develop and implement a detective control to specifically address those instances.

Due to budget cuts resulting in a hiring freeze coupled with increased caseloads and demands for services, offices needed to reassign some of the daily duties to support staff to accommodate the increasing demand for services.

In January 2011, the Seniors and People with Disabilities RACF administrator sent an email to the SPD Sub-Administrators asking them to review their existing reports and remove any unnecessary current access rights.

In February 2011, Children, Adults and Families (CAF), District Business Experts began a manual compensating controls review process. These reviews are occurring in CAF Self Sufficiency Program (SSP) Field offices monthly.

The Resource Access Control Facility (RACF) report is distributed monthly to the CAF Field Business Experts and Self-Sufficiency Office Managers, as well as the SPD Field Offices. The RACF report identifies employees within a branch office and their respective computer access rights. In addition, a two-page cheat-sheet has been developed and distributed to Business Experts and SSP Office managers to assist in reading the report and accurately identifying those employees with conflicting access.

In addition, an ad-hoc monitoring report has been created. This report, finalized in October 2011 is distributed monthly and is used to identify potential SSP and SPD employees who performed conflicting access functions and replaces the previous manual compensating controls process.

It should be noted that a statewide hiring freeze remains in effect. CAF received permission to fill some previously vacant position; however, this will only bring CAF staffing up to 70 percent of the need. Based on continued reduced staffing and limited resources, it is anticipated the need for staff to have conflicting access will continue.

- We recommend that the department management work with the designated federal agency to determine the appropriate way to resolve any overpayments, or to stop using federal funds for future payments in the 52 cases without a revised adoption agreement and to repay amounts previously overpaid.

  After consultation with the Administration for Children and Families, and confirmed in a letter received from ACF, there are no overpayments owed because there is no federal regulation that requires Adoption Assistance Agreements reflect the amount of actual adoption assistance payments. Federal policy allows automatic adjustments without parental concurrence only in the case of an across-the-board rate reduction or increase in foster care maintenance rates. Consequently, when there has been an across-the-board rate reduction or increase in foster care rates, the State could also impose that reduction to the adoption assistance program recipients and the Title IV-E agency need not execute new, signed agreements that reflect the change to the rate. Based on the documentation relative to this finding, ACF will not recover Federal funds. Based on discussions with federal agency, no further actions are required. (See Statewide Single Audit Findings 07-42, 08-28 and 09-19.)

- We recommend the agency implement a process to review applications provided by participants for fraudulent or incorrect information. In addition, we recommend attendance logs be received more timely for review of services provided. We also recommend overpayment letters be sent immediately or as soon as reasonably possible to recover any improper payments.

  Eligibility staff are currently trained to pursue questionable information and utilize available resources including Oregon Birth Verification Records. The DHS Child Care Provider Listing form (DHS7494) also asks the provider if they are related to the children. The form states that DHS will not pay the provider if they are the parent, step parent or legal guardian of the child. When processing the form, the Direct Pay Unit (DPU) reviews all open cases for the provider and client to see if all household members are included on the form. If DPU notices a birth father on the open case, they are prompted to further investigate.

Effective October 1, 2010, DHS eliminated the temporary approval of providers while undergoing the background check and now requires the provider (and other subject individuals) to complete and pass the DHS Background Check before allowing payment or authorization for payment to the provider. Though the main reason for this change was to reduce potential risk to children, it may also help identify some fraudulent providers. If information is discovered in the background check that shows evidence that the child care provider is the parent of the child in care, it is reported to the DHS Direct Pay Unit and the provider will not receive payment. Other rule changes are in process for April 1, 2013, to change the department's payment process to only pay for eligible child care services from the date the provider is in approved DHS listing status.

If the information is discovered after payment has been made, DHS pursues an overpayment on the provider. In the fraud case mentioned in the finding, a referral was made to Investigations, an overpayment was written and the client signed an Intentional Program Violation waiver admitting to the charges. On the other overpayment case mentioned, DHS acknowledges that the overpayment letter was not written timely. However, the overpayment had been identified to be worked prior to the audit. This delay was partially due to reduced staffing in the Overpayment unit.

Temporary Assistance for Needy Families (TANF) eligibility includes the requirement that a parent cooperate with the Division of Child Support (DCS) to establish paternity and locate and obtain child support payments for each needy child. Over the past year, DHS and DCS have jointly developed and delivered tools, cheat sheets and in-person training modules to staff that have resulted in increases to the paternity establishment percentage rate and the number of TANF cases in which a child support collection is made.

With implementation of the ERDC reservation list (October 2010 to April 30, 2011, August 1, 2011 to May 31, 2012 and November 1, 2012 to December 13, 2012), for most clients ERDC eligibility is contingent upon receipt of TANF within the prior three months. Combined with the recent emphasis by Department of

Human Services (DHS) and Division of Child Support (DSC) on child support, the number of ERDC cases in which a payment may be made to a parent is further diminished.

In addition to 11 classes provided to new eligibility workers in 2011, field staff has been given five ERDC refresher classes and one Netlink with expanded questions/scenarios as a reminder on who can be a provider. In 2012 the department provided eleven classes for new eligibility workers, four ERDC refresher classes and five Netlink sessions. All training emphasizes specific questions workers can ask the client if they find a potential provider situation questionable. A May 2011 ERDC Skill Challenge and April 2011 article in the "On Target" staff newsletter reviewed in depth who can be a provider and what to do when a situation is questionable. Another "On Target" article appeared in the November 2012 newsletter which focused on setting accurate percentages for clients who are using multiple child care providers. These clients are required to split their child care hours between the providers on their case, assigning accurate percentages of child care hours has reduced the number of overpayments in the program. Further, 95 ERDC cases are reviewed monthly by the DHS Accuracy Team to identify and give immediate feedback on errors. We have found staff education useful in reducing client and provider fraud.

DHS currently has one overpayment writer who works specifically on child care provider payments. This allows the department timely request and review of attendance logs and special reports for appropriate service payments and the writing of overpayments.

DHS is also moving to real time knowledge of child care usage rather than waiting for provider submission of paper billing forms for manual processing. This will be accomplished with the Child Care Billing and Attendance Tracking (CCBAT) project. This project is in development with a pilot that began January 1, 2013. The pilot will gradually expand monthly until the initial rollout begins later in 2013. The DHS Overpayment Unit has seen a workload decrease due to CCBAT system changes already implemented that reduce the risk of overpayments.

- We recommend management ensure the required ADP risk analysis and system security reviews are conducted on the new Medicaid Management Information System (MMIS)**.**

  The Information Security and Privacy Office (ISPO) ran a successful application assessment of the MMIS on May 6, 2009, and our vendor made corrections based on the findings. This assessment was conducted and the results were verified by ISPO personnel. An application assessment process is being built into the System Development Life Cycle (SDLC).

  ISPO began the MMIS network and server vulnerability scan using the MMIS test environment. ISPO began with the test environment due to the limited number of servers, impact to the business, and ISPO developed the network and server testing processes using a newly purchased software solution.

  ISPO ran a successful assessment of the MMIS test environment on December 9, 2010, resulting in no network and server vulnerabilities. This assessment was run and the results were verified by ISPO personnel.

  The ISPO completed the MMIS production network and server vulnerability scan utilizing the knowledge gained from the test environment assessment. The initial start date for the production assessment occurred on January 31, 2011. This assessment period covered multiple days due to the large number of servers and the use of multiple software solutions. ISPO is also scheduling an annual MMIS network vulnerability assessment.

  ISPO completed an initial application vulnerability assessment for the Medicaid Management Information System (MMIS) web application during May 2011. As part of the MMIS web application Release Management process, ISPO performs an application vulnerability assessment. The last MMIS web application vulnerability assessment was completed during August 2011.

ISPO has been working with HP and MMIS to conduct an application vulnerability assessment in August 2012. The assessment will take several days due to the large number of servers and coordination with HP. In addition, the ISPO is working toward developing and implementing a formalized Risk Management Framework that will include development of regularly scheduled risk assessments and security reviews. It is anticipated that this work will be completed in June 2013.

- We recommend department management identify and correct system coding for all services for which the system is not considering eligibility. Once all service and coding issues have been corrected, department management should identify and reimburse the federal agency the total amount of TANF funds spent on behalf of ineligible clients for these services starting in fiscal year 2009.

  The department discovered during the audit that certain services that meet the TANF requirements were programmed in the department's financial system to be funded by TANF, regardless of the client's eligibility for TANF. The services in question appear to be contracted System of Care services; therefore the department will review the process and procedures for inputting executed contracts into the department's financial system.

  The department will implement the recommendation by ensuring all services which were programmed incorrectly are corrected. The payments will be reprocessed by using a manual adjustment of funds. The amount of the adjustment will be reported to the federal agency. The department will correct the process and procedures for inputting executed contracts if the review of the current process uncovers a deficiency.

  Children, Adults and Families federal compliance, contracts, budget and OR-Kids business analyst staff have completed detailed service definitions, which include appropriate budget and funding sources (federal or state general fund). This work was done with the knowledge of past audit findings and with particular attention to the appropriate use of federal funds.

The OR-Kids system was implemented on August 29, 2011. The OR-Kids system has not been accepted at this time due to significant issues which have not been completely corrected. The OR-Kids Project Team and DHS Executive Team are working with the vendor to determine how and when these issues can be resolved. All eligibility, TANF, Title IV-E and Title XIX, have been significantly impacted by the issues mentioned above.

Also impacted by the implementation of the OR-Kids system is the ability to complete adequate queries of the data maintained in OR-Kids. In June 2012, we began working with the Office of Information Services to design reports for Central and Field Offices to use. An Eligibility Report is still in the design stages and is proposed to be available in September 2012. The Eligibility Report will be the mechanism by which the Federal Revenue Specialists will track all their workload including TANF eligibility determinations.

Due to the issues described above and the estimated schedule for accepting the OR-Kids system, the federal compliance unit will be completing the analysis of prior payments and complete a manual adjustment by March 31, 2013.

- We recommend department management strengthen controls over the eligibility process to ensure that eligibility redeterminations are performed timely and income determinations are accurate.

  One of the three cases lacking timely redetermination documentation addressed above involved Children, Adults and Families (CAF), Child Welfare. In this case, we believe the redetermination was completed in a timely manner; however, the proper documentation was missing from the client's case file. The other two cases lacking timely redeterminations were for Seniors and People with Disabilities (SPD) clients. Both SPD clients were determined eligible for Title XIX prior to and after the audit period.

  The three cases involving incorrect income and resources determinations were Children, Adults and Families (CAF), Self Sufficiency Programs (SSP) cases.

CAF Child Welfare:
A Federal Revenue Specialist (FRS) is responsible for completing Title XIX redeterminations every 12 months. The FACIS system creates a notice on the assigned FRS workload when a redetermination is due. The notice date is based on the review due date captured on the IIS Individual Information screen. Based on conversations with the FRS and the data displayed on the IIS Individual Information screen, the redetermination was completed appropriately.

Unfortunately the legacy system does not capture the history of when redeterminations are completed if there is no change to the eligibility reason code, which was the situation on this case. The only proof that the redetermination was completed timely was dependent upon a paper copy of the CF190 – Medical Eligibility Form, which the FRS prints upon completion of a redetermination. The copy of the CF190 is given to the case worker to be filed in the Financial Section of the case file. The FRS must rely on other support staff or the case worker to ensure the CF190 is filed. This is a manual documentation process that will be remedied with the implementation of the new OR-Kids system.

The department implemented the recommendation by sending a reminder to the FRSs (via email) of the importance of completing redeterminations timely and ensuring that the CF190 is filed in the case file. The process of filing a paper copy of the CF190 will no longer be necessary with the implementation of the new Child Welfare system called OR-Kids. OR-Kids will keep an electronic history of all eligibility determinations and the CF190 can be printed upon request.

The OR-Kids system was implemented on August 29, 2011. While the OR-Kids system does maintain an electronic copy of the Title XIX determination, there is not adequate reporting functionality to monitor that eligibility determinations are being completed timely and accurately. This should be achieved by March 31, 2013.

The OR-Kids system has not been accepted at this time due to significant issues which have not been completely corrected. The OR-Kids Project Team and DHS Executive Team are working with the vendor to

determine how and when all of these issues can be resolved. All eligibility, TANF, Title IV-E and Title XIX, have been significantly impacted by the issues mentioned above.

Also impacted by the implementation of the OR-Kids system is the ability to complete adequate queries of the data maintained in OR-Kids. In June 2012, we began working with the Office of Information Services and the Office of Business Intelligence to design reports for Central and Field Offices use. An Eligibility Report is still in the design stages and is proposed to be available in September 2012. The Eligibility Report will be the mechanism by which the Federal Revenue Specialists will track their workload including Title XIX eligibility.

Seniors and People with Disabilities:
SPD managers will be asked to remind their staff of the importance of annual redeterminations and utilize reports to monitor compliance. Staff will be reminded to use the tickler system for notification. Within available resources, managers will assign case managers to cover staff absences. Seniors and People with Disabilities has provided training to AAA/SPD Field Managers to specifically address these eligibility redetermination issues. This training was completed in April 2011, and we believe it will strengthen and enhance controls over the eligibility process.

CAF Self Sufficiency:
CAF Self Sufficiency Programs continue to look at ways to streamline and simplify Medicaid and CHIP eligibility criteria.

On November 1, 2010, the department eliminated the two-month income average for OHP (including Standard) and Healthy KidsConnect (HKC) and implemented budget month income. The client reports what they have received during the budget month and what they anticipate the rest of the month. This new rule streamlines and simplifies the eligibility determination process for eligibility workers and clients. The rule changed from using two-month average to one-month.

With the budgeting change there is ongoing training, Informational Transmittals, On Target Newsletter, and QC Reviews. This will help staff in placing the client in the correct medical program.

October 2009, the department made a policy change to waive the six-month private major medical coverage to two-months. The department continues to educate staff on when the two-months can be waived. Office of Healthy Kids sent out a "cheat sheet" for staff explaining when the two-months period can be waived. Office of Healthy Kids is also working with the federal government to see if the State can eliminate the two-months wait period.

The department is using more imaging technology. This allows workers instant access to documents and with the use of imaging, this will reduce the amount of paper documents that can potentially be misplaced or misfiled and increase the accuracy of the information used to determine eligibility.

As of July 15, 2010, the department implemented policy requiring only one signature per household. Policy Transmittal was sent to eligibly workers and the Family Services Manual was updated.

Statewide training for all Self Sufficiency Program medical eligibility staff has been provided to support the November and December policy and application changes. Classroom training consisted of 52 half day sessions for approximately 1,030 staff members. In February 2010, an article was placed in the On Target newsletter around the Autumn 2010 SSP policy changes.

Ongoing training and educational efforts include training tools and newsletters to keep staff alert to current trends and successes; resource materials developed to support worker efforts; specialized websites with training tools and resources; monthly policy transmittals; weekly Self Sufficiency policy update teleconference meetings and ongoing cheat sheets for staff.

As of March 1, 2011, Oregon Administrative Rule 461-115-0530 was amended to allow OHP Standard recipients to receive a twelve-month certification period instead of six months as was previously allowed. This change brings OHP Standard into alignment with all other DHS medical programs.

Combined, these changes reduce the number of redeterminations and streamline budgeting and verification requirements among all DHS programs.

SSPAT:
The Self Sufficiency Program Accuracy Team (SSPAT) has developed a new medical error trends training which focuses primarily on the error prone areas of budgeting, income and verification. This is a 3.5 hour scenario-driven block of instruction. The training will be delivered at branch sites to minimize impact on branch production while maximizing communication and learning within branch teams. Training materials were developed in coordination with policy analysts, quality control staff and CAF trainers. The first session was conducted on March 9, 2011. Trainings will be scheduled based on each district's priorities and branch accuracy trends.

MEQC:
CAF SSP Medical Quality Control (MEQC) and Program Management Evaluations review medical policy decisions, processes and medical application procedures and report out errors. Corrective Action Plans to prevent similar errors are developed and implemented statewide.

- We recommend department management ensure that complete and accurate client information is used to compile the quarterly data reports.

On May 16th, 2011, the Child Welfare SFMA cross walk code file was updated to include 103 additional codes identifying child welfare cases paid with TANF funding that were previously left out of our reporting. As a result, the ACF-199 and ACF-209 for the 1st quarter (ending Dec. 2010) were re-transmitted on June 28, 2011 and included over 500 additional cases per month. Since that date, we have not transmitted any

Child Welfare TANF funded cases. The OR-Kids system was implemented on August 29,2011. The OR-Kids system has not been accepted at this time due to significant issues which have not been corrected. The OR-Kids project team and the DHS executive Team are working with the vendor to determine how and when these issues can be resolved. All eligibility for TANF, Title IV-E and title XIX has been impacted. We are unable to complete queries of data maintained in OR-Kids . A new eligibility report is still in design and is currently being validated. Due to this issue we hope to have the report completed and ready to transmit soon. We expect this may take until March 31, 2013.

We have corrected the previously identified coding problem with the JOBS Plus cases. The PTF cases problems were also solved, although PTF cases were discontinued in March 2012.

In addition, although our reports were correctly reflecting our policies related to disability and domestic violence cases being excluded from mandatory participation and thus excluded from the participation reports; we agree that in cases where these clients are voluntarily participating in work activities, we could be including those cases. We made coding changes to also begin bringing those cases into the reports. The cases were retransmitted in June 2012.

- We recommend department management ensure coding is correct when making manual coding adjustments. Department management should correct the coding errors identified.

  All coding errors have been corrected. When the coding errors occurred the funding for the TANF block grant had already been drawn to the limit, therefore no overdraw of federal funds had occurred.

  Correcting transactions were completed in January 2011. Correcting journal entries were made to fix errors and to move funds from federal to other funds. An additional small correcting entry was made in January 2012. Implementation of the new OR-Kids system will restrict the ability to make manual coding adjustments in the future.

- We recommend department management ensure that the clearance pattern used to draw down federal funds is updated to reflect any changes in the treasury-state agreement.

  The State FY 2009 CMIA patterns were inadvertently used for the State FY 2010 federal draws. No interest is due to the Federal government for this issue as funds were drawn at a slower rate than we were entitled to receive.

  Corrective actions were completed in March 2011. The department has verified the correct rates are being used for State FY 2011 draws. In addition, a "task" has been entered on staff's June 2011 calendar to verify any CMIA changes needed for the State FY 2012 draw spreadsheets.

- We recommend department management update their contracting policy to address suspension and debarment for governmental entities and communicate this change to contract staff.

  The Office of Contracts and Procurement has a procedure on checking the Excluded Parties List System; however, the policy indicated only non-governmental entities were required to be checked.

  The debarment policy addressed above was updated on February 14, 2011, to require all contracting entities be checked for debarment. This issue was discussed at the Office of Contracts and Procurement all staff meeting on February 15, 2011. The updated procedure was also distributed to all staff.

8. DHS: Adequate Computer Controls in Place for the Medicaid Management Information System, audit # 2011-12, (dated June 2011)

   - We recommend that department management take action to further expedite resolution of the erroneous transactions that resulted from system errors.

The department supports the findings and timelines of the SOS auditors; however emphasizes that efforts to complete the payment reconciliation process have been underway for several months and were initially scheduled to be completed by June 30, 2011(see below). The new Medicaid Management Information System (MMIS) was brought on-line before all functionality was fully operational. This decision was made to ensure the enhanced Federal funding for this project continued.

During the post-implementation stabilization and subsequent maintenance periods, all operational decisions were made to ensure the critical services provided to our clients and the financial solvency of our servicing providers were maintained. An example of this support was creation of the "transitional payments" process, allowing estimated payments to be made to Managed Care plans, with a subsequent reconciliation effort to resolve discrepancies. Owing to the anticipated operational effects of these decisions and the impact they would have to our servicing providers, many of these decisions were made after consultation and planning with Managed Care plan representatives.

The Managed Care subsystem for enrollment and disenrollment was especially problematic in unique circumstances. The corrective programming required to correct these complex enrollment discrepancies was not completed until October, 2010. These Managed Care enrollment and disenrollment errors are directly linked, and have compounded, the Fee-For-Service (FFS) errors identified by the SOS auditors, by paying claims as FFS when the correct payer should have been (but was unknown at the time due to the enrollment errors) a Managed Care plan. The sequential logic used in the processing of these incorrect capitation and FFS payments must now be sequentially reversed during the corrective action period to ensure additional errors are not created.

Starting in October, 2010, following correction of the majority of system defects, the labor and systematic intensive reconciliation process for Managed Care Organizations (MCO) enrollment errors began. After extensive consultation and planning with our Managed Care partners to develop and execute this large effort, the department expected to complete the enrollment/disenrollment and subsequent capitation

adjustments (both overpayments and underpayments) by June 30, 2011. However, this initial target date was extended to December 30, 2011.

The exact amount of the FFS payment errors, and the corresponding corrective action, could not be fully defined until the MCO reconciliation process was complete. For example, if a FFS claim was paid for a client who was, during the MCO reconciliation process, determined to be covered by a MCO, then the payment associated to the FFS claim would be recovered and the appropriate capitation payment processed. If a FFS claim was paid for a client who was determined to not be covered by a MCO at the time the service was rendered, then the FFS payment was appropriate.

Once the MCO reconciliation process was finalized, then the last sequential step in the payment reconciliation plan began. This last step was to overlay the corrected MCO client enrollment onto the FFS claims payment history and determine the appropriateness of the FFS payments made for these enrollment-adjusted clients. This final reconciliation effort was successfully completed by the December 30, 2011, extended target date.

During the startup phases of the new MMIS, there were many identified system defects. Correction of these defects took many months of time and significant levels of resources, but at the time of this writing, all have been corrected and our MMIS has been retro-certified by CMS back to nearly the first go-live date. It now is not uncommon to identify new defects during normal operations of the MMIS, but once identified, system defects are prioritized above system enhancements for corrective resources. Additionally, service level expectations have been established as part of the contract with the MMIS vendor (HP) that outline the expected effort levels and correction timeframes for identified defects – dependent upon the agreed upon levels of severity of the defects. For example, any defect identified that brings the operation of the MMIS to a standstill must have a correction in test within 26 hours. Adherence to these service level agreements is closely monitored.

- We recommend that department management implement the recommendations provided in our confidential security letter.

The department agrees with the recommendations provided in the confidential security letter provided to the department per ORS 192.501. We have taken and will continue to take corrective actions as discussed in our confidential response to the security letter. These efforts are not yet completed.

Beginning on July 1, 2011, only those reports issued specifically to the Department of Human Services or the Oregon Health Authority (or both) are included in their individual Audit Response Report.

9. OHA: Improve Controls over Child Enrollment Reporting and Advertising Expenditures, audit # 2011-19 (dated September 2011)

- We recommend OHA management develop a consistent process to compile and review the bonus award enrollment figures for future submissions. We also recommend OHA management work with the Federal government to adjust the bonus award amount.

To qualify for a CHIPRA performance bonus payment, a state must apply to the federal government and demonstrate it meets two criteria, defined in CHIPRA law:

- *It implemented specific program features that are known to promote enrollment and retention of children in medical coverage; and*
- *Its enrollment of children in Medicaid increased above the CHIPRA enrollment target.*

If a state meets both criteria, the state qualifies for a bonus award based on the number of children exceeding the target. As mentioned in the report, for federal fiscal year 2009 (the first year states could qualify for CHIPRA bonuses) OHA applied for and received a CHIPRA bonus for $1.6 million. The federal

government awarded only eight other states CHIPRA bonuses for 2009. For federal fiscal year 2010, OHA applied for and received a CHIPRA bonus for $15 million. The federal government awarded only 14 other states CHIPRA bonuses for 2010. As identified in the audit, OHA over reported its 2010 enrollment count by approximately 7,400 non-citizen children. As a result, the federal government awarded OHA approximately $4.5 million more than it should have received. OHA still qualifies for a bonus of more than $10 million.

OHA has already taken a number of steps to correct the 2010 bonus award. OHA contacted the federal government about the enrollment reporting error. OHA stopped drawing bonus money from the federal account, leaving approximately $5 million unspent from which the federal government will adjust the original grant award. OHA corrected, tested, and documented the data query used for CHIPRA enrollment reporting. OHA also submitted to the federal government a revised enrollment count for 2010.
Based on the revised enrollment count, the federal government recalculated Oregon's 2010 bonus award. Based on this recalculation, the federal government decreased OHA's unspent award by $4,488,017 on August 1, 2011.

Moving forward, OHA management will review in detail the data query criteria and data query results with Information Services staff and staff responsible for caseload monitoring before each year's submission of its Medicaid enrollment of qualifying children. OHA will also compare the data query criteria and results with the prior's years data pull to identify any issues.

OHA will utilize the improved process to pull and review the enrollment data for federal fiscal year 2011 in early October to be submitted before the federal deadline of November 1, 2011.

OHA followed the action plan as provided above. OHA management met and reviewed the details of the data query criteria and data query results with staff responsible for pulling the data. The query information was compared to the federal policies and guidance to ensure compliance. The query results were verified to not include non-citizen children who are required to be excluded from the enrollment count. The query results were also compared with the prior year's data pull. No issues were identified. OHA submitted the enrollment

count to the federal government on October 31, 2011. The Office of Forecasting, Research and Analysis retains documentation of the data query criteria and query results.

- To strengthen its controls over the Healthy Kids advertising expenditures, OHA and Healthy Kids management should:
  - ensure purchase orders and contracts are in place as appropriate, and are properly executed;
  - implement an effective payment tracking process to reduce the risk of overpayment;
  - ensure timely delegation of signature authority;
  - obtain and retain proof of performance documentation that clearly supports the services provided;
  - correct the recording errors identified during the audit; and
  - determine and resolve the effect of the incorrect reimbursement rate resulting from the miscoded transactions.

Oregon Healthy Kids is a tremendously important program for families across the state. The new Oregon Health Authority, Office of Healthy Kids was created in August 2009, and since then has enrolled about 94,000 more children into the health coverage they need. As a result, Oregon cut its child uninsurance rate in half during this time, a significant achievement. We appreciate the efforts of the Oregon Audits Division to help us make this highly successful program even stronger.

Healthy Kids has instituted a tighter tracking and filing system for:

- *purchase orders, invoices and contracts that will help make sure that all required documentation is obtained and saved*
- *advertising purchases will explicitly require proof of purchase in all advertising contracts.*

Although Healthy Kids staff did catch the duplicate payment found by the audit prior to the start of the audit and recently received a credit for the remaining $541 outstanding costs, we are in agreement that more systemized tracking methods could further reduce the possibility of any future over or duplicate payments.

Office of Healthy Kids staff have already met with staff from other programs within the Department of Human Services to review their invoice tracking tools and will require all invoices be checked against purchase orders and payments before being submitted for payment.

OHA has updated its delegated authority policy, procedures and form and is implementing a new delegated system that will provide better tracking and reporting of delegations. In addition, the agency is in the process of completing a full roll-out of the new delegation form for all staff with expenditure authority.

Further, the three coding errors identified during the audit have been corrected and the appropriate reimbursement rate recorded.

10. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2011, audit # 2012- 08, (dated March 2012)

- We recommend department management develop controls to ensure all Supplemental Nutritional Assistance Program federal revenues are recorded and year-end financial statement adjustments to expenditures are appropriate.

DHS uses a third-party service provider to administer the Supplemental Nutritional Assistance Program (SNAP). This service provider draws revenue directly from the federal government as benefits are issued to clients. Each month the Office of Financial Services (OFS) receives a report from the service provider and records the federal revenue drawn in the state accounting system. At the end of the year Statewide Financial Reporting unit adjusts expenditures to match the revenue drawn for financial reporting.

The January 2011 revenue recording from the service provider in the amount of $94,357,598 was missed due to lack of cross-training while an individual was on medical leave. At the end of the fiscal year, the expenditures were reduced by an equivalent amount. Since the discovery of this error, cross-training has

been provided to OFS staff and an additional review has been established by the OFS Reconciliation unit to ensure each month's revenue transaction is posted. Additionally, the Statewide Financial Reporting unit reviews the SNAP program trial balances for reasonableness during the reporting year to identify anomalies and to implement needed corrections prior to year-end close.

The implemented cross-training has been followed since implemented and has provided results. The OFS Reconciliations unit identified an error with an entry made for June 2012 and immediately notified the appropriate staff allowing it to be corrected and properly recorded.

- We recommend department management verify that the initial upload of pharmacy rates in MMIS are complete and accurate.

OHA changed our reimbursement methodology for all enrolled pharmacy providers that serve recipients of Medical Assistance Programs (MAP) from a "lesser of" methodology that reimbursed either a percentage discount off of the Average Wholesale Price (AWP); the Federal Upper Limit (FUL) or the pharmacy's Usual and Customary (U&C) to a "lesser of" methodology based on the Actual Acquisition Cost (AAC) of individual drugs paid by pharmacies to wholesalers or the Wholesale Acquisition Cost (WAC) when an AAC has not been determined; the FUL or U&C. This "lesser of" methodology ensures that pharmacy rates in the MMIS are complete.

As an early adopter of a more transparent methodology, Oregon Medicaid hired a contractor in 2010 to perform data collection and rate setting functions for our more than 700 enrolled pharmacy providers, to implement the new AAC methodology which became effect on January 1, 2011, with the initial upload to the MMIS.

We agree to review the initial upload of pharmacy rates into the MMIS to ensure completeness and accuracy. Staff now review reports generated from the MMIS after each weekly rate load that identify both

changes in rates for individual drugs and an error report that identifies whether the load was stopped or unsuccessful in any way.

OHA staff also compares the system generated reports against a weekly report from our rate setting contractor that identifies changes in rates for individual drugs from week to week including those for the initial load. This review allows us to verify that rates have been loaded into the MMIS correctly and resolve any issue or anomalies in the event a rate is loaded incorrectly and to monitor drugs with significant changes in cost from week to week.

The contractor Oregon Medicaid hired to establish the AAC rates is also responsible for addressing pharmacy disputes when reimbursement is below their respective acquisition cost which further serves as a safeguard to ensure accuracy.

- We recommend department management develop procedures to ensure that balance transfers pertaining to prior fiscal years are properly recorded and do not misstate current year fund balances.

In January 2010 Medicaid and CHIP Federal rules changed related to client citizenship documentation requirements. This change allowed the Department to reclassify expenditures from GAAP General Fund to GAAP Health & Social Services Fund for current and prior fiscal years.

These types of adjustments are often large and require complex analysis to determine the appropriate accounting in current and prior periods. OFS will continue to provide training opportunities to program and internal staff on the importance of thorough documentation and understanding correct period recognition of balance transfers that relate to prior periods. The Statewide Financial Reporting unit has updated the year-end task list to include a review of balance transfers that were entered during the accrual period that affect prior periods.

In order to establish criteria for properly recording balance transfers(BT's) pertaining to prior periods, the State Financial Reporting(SFR) unit has researched guidance contained in Generally Accepted Accounting Principles, OAM , and has consulted with DAS. This criterion for properly reporting adjustments of prior period activity was documented, and presented to Shared Services management and Secretary of State Audits. Because prior period adjustment consideration often requires complex analysis, accounting staff were notified (through the LDMS process) to send BT's relating to prior periods to SFR unit for prior period adjustment consideration. SFR unit reviews, discusses the BT's with accounting staff, and educates staff on correct accounting treatment. If a BT is qualified for a prior period adjustment, SFR unit then enters the prior period adjustment to SFMA referencing the BT doc. To further educate staff; at each state fiscal year end, SFR unit sends a training document (with its year end transmittal) and instructions to staff to send their BT's relating to prior periods to SFR unit for prior period adjustment consideration.

- We recommend department management strengthen controls to ensure documentation is maintained in the case files sufficient to demonstrate compliance with federal requirements.

One of the missing applications was for an Adoption Assistance case that began in 2002. Due to prior audit findings for Title IV-E in late 2009, the department instituted a process where the Adoptions Assistance Unit reviews the applications to ensure all documentation which supports the eligibility determination (Title XIX or Title IV-E) is attached. Although this process was not administered retroactively, due to the volume of cases and the lack of resources, cases moving forward should have appropriate documentation. The eligibility for this case was retroactively reviewed and found Title IV-E eligible, thus categorically eligible for Medicaid.

The second missing application was used to apply for Self-Sufficiency program benefits. The application was initially processed by a case worker who determined Supplemental Nutrition Assistance Program (SNAP) eligibility. The same application was used, by a different case worker, to determine Medicaid eligibility, however the application did not get returned to be filed in the case record. The case record was subsequently transferred to a different branch office, and the application could not be located. It has since

been located. The DHS Family Services Manual provides procedures and outlines the steps for transferring case files between branch offices. In addition, DHS Imaging and Records Management Services (IRMS) provides services including imaging of documents and "open archiving" of case records to reduce the volume of applications and case file documents retained in branch offices. DHS sent staff an Informational Transmittal reminding staff of the case file transferring procedures and providing a link to IRMS services information. In addition, DHS published an article in the "On-Target" newsletter for Self-Sufficiency staff about ensuring case files are complete prior to transferring to a different case worker or branch. DHS also added information to the Family Services Manual and Business Procedures manual regarding case file transfer processes internally within a branch. DHS will also research the questioned costs for the Adoption Assistance case and reimburse the Centers for Medicare and Medicaid Services (CMS) the appropriate federal funds. The department hopes to complete this adjustment by June 30, 2012.

DHS will review the case with undocumented income verification and reimburse CMS any federal funds as appropriate based on this review. The department will also address documentation requirements at the next Area Agencies on Aging (AAA) / Seniors and People with Disabilities (SPD) Field Managers meeting and in the newsletter to field staff by June 30, 2012.

To reduce barriers to access and eligibility, the OHA Medical Programs (formerly DHS Medical Programs) have implemented policies that allow a medical program eligibility determination using a previously submitted application, whether or not the prior application was for medical benefits. During this time (the period under review), it was the case worker's responsibility to remember and obtain any additional information, such as private health insurance, needed to determine medical program eligibility.

The department continues to proactively strengthen controls over the eligibility determination process. Within the past 17 months, updates have been made to the Legacy computer systems to revise a field in the Client Maintenance (CM) system. This is now a mandatory field, requiring data entry by the case worker when setting up the medical case. The purpose of this field is to identify whether or not an individual has third party insurance. Training for this systems' change, along with other medical policy changes, was

delivered statewide to field staff beginning in the fall of 2010. In addition, the training material is posted on the Self-Sufficiency Program, Medical Program Staff Tools website.

Medical program eligibility worker training includes guidance on how to process eligibility decisions. In addition, instruction is given to participants on how to "interview" to ask questions to ascertain eligibility information not captured on the current application in the case file, including whether or not individuals have private health insurance. The new data field and purpose is also explained in detail during the trainings.

DHS also researched the questioned costs for both of the cases missing the private health care information and determined no reimbursement to CMS was necessary.

DHS will review the case with the private dental insurance and reimburse CMS any federal funds as appropriate based on this review. The department will provide the case information to the Health Insurance Group (HIG) for entry into MMIS. The department will also address reviewing applications for insurance policy disclosure and the requirement to send the information to HIG at the next AAA/SPD Field Managers meeting and in the newsletter to field staff by June 30, 2012.

- We recommend department management implement controls to ensure correct rates are used when calculating the Medicare Part B buy-ins and reimburse the federal agency for the overdrawn ARRA funds.

In April 2011, the ARRA enhanced FMAP rate was reduced. The Medicare Part B buy-in calculations are performed in an excel spreadsheet. In April, the department inadvertently retained the prior quarter's FMAP rate resulting in an over draw of the ARRA funds. We have since added a box to the excel spreadsheet used in calculating the buy-in and have it highlighted as a reminder to verify the rate being used prior to draw. We have refunded the overdrawn funds to CMS.

The FMAP is now reviewed prior to the draw to ensure an accurate rate. Also, instead of the rate being included in the formula and updating the formula, a box was created to enter the rate and the formula is based on that box.

- We recommend department management use the standardized contract language and ensure contractors include the standardized contract language with subcontractors to ensure compliance with federal regulations.

Beginning in May 2011, the contract used in the renewal process for Child and Adult Foster Home providers was replaced by the Foster Home Medicaid Provider Enrollment Agreement (SDS0738). This agreement includes the federal and state disclosure requirements. These new agreements are now in place for all Foster Home Providers (child and adult).

The department's contract and Intergovernmental Agreements (IGA) include standardized language with regards to compliance with federal regulations (exhibit G). The IGA or contract requires that exhibit G is attached to any sub-contract. The department will include review for this attachment with sub-contracts during field reviews with Community Developmental Disabilities Programs and Adult Support Services Brokerages. All IGAs have been updated with standardized language with the exception of one county, which is expected to be signed by March 1, 2013.

- We recommend department management ensure the review for suspension and debarment is documented in accordance with department policy.

The Office of Contracts and Procurement (OC&P) reviewed the internal procedure, "Federal Debarment and Suspension Confirmation" and the "OC&P File Checklist" to ensure they comply with the federal debarment requirements. The procedure is in compliance with these requirements. The importance of checking debarment was discussed at the OC&P Unit meeting February 22, 2012. An individual conference was held with staff that had a file without debarment documentation to discuss and document the issue. OC&P management staff enhanced the training regarding debarment for new OC&P staff. Debarment is

listed on the OC&P File Checklist, included in the Contract Processing Standards and a link is included on the OC&P intranet site.

- We recommend department management ensure adequate review of the various calculations of the cost pool statistics is performed.

A portion of the cost allocation process has been performed in excel spreadsheets that required some manual entry of statistics each month. In September, the previous month's data had not been removed prior to processing the new data. As a result, the statistics became a blended two month average and was not calculated in accordance with the cost allocation plan. The review process in place did not and would not have picked up this error. The Office of Financial Services has analyzed the impact of the error and made adjustments as appropriate.

The Office of Financial Services implemented a new cost allocation model in July 2011 in which now only relies on one remaining spreadsheet that needs to be automated. The manual intervention of the remaining spreadsheet is to be eliminated by September 2012. The current model in use has eliminated the possibility of this human error happening again.

The automation of the last remaining spreadsheet is complete and currently in testing. It is expected to be put into production beginning February 1, 2013.

- We recommend the Department remove conflicting access rights where it can. In those instances where the conflict remains, the Department should develop and implement a detective control to specifically address those instances.

The prior year's corrective action was not accomplished for the period ending June 30, 2011 due to staff resource issues. However the department is in the process of implementing appropriate controls to ensure

that conflicting access rights are removed where they can be and there is a detective control in place to specifically address those instances.

Our corrective action has multiple parts:

1) DHS has developed expectations that field managers review the monthly Resource Access Control Facility (RACF) report for conflicting access of employees. To assist in this review a cheat-sheet for managers has been developed and distributed,
2) DHS has removed access to perform any update capabilities from non-paid employees, i.e., volunteers and;
3) DHS has developed and distributes monthly a Conflicting Access report. The report identifies employees who may have taken action using conflicting access on individual accounts for further review.

11. DHS and OHA: Strategies to Better Address Federal Level of Effort Requirements, audit # 2012- 11, (dated April 2012)

- To maximize state resources, allocate General Funds strategically, and ensure continued compliance with Level of Effort requirements, we recommend management from Oregon agencies subject to federal Level of Effort requirements:
- encourage program staff to work with their federal agency contact to understand possible financial sources available to meet Level of Effort requirements, including funds outside of those directly budgeted for that program;
- work with the Legislative Fiscal Office to make information available to Oregon Legislative members explaining Level of Effort requirements and consequences for lack of compliance;
- conduct regular communications among program, financial, and budget staff within each agency to discuss Level of Effort compliance and cross-program expenditure possibilities; and

- strengthen certification procedures across programs to allow more cross-program expenditures while ensuring compliance with federal mandates.

  While OHA and DHS generally agree that the recommendations are reasonable expectations, we are concerned that the report contains no specific analysis explaining if the additional efforts it recommends will generate benefits in excess of their anticipated additional costs. It is also unclear to OHA and DHS management how these recommendations should be prioritized amongst the other activities available to the agencies to improve efficiency and effectiveness. With that said, we do see opportunities to make improvements to our communication and coordination processes within the two agencies and with our other state and federal partners.

  As can be seen in the report, Level of Effort is a very complex subject due to all the different grants and specific rules each grant requires. As such it can be difficult to apply general statements and recommendation regarding Level of Effort (LOE) requirements to all of the grants listed in the audit. For some of grants administered by OHA and DHS some of the specific details of the above recommendation do not apply. For the Medicaid and the Children's Health Insurance Program, the LOE requirements are eligibility based and not expenditure level based. Another grant, the Senior Community Services Employment Program, only requires that placement of an enrollee not supplant normally budgeted positions or contract work at the host agency. There are also grants, such as the Block Grants for the Prevention and Treatment of Substance Abuse, that have historically only allowed expenditures from the recipient agency in determining compliance with the LOE requirement.

  OHA and DHS agree that Oregon agency management (including program, fiscal and budget staff) need to understand their grant requirements. We also agree, and do, actively work with the Legislative Fiscal Office (LFO), and the Department of Administrative Services, Chief Financial Office (CFO) to communicate, maintain and ensure compliance with these grant requirements. While we also feel for many of the grants administered by OHA and DHS, we are currently engaged in these discussions at the level necessary, there may be some efforts that could be improved.

Both agencies will review our current communication and coordination efforts related to the individual grants identified in the report to determine if improvements are needed. This will include consideration of a more formalized internal and external meeting structure to discuss ongoing LOE issues and possible changes in other agency programs that may impact LOE (both opportunities and challenges when programs are reduced).

For some grants, such as TANF, we spend significant time analyzing funding opportunities and have put in place a "certification process" as a way to both have routine communications with partner agencies and document other agency LOE related expenditures. We continue to partner with non-traditional MOE programs such as the food banks to explore possible additional opportunities. We also agree there may be additional funding opportunities available and will work with CFO and LFO as necessary to resolve cross-agency issues as they arise.

We will review our programs to determine if there is funding that is in excess of current grant requirements that could help other programs or grants meet their LOE needs. We will continue to work with LFO and CFO to help facilitate the communication of new opportunities as they arise, keeping in mind sufficient analysis is always necessary prior to using any new LOE source to meet specific grant expenditure level requirements.

Both agencies recently made changes to internal grant application processes which enhanced the communication between program and fiscal staff prior to the grant applications being submitted. Both agencies have also continued to actively work with the LFO, and DAS-CFO to communicate, maintain and ensure compliance with these grant requirements. This includes recent detailed history and estimates for the Governor's Budget Process to allow BAM to account for MOE issues as much as possible in the 2013-15 budget process. The agencies have communicated to LFO and CFO any LOE/MOE requirements that are directly tied to all reduction options that might be considered to meet statewide

revenue shortfalls. In addition, the agencies continue to work with other internal programs, agencies or private entities to maximize MOE.

12. OHA: Children's Mental Health: Ensuring Access and Sustaining Services, audit # 2012- 16, (dated May 2012)

- We recommend the Division, in its administration of mental health services, develop better information on service utilization by population. These efforts could include:
  - developing and reporting comparative data to monitor service utilization by population, including Hispanic children, girls aged 2-13, and younger children;
  - reviewing and comparing strategies that address utilization differences;
  - developing targets that assist in addressing differences between populations; and
  - Identifying and disseminating best practices for increasing the use of mental health assessments for younger aged children.

  In our current and ongoing work, we address these issues in a variety of ways.
  - *AMH collaborates with the Department of Human Services Child Welfare on issues affecting both systems, including measures to increase the assessments for children in foster care within 60 days of placement in out-of-home care, the appropriate use of psychotropic medications and the Statewide Children's Wraparound Initiative.*
  - *Through the Community Mental Health Block Grant, AMH reports to the Substance Abuse and Mental Health Services Administration (SAMHSA) on a number of National Outcome Measures. One of these measures is to maintain or increase the proportion of children from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State's children within the same ethnic population.*

- *AMH staff developed a collaborative training with the Mental Health Organization (MHO) children's systems coordinators focusing on assessment and evidence based treatment of young children birth through 5 years using Child Parent Psychotherapy.*
- *AMH participates in the Coalition of Advocates for Equal Access for Girls. The mission and activities of the coalition aims to ensure that girls receive equal access to all of the appropriate gender specific support and services they need to develop to their full potential. Coalition membership includes representatives from AMH, other state agencies, and private non-profit organizations. This coalition also has legislative support.*
- *AMH will continue disseminating Parent Child Interaction Therapy (PCIT), the evidence-based practice for young children 2-7 years old with disruptive behavior disorders with a focus on serving children from Hispanic families in proportion to their presence in the county population.*

AMH will work with the Office of Equity and Inclusion (OEI) to initiate the following to provide better information on service utilization by population:

- *The AMH Program Analysis and Evaluation unit will develop quarterly reports reflecting utilization of mental health services by population specific data, including Hispanic children; girls aged 2-13, younger children, and other demographic groups. These new baseline reports are now available.*
- *AMH will establish targets for each MHO/Coordinated Care Organization (CCO) based on local performance. AMH will work with OEI to identify strategies in communities that are more successful in serving the identified populations. These strategies will be disseminated to communities which are less successful. AMH and OEI have established a monthly work group including community partners to identify targets and strategies for improving services to the identified populations by MHO or CCO. Work to date includes the identification of measures to be used to develop the trend line and the time line for the service utilization by identified populations, identification of criteria for prevalence benchmarks in published literature, and identification of prevalence benchmarks based on published literature for each identified population.*
- *Identify strategies and targets in collaboration with MHOs and CCOs based on community assessments or other means by November 1, 2012.*

- *Within available funding, AMH will support a Local Mental Health Authority to coordinate and oversee training on early childhood mental health assessment and the evidence based practice Child Parent Psychotherapy by November 1, 2012. This contract will support the development of an early childhood mental health network to provide clinician technical assistance and support to implement this practice. In September, AMH funded training to increase clinician ability to conduct comprehensive mental health assessments for young children were provided for 17 clinicians.*

- We recommend the Division improve the continuity of mental health care for children by:
  - ensuring that assessed children who need and desire mental health services receive services in a timely fashion;
  - ensuring that the reasons for children experiencing lengthy breaks in services are captured in case file documentation;
  - periodically analyzing the reasons for service breaks; and
  - ensuring that providers make adequate efforts to re-engage children when unplanned service breaks occur, and that they document these efforts.

  OHA agrees that for children with unmet service needs, it is important to ensure that gaps in service provision are identified and addressed so they can continue making progress at home, in school, and with friends.

  The following are examples of our current and ongoing efforts to address these issues:
  - *AMH reviews Community Mental Health Programs through site reviews and issues Certificates of Approval for one, two or three years for programs that are in substantial compliance with the Oregon Administrative Rules. These site reviews address issues of access to services, engagement and follow up for initial approval or renewal of Certificates of Approval for Community Mental Health Programs.*
  - *Mental health providers follow a standardized process for identifying children with high mental health needs and providing a comprehensive, coordinated array of services that are family and youth driven. The Level of Service Intensity Determination Process is to determine the intensity of service needs for*

children and adolescents with emotional, behavioral, and developmental challenges and to identify children and adolescents who would benefit the most from intensive service coordination planning. The Level of Service Intensity Determination Process provides a uniform and common framework to identify service intensity needs that can be used to inform service planning

- *Families, children (when appropriate) or adolescents receiving the Integrated Service Array develop their own teams which coordinate their services.*

AMH will also initiate the following additional actions to improve the continuity of mental health care for children.

- *Prior to each site review, AMH Compliance Specialists will review service utilization data to identify gaps in accessing services following a mental health assessment, service breaks or during transitions from one type of mental health service to another. They will follow up by reviewing documentation in client charts. AMH's goal will be to incorporate the review of service breaks, engagement and documentation into the regular site review schedule by November 1, 2012. AMH has identified the Client Process Monitoring System (CPMS) enrollment and termination data and Medicaid Management Information System (MMIS) encounter data as the data sources for identifying gaps in service for children moving between levels of service intensity, including post residential treatment. AMH has communicated with stakeholders, including community mental health programs and the MHO children's systems coordinators of the process for reviewing client charts during site certification or re-certification. AMH has also communicated the process to compliance specialists and other staff conducting site reviews. AMH staff are using this information to review client charts identified through data analysis for gaps in service for children receiving services in the Integrated Service Array.*
- *Through CCOs, the system shifts to outcome based performance rather than management of processes. The OHA Outcomes Group will establish monitoring mechanisms for CCO compliance with the outcome measure for clinical follow up within 14 days of transition from a hospital or residential treatment program. The Metrics and Scoring Committee, established in 2012 as a result of SB 1580 (Section 21), has the responsibility of setting overall metrics for CCOs. Over the past several months, the committee has been working to finalize a set of metrics to be used for incentive purposes with the CCOs. One*

example of a metric relevant to the age group discussed in the SOS audit report is follow-up care within seven days after hospitalization. Another metric is insuring that children taken into DHS custody are given a mental health assessment within 60 days. These metrics, as well as others decided by the committee, will be tracked in aggregate in addition to several demographic breakouts, including race, ethnicity, gender, and age groups. The overall goal is to evaluate CCOs based on relevant metrics and not just the volume of service generated.

- *AMH and the Office of Information Services (OIS) initiated the web-based Children's Progress Review reporting system for children enrolled in Intensive Community-based Treatment and Support Services and the Statewide Children's Wraparound Initiative project sites. This system will be upgraded to include the Level of Service Intensity Determination Process which will provide real time data for individuals receiving services at the clinic, MHO or CCO and state levels. This will provide the opportunity for more detailed analysis of services, services breaks and recipients. The Children's Progress Review System has been upgraded to include all children served in the Integrated Service Array (ISA) and Statewide Children's Wraparound Initiative (SCWI) project sites. Level of Service Intensity determination data, which determine entry into the ISA, will also now be submitted through this data reporting system. Real time data regarding quarterly outcomes for individuals receiving services, and parental/caregiver perception of progress while receiving services, will be obtained using the Integrated Service Array/SCWI Progress Review (ISA/SCWI PR) and the Behavioral and Emotional Rating Scale, version 2 (BERS-2) for parents. These data can be reviewed at the community mental health program, CCO or state level by individuals with access to the system, for their particular system. This provides the opportunity to track data changes for individuals and groups over time. Data in this system can be matched with MMIS data (claims, service recipients) to further delineate service breaks related to outcome data.*

13. OHA: Safe Drinking Water Revolving Loan Fund for the Fiscal Year Ended June 30, 2011, audit # 2012- 19, (dated June 2012)

- We recommend agency management:
  - Reconcile, at a minimum, the state's accounting records for revenues and expenditures for each set aside with the federal cash reimbursement system when closing a grant award and ensure any adjustments identified are researched and corrected prior to submission of the final report;
  - Reverse the accounting entry made in December 2011 that moved revenue from current grant awards to older grant awards;
  - Determine whether the $28,274 in valid expenditures identified for grant awards 04, 05 and 06 can be moved to open grant awards enabling the agency to be reimbursed;
  - Obtain state funding for the $10,484 of expenditures incurred at some point in time but never drawn to cover the cash expended; and
  - Return $7,160 in federal revenue/cash currently recorded in grant award 06 to the U.S. Environmental Protection Agency (EPA).

We agree that when closing a grant or phase that the grant revenue and expenses must be reconciled and adjustments must be made in a timely manner. As soon as all invoices have been received and funds drawn, a reconciliation should be completed to ensure the original federal financial report requires no adjustments and the expenses and revenues entered in the Statewide Financial Management Application (SFMA) are in balance. In the future, the agency will also make every effort to have all program invoices processed within 90 days of the grant closing, reducing the potential risks of having to submit revised federal financial reports.

The Oregon Health Authority continues to research the impact of moving the identified $28,274 revenue and its impact on phases 04, 05 and 06. These phases are closed, but there may be outstanding

adjustments requiring resubmission of final reports. Program will be discussing with EPA the option of moving funds between grants to correct prior errors. After we finalize phases 04, 05 and 06 we will contact the EPA requesting their direction as to the final disposition of the $7,160 currently recorded in grant award 06. The Office of Financial Services will also work with the program to determine the appropriate adjustment of the $10,484.

OHA audits in 2011-2013

2011-2013 Internal and External Audits and Reviews for OHA

Internal Audits and Consults

Name of Audit:	MMIS Implementation - Reporting and Documentation Provider Payments
OHA Programs:	Medical Assistance Programs, Information Services
Status:	In Progress
Name of Audit:	Targeted Case Management (TCM)
OHA Programs:	Medical Assistance Programs, Public Health Programs, Shared Services
Status:	In Progress
Name of Audit:	Key Performance Measure 2011 (KPM)
OHA Programs:	Office of Private Health Partnerships, Public Health Programs,
Status:	Completed
Name of Audit:	Small Purchase Order Transaction System (SPOTS) 2011
OHA Programs:	All
Status:	Completed
Name of Audit:	Small Purchase Order Transaction System (SPOTS) 2012
OHA Programs:	All
Status:	In Progress
Name of Audit:	Information Security Program Assessment
OHA Programs:	Information Services
Status:	In Progress
Name of Audit:	Cost Allocation Accuracy
OHA Programs:	Shared Services
Status:	In Progress
Name of Audit:	Federal Reporting and MMIS Interface
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress
Name of Consult:	Protocol for Return of County Programs to State
OHA Programs:	Addictions and Mental Health Programs, Public Health Programs, Shared Services
Status:	In Progress

Name of Consult:	Desk Review of Oregon State Hospital Settlement FYE 6-30-11
OHA Programs:	Addiction and Mental Health Programs, Shared Services
Status:	Completed

Name of Consult:	Blue Mountain Recovery Center Settlement FYE 06-30-11
OHA Programs:	Addiction and Mental Health Programs, Shared Services
Status:	Completed

Name of Consult:	IT Security Controls Assessment (MMIS)
OHA Programs:	Medical Assistance Programs, Information Services
Status:	In Progress

Name of Consult:	Cost Allocation Processes
OHA Programs:	Shared Services
Status:	In Progress

Contracted Audits and Reviews

Name of Audit:	TKW Oregon Controls Audit of MMIS 2011
OHA Programs:	Medical Assistance Programs, Information Services
Status:	Completed

Name of Audit:	Acumentra 2011 External Quality Review OHP Managed Mental Health Care
OHA Programs:	Addictions and Mental Health Programs, Medical Assistance Programs
Status:	Completed

Name of Audit:	Acumentra External Quality Review Annual Report 2010-2011 OHP Managed Care
OHA Programs:	Medical Assistance Programs
Status:	Completed

Name of Audit:	Disproportionate Share Hospital Payments Audit FYE 6/30/2008
OHA Programs:	Medical Assistance Programs
Status:	Completed

Name of Audit:	PEBB Dependent Eligibility Verification
OHA Programs:	Public Employees Benefit Board
Status:	Completed

Name of Audit:	OEBB Dependent Eligibility Audit
OHA Programs:	Oregon Educators Benefit Board
Status:	Completed

Name of Audit:	Acumentra 2012 External Quality Review OHP Managed Mental Health Care
OHA Programs:	Addictions and Mental Health Programs, Medical Assistance Programs
Status:	In Progress

Name of Audit:	Acumentra External Quality Review Annual Report 2011-2012 OHP Managed Care
OHA Programs:	Medical Assistance Programs
Status:	Completed

Name of Audit:	FMIP OPHP Audit of Financial Statements
OHA Programs:	Office of Private Health Partnerships, Shared Services
Status:	Completed

Name of Audit:	Health Professionals Service Program Independent Audit of Program and Monitoring Entity
OHA Programs:	Addictions and Mental Health Programs
Status:	Completed

Name of Audit:	Drug Rebate Program Service Provider Controls
OHA Programs:	Medical Assistance Programs, Information Services
Status:	Completed

Name of Audit:	TKW Oregon Controls Audit of MMIS 2012
OHA Programs:	Medical Assistance Programs, Information Services
Status:	Completed

Name of Audit:	Disproportionate Share Hospital Payments Audit FYE 6/30/2009
OHA Programs:	Medical Assistance Programs
Status:	Completed

Secretary of State Audits

Name of Audit:	SOS Children's Mental Health
OHA Programs:	Addiction and Mental Health Programs
Status:	Completed

Name of Audit:	SOS Healthy Kids
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	Completed

Name of Audit:	SOS Statewide Single Audit Year Ending 6-30-2011
OHA Programs:	All
Status:	Completed

Name of Audit:	SOS Level of Effort
OHA Programs:	All
Status:	Completed

Name of Audit:	SOS Safe Drinking Water Revolving Loan Fund Review Year Ending 6-30-2011
OHA Programs:	Public Health Programs, Shared Services
Status:	Completed

Name of Audit:	SOS Public Assistance
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress

Name of Audit:	SOS Statewide Single Audit Year Ending 6-30-2012
OHA Programs:	All
Status:	In Progress

Name of Audit:	SOS Client Maintenance System Follow-up
OHA Programs:	Medical Assistance Programs, Information Services
Status:	In Progress

Name of Audit:	SOS Health and Human Service Caseload Forecasting
OHA Programs:	Shared Services
Status:	In Progress

Federal Audits and Reviews

Name of Audit:	HHS OIG Family Planning Services Family Planning Expansion Project
OHA Programs:	Medical Assistance Programs, Public Health Programs, Shared Services
Status:	Completed

Name of Audit:	HHS OIG Medicaid Management Information System Cost Review
OHA Programs:	Medical Assistance Programs, Information Services
Status:	Completed

Name of Audit:	CMS Payment Error Rate Measurement (PERM FFY 11)
OHA Programs:	Addiction and Mental Health Programs, Medical Assistance Programs, Office of Private Health Partnerships, Public Health Programs, Shared Services
Status:	Completed

Name of Audit:	GAO Review of Psychotropic Medications Prescribed to Foster Care Children
OHA Programs:	Addictions and Mental Health Programs, Medical Assistance Programs
Status:	Completed
Name of Audit:	USDA FY 2011 WIC STAR Review
OHA Programs:	Public Health Programs, Shared Services
Status:	Completed
Name of Audit:	HHS OIG Excluded Provider Audit
OHA Programs:	Medical Assistance Programs
Status:	Completed
Name of Audit:	SSA Security Compliance Review
OHA Programs:	Medical Assistance Programs, Office of Private Health Partnerships, Public Health Programs, Shared Services
Status:	In Progress
Name of Audit:	CMS Home and Community Based Services (HCBS) Audit
OHA Programs:	Medical Assistance Programs
Status:	In Progress
Name of Audit:	IRS Federal Tax Information Security Review
OHA Programs:	Shared Services
Status:	In Progress
Name of Audit:	USPHS Region X Title X Family Planning Program Review
OHA Programs:	Public Health Programs, Shared Services
Status:	Completed
Name of Audit:	USDOJ Office of Civil Rights Compliance Review
OHA Programs:	Addictions and Mental Health Programs, Shared Services
Status:	Completed
Name of Audit:	HHS OIG Physician Administered Drugs
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress
Name of Audit:	CMS State MMIS Certification Review Final Report for Oregon
OHA Programs:	Medical Assistance Programs, Information Services
Status:	Completed
Name of Audit:	CMS Review of State Preadmission Screening and Resident Review (PASRR) Policies and Procedures

OHA Programs:	Addictions and Mental Health Programs, Medical Assistance Programs
Status:	Completed
Name of Audit:	FBI Criminal Background Checks
OHA Programs:	Public Health Programs, Shared Services
Status:	Completed
Name of Audit:	ONC Health Information Exchange
OHA Programs:	Office of Health Information Technology, Shared Services
Status:	In Progress
Name of Audit:	GAO Psychotropic Medications Prescribed to Foster Care Children Follow-up
OHA Programs:	Addictions and Mental Health Programs, Medical Assistance Programs
Status:	In Progress
Name of Audit:	USDA 2012 WIC STAR Review
OHA Programs:	Public Health Programs, Shared Services
Status:	Completed
Name of Audit:	CMS Provider Tax Financial Review
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress
Name of Audit:	USDA WIC Financial Management Review for FFY 2011
OHA Programs:	Public Health Programs, Shared Services
Status:	Completed
Name of Audit:	EPA State Drinking Water Revolving Fund FY 2011 Program Evaluation Report
OHA Programs:	Public Health Programs, Shared Services
Status:	Completed
Name of Audit:	HHS OIG review of On the Move Program
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress
Name of Audit:	HHS OCR OMIP HIPAA Privacy and Security Review
OHA Programs:	Office of Private Health Partnerships, Information Services
Status:	Completed
Name of Audit:	OIG HHS Estate Recovery Review
OHA Programs:	Medical Assistance Programs, Shared Services
Status:	In Progress

Name of Audit:	HHS CMS Pre-existing Condition Insurance Pool (PCIP)
OHA Programs:	Office of Private Health Partnerships, Shared Services
Status:	In Progress

Name of Audit:	EPA State Drinking Water Revolving Fund FY 2012 Program Evaluation Report
OHA Programs:	Public Health Programs, Shared Services
Status:	In Progress

Other Agency Reviews

Name of Audit:	Information Security Business Risk Assessment Report - 2011
OHA Programs:	Information Services
Status:	Completed

Name of Audit:	Information Security Business Risk Assessment Report - 2012
OHA Programs:	Information Services
Status:	In Progress

Oregon
John A. Kitzhaber, MD, Governor

Department of Administrative Services
Chief Human Resources Office
155 Cottage Street NE, U30
Salem, OR 97301
FAX: (503) 373-7684

January 25, 2013

Via Email Only

Dr. Bruce Goldberg, Director
Oregon Health Authority
500 Summer Street N.E., E-20
Salem, OR 97301

Re: 2012-2013 Agency Ratio – HB 4131

Dear Dr. Goldberg:

On January 25, 2013, the Department of Administrative Services ran an HB 4131 ratio report for the Oregon Health Authority. The report reflects OHA successfully increased the agency's ratio from 1 to 8 to 1 to 9 supervisory to non-supervisory budgeted positions.

This letter serves as your notification for the reporting period ending October 31, 2013, that OHA is no longer subject to the application process for exceptions to hire budgeted supervisory positions so long as it maintains the 1 to 9 ratio. On November 1, 2013, the agency's baseline ratio will reset and it will again be subject to the supervisory hiring restrictions.

If you have any questions, please do not hesitate to contact me, Twyla Lawson at 503-373-7677 or Susan Hoeye at 503-378-8301.

Sincerely,

Clyde Saiki
Interim Chief Human Resource Officer

c: Cheryl Miller, OHA HR
Angela Young, OHA HR
CHRO Exception Staff
Ken Rocco, LFO
Daron Hill, LFO
Brian DeForest, DAS BAM
Donna Lantz, CHRO/PPDB

Oregon Health Authority 2013 – 2015 Governor's Balanced Budget

Report on House Bill 2020 and House Bill 4131 Compliance

OHA's mission given to us by the Governor, the Legislature and agency leadership is that we must ensure the agency can support a health care system that is patient-centered, coordinated and reduces waste and inefficiency.

We are approaching this in a way that balances the intent of House Bill 2020 and House Bill 4131, the intent of the changes to the health delivery system and how OHA can support these changes long term, including the implementation of our management system.

For House Bill 2020, working with Department of Administrative Services, OHA reviewed approximately 200 positions and changed 72 from management service supervisory and non-supervisory to represented or unrepresented, depending on the program area.

Regarding House Bill 4131, OHA had increased its supervisory to non-supervisory ratio by one as required by the legislation (from 7 to 1 to an 8 to 1 level) and the plan was submitted and approved by the Department of Administrative Services (DAS) on July 25, 2012.

On January 25, 2013 DAS approved the next phase for OHA and we have again increased our ratio and reached our target bringing OHA to a 9 to 1 ratio.

Oregon Health Authority

Department Wide **Agency Number: 44300**

2013-2015 Biennium

Department-Wide Priorities for 2013-15 Biennium

	2	3		4	5	6	7	9	10	11	12	13	14	15	16	17	18	19
Priority (ranked with highest priority first)	**Program/Div (Orbits B Level)**	**(Orbits A Level Title)**	**Is Program leveraged for the DSHP Waiver?**	**Program Unit/Activity Description**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**New or Enhanced Program (Y/N)**	**Included as Reduction Option (Y/N)**	**Legal Req. Code (C, F, or D)**
1	Medical Assistance Prgms-OHP Payment	OHP & CHIP	No	The Oregon Health Plan (OHP) provides physical health, mental health and dental services to qualifying low-income and vulnerable Oregonians. The division pays managed care organizations to provide most of the care on a per capita basis with rates that are set by an independent actuary to reflect the cost of providing services. Some services are paid on a fee-for-service basis with rates that are typically less than cost. The Children's Health Insurance Program (CHIP) provides physical health, mental health and dental services to uninsured Oregon children. The division pays managed care organizations to provide most of the care on a per capita basis with rates that are set by an independent actuary to reflect the cost of providing services. Some services are paid on a fee-for-service	Preventive services for OHP youth and adults, Preventive services for OHP children, Appropriate prenatal care for OHP clients, PQI Hospitalizations of OHP clients	12	735,167,922		1,803,660,131		6,773,600,326		$ 9,312,428,379			N	N	F
2	Medical Assistance Prgms-OHP Payment	Non-OHP	Small amount	The Non-OHP budget includes the following programs: 1) the Breast and Cervical Cancer Medical program, which provides comprehensive health coverage to uninsured women who have been diagnosed with breast or cervical cancer; 2) the Citizen/Alien Waived Emergency Medical (CAWEM) program, which provides emergency medical services to children and adults who are ineligible for medical assistance solely because they do not meet the Medicaid citizenship or immigration status requirements; 3) the Health Insurance Premium program, which reimburses clients for employer-sponsored insurance premiums. Non-OHP also includes "clawback" payments to the federal government to help pay for the Medicare Prescription	Preventive services for OHP youth and adults, Preventive services for OHP children, Appropriate prenatal care for OHP clients, PQI Hospitalizations of OHP clients	12	342,552,360		12,918,634		326,903,357		$ 682,374,351			N	N	
3	Medical Assistance Prgms-OHP Payment	Oregon Healthy Kids	No	The Office of Healthy Kids (OHK) provides outreach and education statewide to ensure all Oregonian children have access to no cost and low cost health care coverage. OHK will provide education and support to DHS field offices, community organizations and partners for Health Systems Transformation implementation.	Medicaid eligible children enrollment. Number of partners and organizations provided training and education.	12	2,695,831		2,868,964		6,478,358		$ 12,043,153	17	16.90	N	Y	
4	Medical Assistance Prgms-OHP Payment	Pharmacy Programs	No	Pharmacy Programs provide all Oregonians access to reduced priced drugs through the Oregon Prescription Drug Program (OPDP). OPDP also provides consolidated purchasing power for the Oregon Education Benefit Board by jointly purchasing prescription drugs with the state of Washington through the NW Drug Consortium. Pharmacy Programs also provides health insurance to persons who are HIV positive through CAREAssist, Oregon's version of the Ryan White AIDS Drug Assistance Program	Reduced cost of prescription drugs by consolidating all OHA drug purchasing in one. Provide drug assistance to individuals with the state who are HIV positive.	12	4,103,701		58,825,446		10,423,057		$ 73,352,204	12	12.00	N	Y	
5	Addictions and Mental Health Program	Alcohol and Drug Treatment	Small amount	Alcohol and drug treatment programs provide an array of services tailored to the clients' needs. These include: assessment; detoxification; and individual, group and family counseling, residential treatment, and medications.	Completion of alcohol & drug treatment, Alcohol & drug treatment effectiveness: Employment, Child reunification, School performance	12	33,276,430		15,696,871		51,395,842		$ 100,369,143			N	Y	S,F
6	Addictions and Mental Health Program	Community Mental Health	Partially	Community programs provide a range of services tailored to the consumer's needs, including community/outpatient intervention and therapy, case management, residential and foster care, supported education, acute hospital care, and crisis and pre-commitment services. The community also provides supervision and treatment for persons under the jurisdiction of the Psychiatric Security Review Board.	Mental health client level of functioning, Child & Adult Mental Health Services	12	272,489,724		2,030,357		156,557,994		$ 431,078,075			N	Y	S,F
7	Public Health Programs	Center for Prevention and Health Promotion	Yes	Responsible for chronic disease prevention and health promotion, injury prevention, Prescription Drug Monitoring program, Women, Infants and children (WIC) Nutrition program, family planning, oral health, prenatal care, newborn hearing screening, and school-based health centers.	Teen suicide, Tobacco use, Cigarette packs sold, Teen pregnancy, Early prenatal care	10	12,457,252		7,641,584	40,000,000	113,186,821	101,929,051	$ 275,214,708			N	Y-Partial	S,F

Oregon Health Authority
Department Wide **Agency Number: 44300**
2013-2015 Biennium

Department-Wide Priorities for 2013-15 Biennium

	2	3		4	5	6	7	9	10	11	12	13	14	15	16	17	18	19
Priority (ranked with highest priority first)	**Program/Div (Orbits B Level)**	**(Orbits A Level Title)**	**Is Program leveraged for the DSHP Waiver?**	**Program Unit/Activity Description**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**New or Enhanced Program (Y/N)**	**Included as Reduction Option (Y/N)**	**Legal Req. Code (C, F, or D)**
8	Public Health Programs	State Public Health Director	No	Responsible for state emergency preparedness, planning, and response.		8, 10					15,953,143		$ 15,953,143			N	N	S,F
9	Public Health Programs	Center for Public Health Practice	Yes	Responsible for state support to local health departments core capacity in disease control and surveillance, HIV/STD/TB, immunization, statewide communicable disease control and testing, maintaining vital records and health statistics.	HIV rate, child immunizations, Influenza vaccinations for seniors	8,10	18,121,587		32,768,662		50,351,489		$ 101,241,738			N	Y-Partial	S,F
10	Public Health Programs	Center for Health Protection	Yes	Responsible for the State Drinking Water Program (Primacy) and EPA Revolving Loan Fund which provides approx. $12M annually to local water systems for capital improvement initiatives. Also identifying and preventing environmental and occupational safety hazards, and initiatives such as the health faciilities licensure, quality improvemnet and regulation, medical marijuana, and Patient Safety Commission.		9,10			976,525		3,018,134		$ 3,994,659			N	N	S,F
11	Addictions and Mental Health Program	State Hospital System	3 Non-Medicaid Gero units	The State Hospitals - located in Salem and Portland provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed to the Department are a danger to themselves or others, including people who have been found guilty except for insanity.	OSH restraint rate, OSH length of stay	12	346,454,822		13,494,872		43,065,863		$ 403,015,557	2,222	1,994.99	Y	Y	S,F
12	Addictions and Mental Health Program	Gambling Treatment and Prevention	No	Gambling treatment and prevention programs provide an array of services tailored to the clients' needs. These include: assessment; individual, group and family counseling; and residential treatment.	Gambling Treatment Effectiveness	12	0	7,857,518	0		0		$ 7,857,518			N	N	S
13	Addictions and Mental Health Program	State Delivered SRTF's	No	The state operated 16-bed facilities permit the safe movement of persons from the State Hospital(s) into the community that current providers choose not to serve.		12	5,434,775		494,210		2,030,274		$ 7,959,259	46	46.00	Y	N	S,F
14	Private Health Partnerships	State High Risk Pool (OMIP)	Yes	OMIP, in cooperation with the FMIP program, offers guaranteed-issue health insurance coverage for individuals, regardless of income level, who are unable to obtain medical insurance because of health conditions.		12	0	0	1,444,771	233,085,130	54,262,291	0	$ 288,792,192	7	6.50	N	N	
15	Private Health Partnerships	Healthy KidsConnect (HKC)	No	HKC is the private market insurance component or "mini-exchange" portion of the state's Healthy Kids program. Healthy Kids provides health insurance options for uninsured children age 18 and under, regardless of family income. HKC provides choices for families that earn too much to qualify for the Oregon Health Plan, but can't afford to pay the full cost of private health insurance premiums on their own.		12	20,574,526	0	5,575,726	0	70,985,633	0	$ 97,135,885	22	22.00	N	N	F
16	Private Health Partnerships	Family Health Insurance Assistance Program (FHIAP)	No	FHIAP helps uninsured, income-eligible Oregonians afford private health insurance. The program subsidizes a portion of the member's monthly health insurance premium. A member's subsidy level decreases as their annual income increases. FHIAP members are responsible for their own co-payments and deductibles.		12	5,737,268	0	1,877,720	0	12,498,209	0	$ 20,113,197	31	30.25	N	Y	

Oregon Health Authority
Department Wide **Agency Number: 44300**
2013-2015 Biennium

Department-Wide Priorities for 2013-15 Biennium

	2	3		4	5	6	7	9	10	11	12	13	14	15	16	17	18	19
Priority (ranked with highest priority first)	**Program/Div (Orbits B Level)**	**(Orbits A Level Title)**	**Is Program leveraged for the DSHP Waiver?**	**Program Unit/Activity Description**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**New or Enhanced Program (Y/N)**	**Included as Reduction Option (Y/N)**	**Legal Req. Code (C, F, or D)**
17	Private Health Partnerships	Federal High Risk Pool (FMIP)	No	FMIP, in cooperation with the OMIP program, offers guaranteed-issue health insurance coverage for individuals, regardless of income level, who are unable to obtain medical insurance because of health conditions.		12	0	0	13,931,687	0	40,890,795	0	$ 54,822,482	0	0.00	N	N	
18	PEBB Stabilization	Stabilization	No	(1) There is created the Public Employees' Revolving Fund, separate and distinct from the General Fund. The balances of the Public Employees' Revolving Fund are continuously appropriated to cover expenses incurred in connection with the administration of ORS 243.105 to 243.285 and 292.051. Assets of the Public Employees' Revolving Fund may be retained for limited periods of time as established by the Public Employees' Benefit Board by rule. Among other purposes, the board may retain the funds to control expenditures, stabilize benefit premium rates and self-insure. The board may establish subaccounts within the Public Employees' Revolving Fund. (2) There is appropriated to the Public Employees' Revolving Fund all unused employer contributions for employee benefits and all refunds, dividends, unused premiums and other payments attributable to any employee contribution or employer contribution made from any carrier or contractor that has provided employee benefits administered by the board, and all interest earned on such moneys.	243.167 Public Employees' Revolving Fund; continuing appropriation to fund	10				42,515,000			$ 42,515,000	0	0.00	N	N	S
19	PEBB Self-Insurance	Self-Insurance	No	(1) There is created the Public Employees' Revolving Fund, separate and distinct from the General Fund. The balances of the Public Employees' Revolving Fund are continuously appropriated to cover expenses incurred in connection with the administration of ORS 243.105 to 243.285 and 292.051. Assets of the Public Employees' Revolving Fund may be retained for limited periods of time as established by the Public Employees' Benefit Board by rule. Among other purposes, the board may retain the funds to control expenditures, stabilize benefit premium rates and self-insure. The board may establish subaccounts within the Public Employees' Revolving Fund. (2) There is appropriated to the Public Employees' Revolving Fund all unused employer contributions for employee benefits and all refunds, dividends, unused premiums and other payments attributable to any employee contribution or employer contribution made from any carrier or contractor that has provided employee benefits administered by the board, and all interest earned on such moneys.	243.167 Public Employees' Revolving Fund; continuing appropriation to fund	10				1,709,000,000			$ 1,709,000,000	0	0.00	N	N	S
20	PEBB Flex Benefit Admin	Flex Benefit Admin	No	(1) In addition to the powers and duties otherwise provided by law to provide employee benefits, the Public Employees' Benefit Board may provide, administer and maintain flexible benefit plans under which eligible employees of this state may choose among taxable and nontaxable benefits as provided in the federal Internal Revenue Code. (2) In providing flexible benefit plans, the board may offer: (a) Health or dental benefits as provided in ORS 243.125 and 243.135. (b) Other insurance benefits as provided in ORS 243.275. (c) Dependent care assistance as provided in ORS 243.550. (d) Expense reimbursement as provided in ORS 243.560. (e) Any other benefit that may be excluded from an employee's gross income under the federal Internal Revenue Code. (f) Any part or all of the state contribution for employee benefits in cash to the employee. (3) In developing flexible benefit plans under this section, the board shall design the plan on the best basis possible with relation to the welfare of employees and to the state.	243.221 Options that may be offered under flexible benefit plan	10				820,080			$ 820,080	0	0.00	N	N	S

Oregon Health Authority

Department Wide **Agency Number: 44300**

2013-2015 Biennium

Department-Wide Priorities for 2013-15 Biennium

	2	3		4	5	6	7	9	10	11	12	13	14	15	16	17	18	19
Priority (ranked with highest priority first)	**Program/Div (Orbits B Level)**	**(Orbits A Level Title)**	**Is Program leveraged for the DSHP Waiver?**	**Program Unit/Activity Description**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**New or Enhanced Program (Y/N)**	**Included as Reduction Option (Y/N)**	**Legal Req. Code (C, F, or D)**
21	OEBB Stabilization	Stabilization	No	There is created the Oregon Educators Revolving Fund, separate and distinct from the General Fund. Moneys in the Oregon Educators Revolving Fund are continuously appropriated to the Oregon Educators Benefit Board to cover the board's expenses incurred in connection with the administration of ORS 243.860 to 243.886. Moneys in the Oregon Educators Revolving Fund may be retained for limited periods of time as established by the board by rule. Among other purposes, the board may retain the funds to pay premiums, control expenditures, stabilize premiums and self-insure.	243.884 Oregon Educators Revolving Fund; continuous appropriation to board; purposes; rules; moneys paid into fund	10				1,628,294,000			$ 1,628,294,000	0	0.00	N	N	S
													$ -					
							1,799,066,198	7,857,518	1,974,206,160	3,653,714,210	7,731,601,586	101,929,051	15,268,374,723	2,357	2,128.64			

7. Primary Purpose Program/Activity Exists

1 Civil Justice
2 Community Development
3 Consumer Protection
4 Administrative Function
5 Criminal Justice
6 Economic Development
7 Education & Skill Development
8 Emergency Services
9 Environmental Protection
10 Public Health
11 Recreation, Heritage, or Cultural
12 Social Support

19. Legal Requirement Code

C Constitutional
F Federal
D Debt Service
S State

In prioritizing its programs, the department continued to use the basic criteria used in prior prioritizations that includes: fulfillment of mandates, long term implications, number of clients served, level of need of those served, and degree of Federal financial participation. In addition to these criteria, the department also considered:

1. Maintaining our current investment - Continue operating basic programs.
2. Capacity to provide basic services statewide - expanding coverage to more vulnerable populations.
3. Prevention - preventing higher costs downstream - front-end services (including non-Medicaid programs).
4. Technological advances to better serve clients & providers - addressing critical information needs.
5. Maintaining protection - keeping vulnerable populations (kids, seniors, disabled, etc) safe.
6. Adequate administrative capacity - linking admin support to program priorities.
7. Improve health care - improving access for all Oregonians.
8. Lower priority for new initiatives to our current portfolio.

While these criteria were considered in prioritization, the wide array of programs that OHA provides and the diverse populations served make application of any set of criteria difficult.

10% General Fund / 10% Other & Federal Fund Reduction Options

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revised 2-20-2013

DSHP Yes or No	Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	Employee FTE Affected	Impact of Reduction on Services and Outcomes
~~No~~	~~-0.05%~~	~~1~~	~~OHA Central Services & Administration~~	~~**Hold positions vacant:** This action includes leaving positions vacant within the OHA Director's Office, Office of Health Policy & Research, Budget & Planning Analysis, and OHA Communications.~~ **This Reduction Option taken as part of the Governor's Balanced Budget .**	~~No~~	~~$ (1,471,300)~~	~~$ (79,125)~~	~~$ (1,337,580)~~	~~$ (2,888,005)~~	~~(16)~~	~~(13.81)~~	~~Holding these positions vacant and/or elimination of these positions will reduce reaction time to requests, services to program areas, cause delays in recruitment efforts, delay Health Systems Transformation work and assist the CCOs and other panels and boards.~~
No	**-0.14%**	**2**	**MAP Admin & Program Support**	The MAP Admin and program support budget includes the Medicaid Health Director, Oregon Healthy Kids, MAP Program support and the Office of Client and Community Services Processing Center.	No	($2,500,000)	$ -	$ (2,500,000)	$ (5,000,000)	(8)	(8.00)	This combination of reductions will affect positions, services and supplies and professional service contracts. Staff positions affected through layoff will be both management service and represented staff.
No	**-0.20%**	**3**	**AMH - Admin and Program Support**	Maintain current vacancies, including 2 mgmt positions which would collapse the mgmt structure and merge adult and child mental health units in addition to holding an additional 11 positions vacant.	No	$ (1,501,512)	$ (108,460)	$ (636,064)	$ (2,246,036)	(13)	(13.00)	This action will result in longer response times for requests for information, files and data on Medicaid expenditures. There will be less support available to individuals to assist patients in transitioning from the state hospital and less support for those who need alcohol and drug free housing in developing and managing new Oxford Houses.
~~No~~	~~-0.20%~~	~~4~~	~~OPHP IEO~~	~~Reduce IEO administration by 5% in Services & Supplies.~~ **This item taken as part of the Governor's Balanced Budget.**	~~No~~	~~(19,790)~~		~~$ -~~	~~(19,790)~~	~~0~~	~~0.00~~	~~Decreases the program's ability to provide training and education activities on statutory changes, program changes, and health options available to small businesses and the general public.~~
Partially	**-0.23%**	**5**	**PH Admin and Program Support**	PH would make administrative reductions throughout the Office of The State Public Health Director as well as the 3 Centers which support all PH activities throughout it's programs.	No	$ (700,000)	$ -	$ -	$ (700,000)	(3)	(3.00)	This combination of reductions will affect positions, services and supplies and professional service contracts. Staff positions affected through layoff will be both management service and represented staff.
~~No~~	~~-0.81%~~	~~6~~	~~AMH-BMRC~~	~~AMH - Closure of the Blue Mountain Recovery Center for the last 18 months of the 13-15 biennium, with the transition of patients to OSH and Junction City- whichever is more appropriate for the level of care needed.~~ **This Reduction Option taken as part of the Governor's Balanced Budget.**	~~No~~	~~$ (15,962,595)~~	~~$ (3,102,392)~~	~~$ (964,050)~~	~~$ (20,029,037)~~	~~(136)~~	~~(97.62)~~	~~Early closure of Blue Mountain Recovery Center (BMRC). BMRC's closure was originally scheduled for Spring 2015. This action would close the facility earlier and move those patients not ready to transition to community settings to the Salem campus of the Oregon State Hospital. This move would put the Salem campus at nearly 90% of available occupancy -- assuming current census and not counting the Portland campus of the hospital. There will be a loss of 60 psychiatric hospital beds in the system, until the completion of the Junction City hospital. Once that facility is opened, it will lessen the burden on the Salem campus. At 90% capacity, the Salem campus will not be able to meet the needs of incoming patients, including the aid and assist patients that are mandated to be admitted within seven days of the order promulgation. Loss of this ability will create an increase in the wait list in local acute psychiatric hospitals as well as potential burden on jail populations. As scuh, if OSH is operating at a 90% capacity, there is increased levels of violence from patients to staff.~~
~~No~~	~~-1.16%~~	~~7~~	~~AMH - OSH~~	~~**The Oregon State Hospital will continue the Non-Direct Care/Administrative cost reduction measures that have been implemented during the 2011-13 biennium and prior.** These measures include a department wide hiring freeze, and targeted reductions of all Service & Supply expenditure budgets, and change the float pool from permanent full time positions to temporary positions thereby eliminating cost of benefits.~~ **This Reduction Option taken as part of the Governor's Balanced Budget.**	~~No~~	~~$ (9,697,920)~~	~~$ -~~	~~$ -~~	~~$ (9,697,920)~~	~~(32)~~	~~(32.00)~~	~~These measures include a department wide hiring freeze, and targeted reductions of all Service & Supply expenditure budgets, and change the float pool from permanent full time positions to temporary positions thereby eliminating cost of benefits.~~

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revised 2-20-2013

DSHP Yes or No	Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	Employee FTE Affected	Impact of Reduction on Services and Outcomes
No	**-1.18%**	**8**	**AMH**	**Defer the capital improvement budget for another biennium.**	No	$ (679,238)	$ -	$ -	$ (679,238)	-	-	This action defers the capital improvement budget for the third biennium in a row. Due to new construction for the Salem campus of the hospital system, and the planned construction of a new facility in Junction City, it is anticipated that the need for remodel or improvement projects is low, which will allow this move without great risk to the agency.
~~**Yes**~~	~~**-1.49%**~~	~~**9**~~	~~**AMH**~~	~~**AMH - Eliminate Cost of Living Increases** in the Current Service Level budget for those areas that OHA has discretion over COLAs such, as program service contracts.~~ **This Reduction Option revised and taken as part of the Governor's Balanced Budget.**	~~No~~	~~(8,448,361)~~	~~(633,368)~~	~~(5,789,074)~~	~~$ (14,870,803)~~			~~This would be the second biennium that providers were not given an increase for providing services. As actual costs do increase, this means there would be less ability to provide the same level of service to clients in the community programs. There would likely be reductions in workforce in community providers and the loss of some smaller providers due to the inability to secure funding through other sources. This action will lead to a loss of residential capacity in the community system.~~
No	**-1.56%**	**10**	**AMH - A & D Treatment**	**Parent Child Interaction Therapy (PCIT) reduction.** This reduction cuts nearly $1.8 million under service element A&D 60 for special projects.	No	(1,787,086)	$ -	$ -	$ (1,787,086)			Without this project, there will be a loss of infrastructure for Parent Child Interaction Therapy, an EBP addressing disruptive behavior disorders in young children. Adverse effects would be experienced by communities poised to train clinicians and implement PCIT. Families whose children exhibit these disorders would not be served. This will result in the need for child welfare services relating to permanency, increase in school failure, out-of-home placement, crime, special education, and K-12 grade repetition. This reduction will jeopardize the Maintenance of Effort (MOE) requirement of the Substance Abuse Prevention and Treatment (SAPT) block grant.
Yes	**-1.87%**	**11**	**AMH-CMH**	**Propose select Mental Health program reductions from the 2011-13 reduction list.**	No	(8,701,985)	$ -	$ -	$ (8,701,985)			This reduction will significantly affect 2,983 Oregonians with mental illness. Access to crisis services, acute psychiatric treatment (in a hospital setting), medications and case management services will be reduced by this reduction. This will likely result in people becoming more ill, doing poorly in school, experiencing strained family relationships and in some instances people will become homeless or may be jailed. There will be increased demands on the crowded state hospital. These reductions could jeopardize the Maintenance of Effort requirements for the Mental Health Block Grant.
Yes	**-1.94%**	**12**	**AMH - Community BH**	**1% reduction in flexible funding for community mental health, A&D tx, A&D prevention, Problem Gambling treatment and prevention services. (revised at GBB)**	No	$ (1,890,281)	$ -	$ -	$ (1,890,281)	-	-	To accomplish the 5% reductions target equates to a 1% reduction in funding for community addictions and mental health services. This will result in more than 16,000 adults, youth and children a year not eligible for Medicaid or insurance funding not receiving needed mental health and addictions services. Other non-Medicaid community services would be reduced for all individuals. Without these services individuals who are very ill may injure themselves or others. There would be an increase in deaths related to mental health crises in the community. Counties would not be able to fully meet their statutory obligations to investigate civil commitments. Without treatment people will continue to abuse alcohol & drugs, be at risk for infectious diseases, commit crimes, endanger their children, and lose their jobs. This will increase health costs, child welfare caseloads and reduce the ability of TANF clients to become employable. This reduction jeopardizes the MOE requirements for federal block grants.
Yes	**-1.95%**	**13**	**PH**	**Parasitology and Syphilis Testing at State Public Health Laboratory**	No	$ (200,000)	$ -	$ -	$ (200,000)	(1)	(1.00)	The State of Oregon would stop conducting parasitology testing and syphilis testing (RPR and FTA) for statewide disease control purposes. Local and state disease control programs will be unable to diagnose and prevent these infections, which will spread in the community, resulting in greater morbidity and mortality. Public Health will be unable to fulfill its statutory requirement to provide testing to local health departments for reportable diseases (ORS 433.012). This could have a potential impact on CCO funding since this General Fund is used as match for the federal Medicaid DSHP waiver.

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Yes	-1.97%	14	PH	**State Support to Local Health Departments**	No	$ (623,459)	$ -	$ -	$ (623,459)	-	-	Local County Public Health Departments (LPHD) would receive $1.03 per capita per year for public health services rather than $1.11 per capita per year. The impact by county would vary. These state funds are to conduct early detection, epidemiological investigations, and prevention activities to help report, monitor, and control communicable diseases, like influenza and foodborne illnesses. In addition, because these state dollars are used to provide the required match on several federal funding sources including the Public Health Preparedness Program, millions of dollars of other federal grant funds may be jeopardized.
~~No~~	~~-2.04%~~	~~15~~	~~OPHP FHIAP~~	~~Reduce the G/F support for Office of Private Health Partnership. This would be administered as a reduction to FHIAP subsidy payments.~~ **Adjustments to the FHIAP Budget are accounted for in the Governor's Balanced Budget.**	~~No~~	~~(1,802,383)~~		~~$ (2,907,069)~~	~~$ (4,709,452)~~			~~Reduces the amount of GF-supported subsidy payments and the associated federal match for FHIAP enrollees, resulting in a reduction of approx. 617 lives covered by the FHIAP program (24 month average)~~
~~No~~	~~-2.12%~~	~~16~~	~~MAP~~	~~**Make the physical health preferred drug list (PDL) enforceable.** Amendments to ORS 414.325 become operative January 2014 that effectively end the enforcement of a physical health preferred drug list. These savings are phased out of the Current Service Level (CSL) budget for Medical Assistance Programs. There is a Legislative Concept to continue the enforceable PDL.~~ **This Reduction Option taken as part of the Governor's Balanced Budget.**	~~No~~	~~(2,337,592)~~	~~$ (391,742)~~	~~$ (4,653,629)~~	~~$ (7,382,963)~~			~~The enforceable physical health preferred drug list has been in effect since April 2011. It generates significant savings in the Medical Assistance Programs budget. Without the authority to continue the list, there is little or no ability for OHA to control its expenditures on prescription drugs for Oregon Health Plan clients.~~
~~No~~	~~-2.22%~~	~~17~~	~~MAP~~	~~**Make the mental health preferred drug list (PDL) enforceable.** Prescribers of mental health medications would be required to adhere to the PDL. Exceptions to the PDL would be administered by prior authorization. An enforceable PDL for mental health medications would increase usage of preferred drugs. There would be no limitation on access to prescriptions under this reduction. Before being placed on the PDL, drugs are subjected to rigorous evidence review. This projection uses the latest MH drug cost information and assumptions from OSU Pharmacy College. Grandfathering current MH drug prescriptions for existing clients is one of the new assumptions.~~ ~~**LEGISLATIVE ACTION REQUIRED. CMS APPROVAL REQUIRED (assumes January 1, 2014 implementation date).**~~ **This Reduction Option taken as part of the Governor's Balanced Budget**	~~Yes, CMS would need to approve a Medicaid SPA.~~	~~$ (2,570,040)~~	~~$ (32,754)~~	~~$ (6,691,827)~~	~~$ (9,294,621)~~			~~Many mental health organizations, including the National Alliance of Mental Illness (NAMI), strongly oppose putting mental health drugs on an enforceable PDL stating that many drugs have little research or outcome data to be evaluated properly.~~
Potentially	-2.35%	18	MAP	**Eliminate the Indirect Medical Education (IME) component of the Graduate Medical Education (GME) program.** The agency would eliminate Medicaid payments to teaching hospitals that help offset indirect costs associated with their GME programs. IME includes indirect costs that arise from the inexperience of residents such as extra medical tests and reduced productivity. **CMS APPROVAL REQUIRED (assumes January 1, 2014 implementation date).**	Yes, CMS would need to approve a Medicaid SPA, new capitation rates and MCO contracts	$ (3,710,000)	$ (940,000)	$ (7,740,000)	$ (12,390,000)			This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians.
Potentially	-2.70%	19	MAP	**Eliminate the Direct Medical Education (DME) component of the Graduate Medical Education (GME) program.** The agency would eliminate Medicaid payments to teaching hospitals that help offset costs associated with their graduate medical education programs. DME includes costs associated with stipends or salaries for residents, payments to supervising physicians, and direct program administration costs. **CMS APPROVAL REQUIRED (assumes January 1, 2014 implementation date).**	Yes, CMS would need to approve a Medicaid SPA, new capitation rates and MCO contracts	$ (9,540,000)	$ (2,410,000)	$ (19,910,000)	$ (31,860,000)			This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians.
No	-2.71%	20	MAP	**Reduce specific Oregon Health Plan fee-for-service (FFS) rates by 5%.** The agency would implement targeted FFS rate reductions in the following areas: physicians and other professional services, except for primary care; anesthesia; therapies; durable medical equipment; ambulance: home health; vision; dental; mental health, except for assessment and treatment planning; and, inpatient and outpatient rates to large hospitals (those with 50 beds or more). **CMS APPROVAL REQUIRED (assumes January 1, 2014 implementation date).**	Yes, CMS would need to approve a Medicaid SPA.	$ (321,582)	$ (193,149)	$ (967,343)	$ (1,482,074)			Because the agency has already implemented Oregon Health Plan (OHP) rate cuts during the 2011-13 biennium, the Centers for Medicare and Medicaid Services (CMS) would be reluctant to approve further rate reductions. CMS would require extensive analysis and documentation demonstrating that OHP clients would still have adequate access to services following such cuts.

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~~No~~	~~-2.73%~~	~~21~~	~~OHA Central Services & Administration~~	~~**Reductions to Services & Supplies:** This action includes reduction of professional services, publicity & publications, and Attorney General fees.~~ **This Reduction Option taken as part of the Governor's Balanced Budget.**	~~No~~	~~$ (589,115)~~	~~$ (151,950)~~	~~$ (203,404)~~	~~$ (944,469)~~	~~-~~	~~-~~	~~Reduces the use of outside expertise to work on major projects and initiatives including Health Systems Transformation & CCOs. Will slow progress on work towards Governor's initiatives. May cause delays in program implementation, causing non-compliance for the agency which could result in loss of funding or penalties.~~
No	**-2.82%**	**22**	**MAP Admin & Program Support**	The MAP Admin and program support budget includes the Medicaid Health Director, Oregon Healthy Kids, MAP Program support and the Office of Client and Community Services Processing Center.	No	($2,500,000)	$ -	$ (2,500,000)	$ (5,000,000)	(8)	(8.00)	This combination of reductions will affect positions, services and supplies and professional service contracts. Staff positions affected through layoff will be both management service and represented staff.
No	**-2.86%**	**23**	**AMH - Admin and Program Support**	Maintain current vacancies, hold an additional 8 positions vacant.	No	$ (1,015,143)	$ -	$ (552,210)	$ (1,567,353)	(8)	(8.00)	This action will result in longer response times for requests for information, files and data on Medicaid expenditures. There will be less support available to individuals to assist patients in transitioning from the state hospital and less support for those who need alcohol and drug free housing in developing and managing new Oxford Houses.
Partially	**-2.88%**	**24**	**PH Admin and Program Support**	PH would make administrative reductions throughout the Office of The State Public Health Director as well as the 3 Centers which support all PH activities throughout its programs.	No	$ (700,000)	$ -	$ -	$ (700,000)	(3)	(3.00)	This combination of reductions will affect positions, services and supplies and professional service contracts. Staff positions affected through layoff will be both management service and represented staff.
~~No~~	~~-2.89%~~	~~25~~	~~OPHP IEO~~	~~Reduce IEO administration by 5% in Services & Supplies.~~ **This item taken as part of the Governor's Balanced Budget.**	~~No~~	~~(19,790)~~		~~$ -~~	~~$ (19,790)~~	~~0~~	~~0.00~~	~~Decreases the program's ability to provide training and education activities on statutory changes, program changes, and health options available to small businesses and the general public.~~
~~No~~	~~-2.99%~~	~~26~~	~~AMH - OSH~~	~~**Outsource Pharmacy** This Reduction Option taken as part of the Governor's Balanced Budget.~~	~~No~~	~~$ (3,000,000)~~	~~$ -~~	~~$ -~~	~~$ (3,000,000)~~			~~This requires the installation of an automated pharmacy system, which is currently being pursued.~~
No	**-3.02%**	**27**	**AMH - Program Support**	**Targeted reduction of Personal Services Contracts that support both Mental Health and Alcohol and Drug programs.**	No	$ (693,069)	$ (17,896)	$ (346,441)	$ (1,057,406)	-	-	This would reduce several personal services contracts by 50%. Contract reductions would include the suicide helpline, Morrow County Warmline, support for Oxford Houses, supported employment, and Afro Centric Services through the Oregon Health Sciences University. Reductions in these contracts will increase the need for face-to-face crisis services and reduce culturally specific services for African Americans.
~~Yes~~	~~-3.34%~~	~~28~~	~~AMH - OSH~~	~~**Close one Geropsychiatric Ward - discharge at least 24 patients from unit that serves older clients with psychiatric and behavioral symptoms and younger brain injured adults with similar symptoms will be closed without community alternatives. It is unknown at this time who might be eligible for SPD services.** This Reduction Option taken as part of the Governor's Balanced Budget.~~	~~No~~	~~$ (8,839,080)~~	~~$ -~~	~~$ -~~	~~$ (8,839,080)~~	~~(43)~~	~~(43.00)~~	~~This reduction closes 1 ward in the Geropsychiatric Hospital Program that serves clients who themselves or whose services are not eligible for Medicaid reimbursement. The hospital would lose 24 beds and patients formerly served will be discharged into existing community programs that were unable to meet their complex medical, behavioral and mental health needs in the first place. This cut will destabilize the planning for the replacement of OSH which assumes a growth in the population. Program cuts of this magnitude may require suspension of the mental health civil commitment statutes found in ORS 426.005 through 429.320. This action could lead to increased costs in community settings for both Community Mental Health and Aging and People with Disabilities programs. Implementation requires additional community resources for consumers with dementia and/or traumatic brain injury. Movement of such patients from Oregon State Hospital, however, is in line with existing plans for treatment of such patients in more appropriate less restrictive, community-based settings.~~

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	-3.95%	**29**	**AMH - Community BH**	**11% reduction in flexible funding for community mental health, A&D tx, A&D prevention, Problem Gambling treatment and prevention services.** ***Note: this action includes 10% of the Lottery Fund reduction - at $1.1 million.***	No	$ (16,779,366)	$ -	$ -	$ (16,779,366)	-	-	To accomplish the 10% reductions target equates to an additional 11% reduction in funding for community addictions and mental health services (total 12%). This will result in more than 16,000 adults, youth and children a year not eligible for Medicaid or insurance funding not receiving needed mental health and addictions services. Other non-Medicaid community services would be reduced for all individuals. Without these services individuals who are very ill may injure themselves or others. There would be an increase in deaths related to mental health crises in the community. Counties would not be able to fully meet their statutory obligations to investigate civil commitments. Without treatment people will continue to abuse alcohol & drugs, be at risk for infectious diseases, commit crimes, endanger their children, and lose their jobs. This will increase health costs, child welfare caseloads and reduce the ability of TANF clients to become employable. This reduction jeopardizes the MOE requirements for federal block grants.
No	**-4.02%**	**30**	**AMH - Program Support**	**Discontinue the Compass Project - Eliminate 6 positions and terminate contract with FEI ($741,000)**	No	$ (1,835,617)	$ -	$ (102,301)	$ (1,937,918)	(6)	(6.00)	This project is an effort to replace old, outdated contracting and data systems. It would position the mental health and addictions programs for linkage to the Coordinated Care Organizations. This action could result in the project to replace legacy systems incomplete. Further, by eliminating the positions associated with the project, there would be a negative impact on the ability to fully implement the portions of the project that are completed. This action would put completion of the project at risk, and eliminates staffing intended to support the system once fully operational.
No	**-4.06%**	**31**	**PHD**	**Contraceptive Care**	No	(1,119,366)		(10,074,294)	$ (11,193,660)			This cut would mean 40,741 fewer reproductive health services visits for under or uninsured men and women. As a result the number of Medicaid-paid births in Oregon would increase, and more than $10 million dollars in federal matching funds would be lost.
No	**-4.13%**	**32**	**PH**	**School Based Health Centers (SBHCs)**	No	(1,800,000)		-	$ (1,800,000)			An estimated 7,000 school-aged youth would not receive preventive physical and mental health services if the program were reduced and some centers would close (state support to 15 to 22 SBHCs would be eliminated). Client level impact will result in increases in foregone care including reductions in preventive care visits & screenings, treatment for acute and chronic illness or disease, immunizations, reproductive health services, mental or emotional conditions, delayed care that then requires more complex/expensive treatment.
No	**-4.13%**	**33**	**OPHP-OEI**	Reduce IEO administration by an additional 5% in Services & Supplies.	No	$ (19,790)	$ -	$ -	$ (19,790)	-	-	Further erodes the program's ability to provide training and education activities on statutory changes; program changes and health options available to small businesses and the general public.
~~**No**~~	~~**-4.19%**~~	~~**34**~~	~~**OPHP FHIAP**~~	~~Reduce the G/F support for Office of Private Health Partnership. This would be administered as a reduction to FHIAP subsidy payments.~~ **Adjustments to the FHIAP Budget are accounted for in the Governor's Balanced Budget.**	~~No~~	~~(1,802,383)~~		~~$ (2,907,069)~~	~~$ (4,709,452)~~			~~Reduces the amount of GF-supported subsidy payments and the associated federal match for FHIAP enrollees, resulting in a reduction of approx. 617 lives covered by the FHIAP program (24 month average)~~
No	**-4.34%**	**35**	**MAP**	**Eliminate coverage for specific dental services for Oregon Health Plan (OHP) Plus adult clients.** The agency would no longer cover the following dental services for adults (including pregnant adults) receiving the OHP Plus benefit package: root canals for permanent teeth and retreatment of root canals (i.e., endodontics); full and partial dentures; and crowns. Oregon Health Plan coverage is based on the Prioritized List of Health Services. The dental services eliminated for OHP Plus adults under this reduction are those found on lines 414, 436, 468, 477, 480 and 494 of the prioritized list. **The Health System Transformation waiver Special Terms and Conditions (STCs) prohibits the state from reducing eligibility or benefits. Because CMS approval is required assumes January 1, 2014 implementation date.**	Yes, CMS would need to approve a waiver amendment, Medicaid SPA, new capitation rates and MCO contracts.	$ (3,995,971)	$ -	$ (12,728,484)	$ (16,724,455)			Adults receiving the OHP Plus benefit package could end up requiring more teeth extracted if they cannot be restored. Loss of denture coverage would prevent these clients from getting dentures to replace missing teeth, which can result in difficulty eating and finding employment. With reduced dental benefits, clients may access the emergency department more often because of unmet dental needs.

10% General Fund / 10% Other & Federal Fund Reduction Options

(Limited Other and Federal Funds only - does not include non-limited funds)

Current Service Level Budget - OHA	**2,747,841,229**	**1,036,529,686**	**6,639,647,487**	**10,424,018,402**
10% Target	**274,784,123**	**103,652,969**	**663,964,749**	**1,042,401,840**

revised 2-20-2013

DSHP Yes or No	Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	Employee FTE Affected	Impact of Reduction on Services and Outcomes
No	-5.59%	36	MAP	**Eliminate non-emergent dental coverage for OHP Plus non-pregnant clients.** OHP Plus non-pregnant adults would have the same dental coverage as provided by the OHP Standard benefit package, which limited to emergency dental services (e.g., acute infection or abscess, severe tooth pain, tooth re-implantation and extraction of symptomatic teeth). **The Health System Transformation waiver Special Terms and Conditions (STCs) prohibits the state from reducing eligibility or benefits. LEGISLATIVE ACTION REQUIRED. Because CMS approval is required assumes January 1, 2014 implementation date.**	Yes, CMS would need to approve a waiver amendment, Medicaid SPA, new capitation rates and MCO contracts.	$ (34,415,950)	$ -	$ (78,342,816)	$ (112,758,766)			Non-pregnant adults who receive the OHP Plus benefit package would receive the same limited dental package as provided to OHP Standard clients. OHP Standard dental benefits are limited to services requiring immediate treatment and are not intended to restore teeth. Services provided include treatment for the following: acute infection; acute abscesses; severe tooth pain; tooth re-implantation when clinically appropriate; and extraction of teeth, limited to those teeth that are symptomatic. Lack of comprehensive dental benefits and untreated oral health conditions can cause disfiguring tooth loss and decay that can limit employment options and lower self-esteem. Problems with oral health can exacerbate and cause other serious health conditions.
No	-5.61%	37	MAP	**Eliminate coverage for therapy services for Oregon Health Plan (OHP) Plus non-pregnant adults.** The agency would eliminate physical therapy, occupational therapy, and speech therapy from the OHP Plus benefit package for non-pregnant adults. **The Health System Transformation waiver Special Terms and Conditions (STCs) prohibits the state from reducing eligibility or benefits. LEGISLATIVE ACTION REQUIRED. Because CMS approval is required assumes January 1, 2014 implementation date.**	Yes, CMS would need to approve a waiver amendment, Medicaid SPA, new capitation rates and MCO contracts.	$ (666,225)	$ -	$ (1,109,901)	$ (1,776,126)	(1)	(0.50)	Non-pregnant adult Oregon Health Plan clients needing these services would experience prolonged health care issues affecting their ability to become self-sufficient. Hospital stays and the length of time for recovery from orthopedic surgery would increase. This reduction would negatively impact health system transformation as fewer services and dollars would be available.
No	-5.65%	38	MAP	**Eliminate coverage for prosthetic devices, hearing aids, chiropractic services and podiatry services for Oregon Health Plan (OHP) Plus non-pregnant adults.** The agency would eliminate coverage for prosthetic devices, hearing aids, chiropractic services, and podiatry services from the OHP Plus benefit package for non-pregnant adults. **The Health System Transformation waiver Special Terms and Conditions (STCs) prohibits the state from reducing eligibility or benefits. LEGISLATIVE ACTION REQUIRED. Because CMS approval is required assumes January 1, 2014 implementation date.**	Yes, CMS would need to approve a waiver amendment, Medicaid SPA, new capitation rates and MCO contracts.	$ (1,055,976)	$ (1,943)	$ (1,762,446)	$ (2,820,365)			Health care needs for a significant number of non-pregnant adult Oregon Health Plan clients, especially seniors and people with disabilities would go unmet. For example, individuals would live without prosthetic devices for amputated limbs; individuals with hearing impairments would go without necessary aids; and, individuals with diabetic or neuropathic conditions would go without foot care treatment. In some instances, other agency programs would have to fund these services. This reduction would negatively impact health system transformation as fewer services and dollars would be available.
No	-5.91%	39	MAP	**Eliminate dental coverage for Oregon Health Plan (OHP) Plus non-pregnant adults and OHP Standard clients.** The agency would eliminate the remaining non-pregnant adult dental coverage for the OHP Plus and OHP Standard benefit packages. **The Health System Transformation waiver Special Terms and Conditions (STCs) prohibits the state from reducing eligibility or benefits. LEGISLATIVE ACTION REQUIRED. Because CMS approval is required assumes January 1, 2014 implementation date.**	Yes, CMS would need to approve a waiver amendment, Medicaid SPA, new capitation rates and MCO contracts.	$ (7,072,321)	$ -	$ (22,724,861)	$ (29,797,182)			The lack of a dental benefit for non-pregnant adults on the Oregon Health Plan (OHP) would cause adverse effects on their physical health, such diabetes and cardiovascular disease. Emergency room visits would increase. The OHP dental care organization infrastructure would be threatened with the loss of the adult population. This reduction would negatively impact health system transformation as fewer services and dollars would be available.
No	-7.81%	40	MAP	**Cover 29 fewer lines on Prioritized List of Health Services.** Oregon Health Plan (OHP) coverage is based on the Prioritized List of Health Services, which ranks treatment and condition pairs in order of effectiveness. Starting July 1, 2013, OHP would cover lines 1 through 468. The agency would seek federal approval to no longer cover lines 469 through 498 for the OHP Plus and OHP Standard benefit packages. **The Health System Transformation waiver Special Terms and Conditions (STCs) prohibits the state from reducing eligibility or benefits. LEGISLATIVE ACTION REQUIRED. Because CMS approval is required assumes January 1, 2014 implementation date.**	Yes, CMS would need to approve a waiver amendment, Medicaid SPA, new capitation rates and MCO contracts.	($52,338,801)		($93,185,646)	$ (145,524,447)	-	-	This action would have a dramatic impact on health care services that are covered for all OHP clients, including pregnant women, children, and other groups. Coverage for treatments of conditions such as collapsed structure of a lung, hearing loss, adjustment disorders and neonatal eye infections would end. Conditions that may cause significant functional disability would no longer be covered, including urinary incontinence and osteoarthritis and uterine prolapse. Several mental health conditions would no longer be covered, including social phobias and obsessive compulsive disorders which would likely result in broader family and community impacts. In addition, coverage of many basic dental treatments, such as missing teeth, dental caries and dentures, would be eliminated for all eligibility groups. Elimination of coverage of this magnitude would make it very difficult for physical, dental, and mental health providers to deliver high quality, comprehensive care. This proposal would significantly increase administrative burden for providers and for the department.

10% General Fund / 10% Other & Federal Fund Reduction Options

(Limited Other and Federal Funds only - does not include non-limited funds)

Current Service Level Budget - OHA	**2,747,841,229**	**1,036,529,686**	**6,639,647,487**	**10,424,018,402**
10% Target	**274,784,123**	**103,652,969**	**663,964,749**	**1,042,401,840**

revised 2-20-2013

DSHP Yes or No	Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	Employee FTE Affected	Impact of Reduction on Services and Outcomes
No	**-9.30%**	**41**	**MAP**	**Reduce the DRG hospital component of managed care rates from 80% of Medicare to 70%.** The 2013-15 Current Service Level (CSL) budget assumes that, starting January 2014, the base reimbursement rate by managed care organizations, including Coordinated Care Organizations, to DRG hospitals is funded at 80% of Medicare rates. This reduction would lower the base rate to 70% of Medicare. **CMS APPROVAL REQUIRED (assumes January 1, 2014 implementation date).**	Yes, CMS would need to approve contract and rate changes	$ (40,826,847)	$ -	$ (103,025,602)	$ (143,852,449)			This reduction would lower the amount of money managed care organizations, including Coordinated Care Organizations, would have in their rates for services provided by hospital that are reimbursed by Medicare based on diagnostic related groups (DRGs).
No	**-10.04%**	**42**	**MAP**	**Reduce the DRG hospital component of managed care rates from 70% of Medicare to 65%.** The 2013-15 Current Service Level (CCSL) budget assumes that, starting January 2014, base reimbursement rate by managed care organizations, including Coordinated Care Organizations, to DRG hospitals is funded at 80% of Medicare rates. A reduction option higher on the list would lower the base rate to 70% of Medicare from 80%. This reduction would further lower the base rate to 65 percent of Medicare. **CMS APPROVAL REQUIRED (assumes January 1, 2014 implementation date).**	Yes, CMS would need to approve contract and rate changes	$ (20,413,423)	$ -	$ (51,512,801)	$ (71,926,224)			This reduction would lower the amount of money managed care organizations, including Coordinated Care Organizations, would have in their rates for services provided by hospital that are reimbursed by Medicare based on diagnostic related groups (DRGs).
Partially	**-10.04%**	**43**	**All-OHA**	**Additional program reductions within O/F and F/F programs for HB 3182**	Yes, CMS would need to approve a Medicaid SPA for anything affecting MAP Program changes.	$ -	$ (95,567,524)	$ (231,671,914)	$ (327,239,438)			Addition reductions to meet a 10% reduction in O/F and F/F limitation would affect many PHD programs (e.g. OMMP, Vital Records, PHL, and significant MAP programs such Prescription Drug Monitoring, Care Assist, as well as OHP line items funded by General Fund and Tobacco Tax. These may include reductions to Mental health services for non-pregnant adults, and the other governmental entities which provide leverage for Medicaid funding to Graduate Medical Education (GME) with OHSU, TCM, administrative claiming for Education Service Districts, and Behavioral Rehabilitation Services with ten juvenile justice departments. OPHP and OEBB/PEBB Programs would also have programs affected by limitation adjustments.
				revised 2-20-2013		**$ (275,963,357)**	**$ (103,630,303)**	**$ (666,846,826)**	**$ (1,046,440,486)**	**(278.00)**	**(236.93)**	

Addictions and Mental Health (AMH) Program Support & Administration

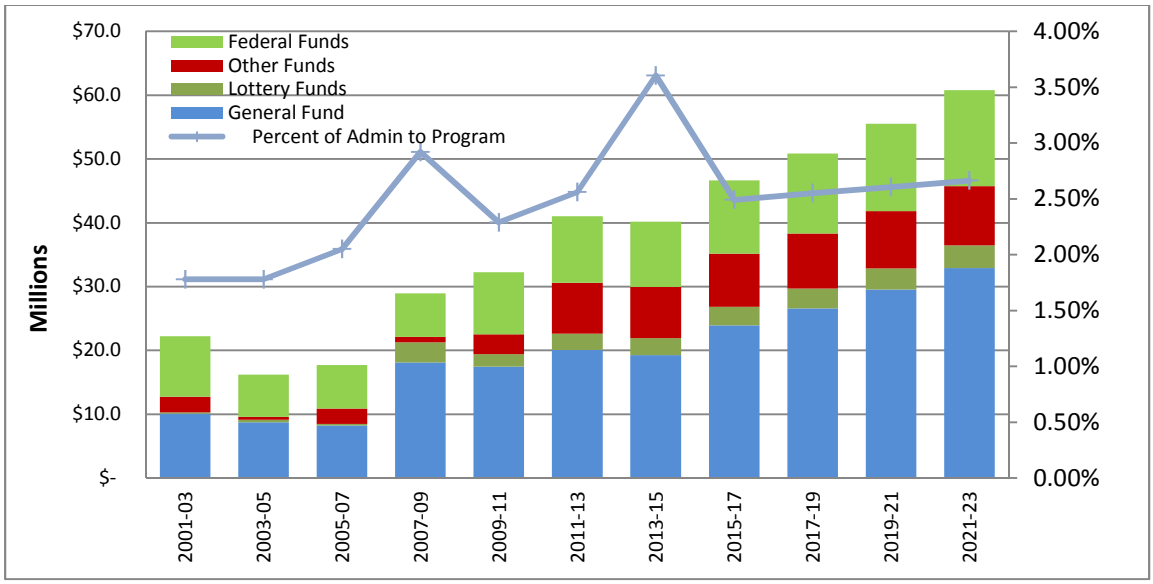
BIENNIUM	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
General Fund	10,119,632	8,744,800	8,221,445	18,115,313	17,447,420	20,089,493	19,253,019	23,932,685	26,584,019	29,558,994	32,909,172
Lottery Funds	171,186	402,683	293,900	3,171,000	1,959,562	2,538,902	2,683,647	2,892,548	3,091,153	3,307,462	3,547,438
Other Funds	2,446,390	447,957	2,363,054	835,464	3,130,003	7,959,141	7,999,787	8,316,388	8,626,355	8,941,352	9,277,944
Federal Funds	9,510,768	6,606,748	6,859,484	6,819,839	9,705,937	10,433,033	10,229,528	11,514,913	12,564,416	13,729,893	15,035,652
Total Funds	22,247,976	16,202,188	17,737,883	28,941,616	32,242,922	41,020,569	40,165,981	46,656,534	50,865,943	55,537,701	60,770,206
Positions	99	92	97	232	150	149	119	130	130	130	130
FTE	95.09	91.00	94.50	162.08	143.99	141.06	117.74	128.74	128.74	128.74	128.74

ɔgram Performance

Quantity Metric											
Percent of Admin to Progra	1.78%	1.78%	2.05%	2.92%	2.29%	2.56%	3.60%	2.49%	2.55%	2.61%	2.66%

Agency Name: Addictions and Mental Health (AMH) Program Support & Administration

Primary Outcome Area: Healthy People
Secondary Outcome Area: Good Government
Program Contact: Linda Hammond 503-480-4786, Linda.Hammond@state.or.us



Note: 2011-13 includes nearly $17 million in Other and Federal Fund limitation that has no revenue nor expenditures associated with it and will be removed in 2013-15. In addition, there is $4 million allocated to a new data system. It is one-time in this budget and will be returned to program budget in 2013-15.

Executive Summary

The AMH Program Office provides leadership and collaborates with external partners and stakeholders to create the vision for the prevention and treatment systems of care for mental health and substance abuse including problem gambling disorders. The program office also sets policy and develops programs which bring the vision into practice. Leadership is essential to implement, contract for services and hold contractors accountable to provide the highest quality services to treat these disorders effectively so that clients recover and live as independently as possible.

Program Description

The Program Office staff are responsible for developing and implementing addictions and mental health policies and programs as directed by the Legislature. The areas of responsibility include community-based services for people with addictions and mental health disorders, oversight of the Oregon State Hospital (OSH) system and the capital project to replace the aging buildings of OSH. Services are available to Oregonians in all 36 counties and in the state hospitals with three campuses in Salem, Portland and Pendleton. The work is achieved by:

- Developing state plans for substance abuse prevention and treatment services and mental health services;
- Implementing state addictions, gambling and mental health programs and laws;
- Directing services for persons with substance use disorders; with problem and pathological gambling; and for persons with mental health disorders;
- Directing services for persons with co-occurring mental health and substance use disorders; and
- Providing treatment and custody of persons committed by courts to the state for care and treatment of mental illness.

These services are provided through statutory partnerships with the local Mental Health Authority in each county. There are also partnerships with Mental Health Organizations (soon to be Coordinated Care Organizations - CCOs), providers, people in recovery and their families. The program office is cost-effective administration. For the 2013-15 bienium, the percent of Program Support and Administration budget to total Program is 3.60%.

The Oregon Health Authority (OHA) and AMH are determining the essential processes to lead and manage differently for a transformed, integrated and accountable health care delivery system. These changes will streamline administrative requirements and efficiently focus work on the most critical processes that result in the achievement of the goals of improved access to health care, improved experience of health care and reduced costs.

Program Justification and Link to 10-Year Outcome

The work of the Program Office is essential to establish, develop, fund and monitor programs that deliver services to people with addictions and mental health disorders. These services contribute to the reduction in health care costs and to reducing the years of life lost because of these disorders. Program Office leadership and support is essential to the development of effective prevention and early intervention programs that help people gain the skills needed to avoid the development of chronic illnesses and increase life expectancy by 10 years.

The certification and licensing of programs ensures that providers are meeting quality standards for safe and effective services.

Program Performance

In the development, management and monitoring of the community system for mental health and addiction treatment, the program support staff fulfill critical functions including initiating major program changes, working with partners to develop safe and affordable housing for people with addiction or mental health disorders, contracting for services, licensing and certifying programs for quality, health and safety and improving data systems. All of this is done working with stakeholders.

Major Initiatives:

AMH System Change – This initiative parallels the OHA Health System Transformation and integrates addiction and mental health treatment services for individuals who are not eligible for Medicaid. It provides flexibility to local communities to allocate resources where they are most needed to serve people in their community. This is balanced by outcomes-based management that holds the counties and providers accountable.

The Adult Mental Health Initiative provides resources to the community to more rapidly discharge individuals who are ready to transition from the state hospital or from more intensive to more integrated and independent levels of care in the community. The flexibility is balanced with outcome requirements. Since September 2010, 1,044 individuals have moved from more restrictive to less restrictive levels of care. More than half have transitioned to independent living in the community.

Housing Development – Alcohol & Drug Free Housing 421 people are living in 39 projects developed over the last 10 years; this biennium 167 individuals and 192 families with 283 children have received assistance finding and affording alcohol and drug free housing in the competitive market, and Oregon Recovery Homes have developed 157 Oxford Houses for 1536 people including 300 children.

Mental Health Housing – Since 1989, 117 projects have been developed which provide housing for 1383 adults with severe persistent mental illness; each state dollar has leveraged $36. The housing trust set up with the proceeds from the sale of Dammasch State Hospital has funded 34 projects housing 426 people and most recently funded 24 units of supported housing.

Replacement of 30-year-old data systems – AMH initiated the COMPASS project to replace the community data system, the acute hospital civil commitment and other data system and the contracting data system. The project will be completed in stages over the 2011-13 and the 2013-15 biennia.

Quality Improvement staff have licensed 306 residential programs, certified 640 community programs and licensed 620 people to do civil commitment examinations and to order seclusion and restraint for children in psychiatric residential treatment programs.

The contracting staff process 170 contracts and 1,303 amendments each biennium.

Enabling Legislation/Program Authorization

Oregon Revised Statute (ORS) 426 provides OHA the statutory framework for the legal and other processes for delivering mandated treatment to persons who because of a mental illness are a danger to themselves or others; these responsibilities are delegated to AMH. This includes the responsibilities of Oregon State Hospital and Blue Mountain Recovery Center as the state hospital to meet the longer term treatment needs of the population. ORS 430 provides OHA the statutory framework for the development, implementation and continuous operation of the community treatment programs to serve people with addiction disorders and mental health disorders subject to the availability of funds. Under ORS 161.370, AMH is delegated to provide

the evaluation services to determine if an allegedly mentally ill individual who is accused of a crime is fit to proceed through the judicial processes.

Under ORS 161.390, AMH provides treatment services for individuals who have been found guilty of a crime except for insanity. Treatment is provided in OSH and in the community.

Funding Streams

General Fund: Legislatively appropriated for the administration and support of addictions and mental health treatment services.

Other Funds: Limited amount of licensing revenue and small contracts for data reporting to federal government and educating the system relative to the Olmstead Supreme Court decision.

Lottery Funds: A portion of the 1% to support problem gambling treatment programs.

Federal Funds: Medicaid administrative match, small amounts of the federal block grants to meet administrative requirements and other federal grants to fulfill the grant obligations.

Significant Proposed Program Changes from 2011-13

AMH will continue to closely manage expenses in the next biennium. AMH continues to work with the other OHA divisions to align functions to support the Health System Transformation. The alignment will likely result in the movement of positions within OHA to support transformation while gaining efficiencies.

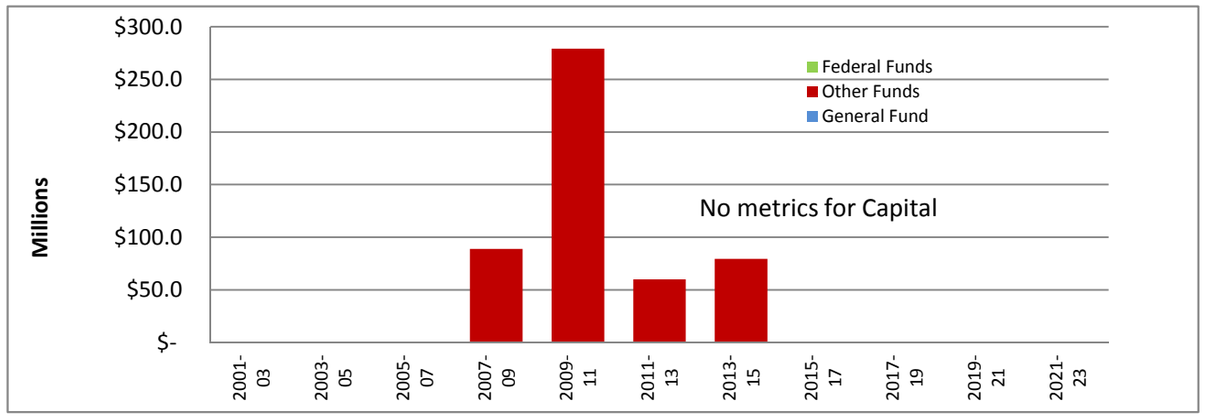
OHA - Addictions and Mental Health (AMH) Alcohol & Drug Prevention & Treatment Programs

BIENNIUM	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	31,374,471	17,854,944	25,879,873	41,717,861	32,127,034	36,321,990	33,697,718	45,163,152	46,337,394	47,449,491	48,588,279
Other Funds	20,552,945	14,583,129	18,624,453	9,694,416	11,573,904	16,892,256	16,892,256	17,764,707	18,226,589	18,664,027	19,111,964
Federal Funds	48,335,997	47,728,843	58,719,677	50,802,509	60,662,183	63,579,161	63,591,624	62,593,571	64,221,004	65,762,308	67,340,603
Total Funds	100,263,413	80,166,916	103,224,003	102,214,786	104,363,121	116,793,407	114,181,598	125,521,430	128,784,987	131,875,826	135,040,846
Positions											
FTE											
Program Performance											
Quantity Metric											
# People Served	102,445	96,176	99,484	100,457	95,071	99,671	102,885	102,885	102,885	102,885	102,885
Cost Per Unit Metric											
Average Cost per Person Served	Not Available	Not Available	$ 1,260	$ 1,443	$ 1,579	Not Available					

Agency Name: Capital Construction

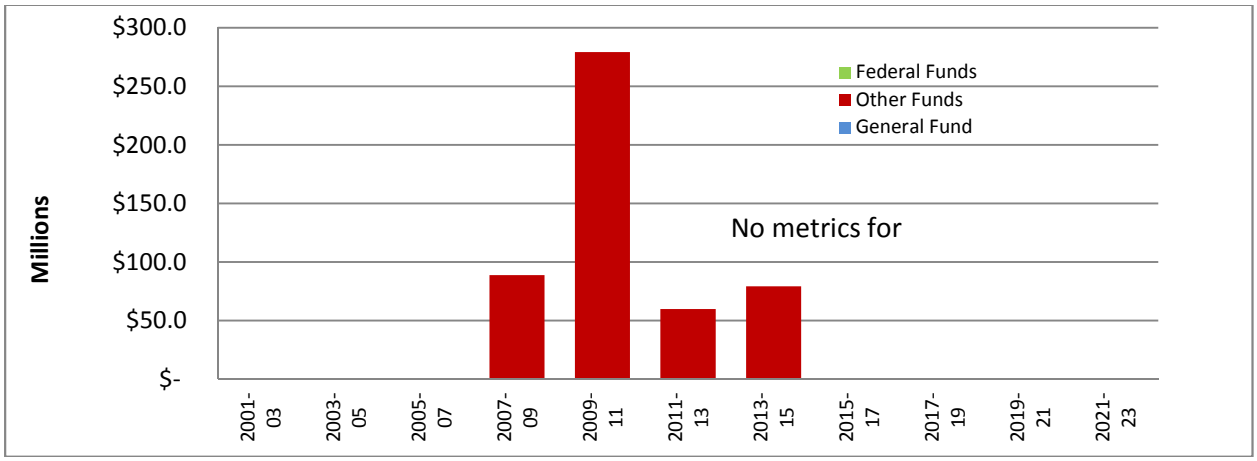
BIENNIUM	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
General Fund	-	-	-	-	-	-					
Other Funds	-	-	1	89,022,165	279,179,118	59,900,000	79,401,530				
Federal Funds	-	-	-	-	-	-					
Total Funds	-	-	1	89,022,165	279,179,118	59,900,000	79,401,530	-	-	-	-
Positions											
FTE											

Program Performance



Oregon Health Authority: Capital Construction – Oregon State Hospital Replacement Project (OSHRP)

Primary Outcome Area: Healthy People
Secondary Outcome Area: Safety
Program Contact: Linda Hammond 503-480-4786, Linda.Hammond@state.or.us



Executive Summary

The purpose of this project is to complete the legislatively approved direction to replace the outdated and dangerous buildings of the Oregon State Hospital (OSH). The original legislatively-approved plan called for 980 beds: 620 in Salem and 360 in Junction City. In late 2010, based upon a new analysis of future need, the Oregon Health Authority (OHA) revised the need to 794 beds, downsizing the Junction City hospital to 174 beds. The 620 bed hospital in Salem completed moving patients into the new facility in March 2012. Work is under way on the site preparation and design of the second campus; the 174 bed facility in Junction City is expected to be completed in 2013-15. The 794 hospital level of care beds are needed to meet the treatment needs of individuals with severe mental illness who cannot be safely and effectively treated in community programs and are civilly or criminally committed to the state for treatment and to maintain public safety.

Program Description

This project is to complete the design, site preparation and construction of the new state hospital in Junction City, Lane County. The hospital will serve adults with severe mental illnesses who have been civilly committed as a danger to themselves or others, or who have been found guilty except for insanity in a criminal proceeding and court committed. This project completes the replacement of OSH as directed by the Legislature. These projects occur once in 50 years; the last new building was built in the 1960s.

This project has established a strong partnership between the state and the major contractor. The major cost drivers are the square footage, the requirements that the Junction City site meet the

solar energy requirements in Oregon Revised Statute (ORS) 279C.527 to 279C.528, the coverage of furniture, fixtures and equipment within the construction budget, use of reusable materials, the extension of the Behavioral Health Integration Project (BHIP) electronic medical record project to Junction City, and the value engineering work. State leadership will look for ongoing opportunities to improve the cost effectiveness and the functionality of the new state hospital building.

Program Justification and Link to 10-Year Outcome

The programs at the Oregon State Hospital campuses fall under Healthy People Outcome Strategies 1 and 2 - Reduce per capita cost, improve patient experience, and reduce chronic disease costs, and increase the life expectancy of people who receive substance abuse and/or mental health treatment by 10 years.

A new facility is critical in order to provide safe and effective treatment for adults with mental illness who cannot be legally and safely treated in a community-based environment. Treatment in an appropriate environment that supports 20 hours of active treatment weekly for each patient will improve the health of these individuals and will reduce the per capita cost of their care.

The treatment in a safe and modern environment also will assist in increasing the life expectancy of adults with mental illness, thereby contributing to the goal of a 10-year increase in life expectancy.

Program Performance

The Salem Campus of the new Oregon State Hospital received the final group of patients from the old hospital in March 2012. During the life of the project:

- 4,341 people worked for the construction contractor or subcontractors;
- 84% of the people employed were Oregon workers;
- 377 trade contractors worked on the project;
- 82% of the trade contractors were from Oregon;
- 92% of the dollars contracted went to Oregon contractors; and
- 14.4% of the $273 million in contractor labor was awarded to Minority, Women or Emerging Small Business contractors.

The new Oregon State Hospital is 850,524 square feet within a secure perimeter; of that 730,127 is new construction and 120,397 is the revitalized original 1883 Kirkbride Building.

The project to date has receivedfour awards:

- The 2011 Hammurabi Award of Honor for Design and Use of Masonry. This award is granted by the Masonry and Ceramic Tile Institute of Oregon to honor innovative and unique architectural designs in masonry.

- The Willamette Heritage Center awarded the Mill Heritage Enterprise Award for 2012 to the project in recognition of a significant long-term contribution to the economy and quality of life of the Salem community.

  The Construction Management Association of America (CMAA) awarded the 2012 Construction Management Project Achievement Award to the project. CMAA recognized the OSHRP team, Salem CH2M HILL, HOK/SRG, Hoffman Construction and Oregon Health Authority in the New Building Construction Project, value greater than $100 million, category. CMAA is the leading organization advancing professional construction and program management worldwide. Its membership comprises more than 10,000 public and private organizations, owners and individual practitioners.
- The Mason Contractors Association of America awarded the 2012 Team Award to the project

Enabling Legislation/Program Authorization

OSHRP was initially authorized by the Legislative Emergency Board in September 2006. The project was fully authorized during the 2007 session by House Bill 5005 and House Bill 5006. It was reauthorized in 2009 by Senate Bill 5505 and Senate Bill 5506. The 2011 session reauthorized the project in House Bill 5005 and House Bill 5006.

Funding Streams

Other Funds: 100% with Other Fund Certificates of Participation (COP) and General Obligation Bonds (GOB) for the construction costs. The Governor's Balanced Budget includes authorization for $79,401,530 in GOB Funding for the 13-15 biennium.

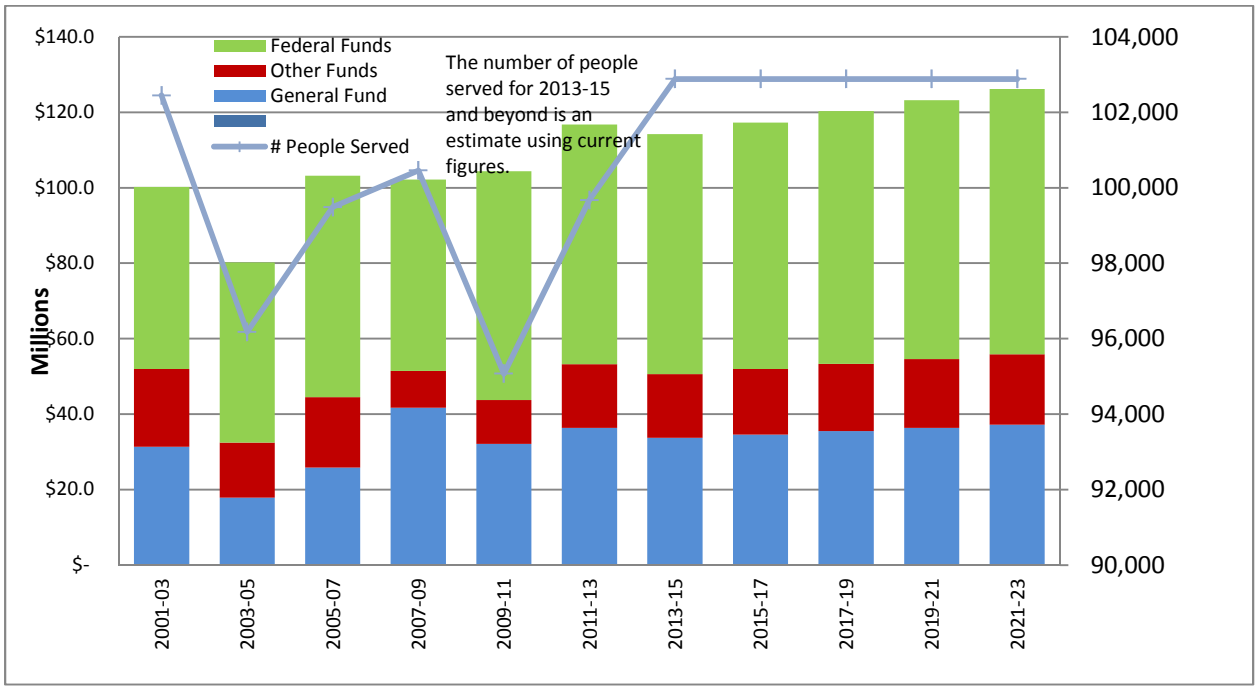
State General Fund: appropriated by the Legislature to cover Debt Service costs.

Significant Proposed Program Changes from 2011-13

The completion of the Junction City campus will enable the closure of the Blue Mountain Recovery Center, which is outdated and not suited to new treatment modalities, and the Portland campus of the Oregon State Hospital, which has a lease that will end in the spring of 2015 and not be renewed. This will allow all patients in hospital care to benefit from new treatment modalities.

Agency Name: Addictions and Mental Health (AMH) Alcohol & Drug Prevention & Treatment Programs

Primary Outcome Area: Healthy People
Secondary Outcome Area: Safety
Program Contact: Linda Hammond 503-480-4786, Linda.Hammond@state.or.us



Executive Summary

Alcohol and drug prevention programs provide evidence-based services to reduce the risks associated with inappropriate use of alcohol and drugs by youth and adults. Alcohol and drug treatment programs provide evidence-based services to assist people in recovering from addiction and to improve health, functioning in society, work, improve parenting and stop committing crimes.

Program Description

Alcohol and drug prevention and treatment services are available in every Oregon county; services are delivered by community mental health programs, tribes and nonprofit providers. Evidence-based prevention services, when funded, serve entire populations and people at above average risk of involvement with alcohol and other drugs. Treatment services are provided to adults and adolescents whose lives are negatively affected by alcohol and/or drug use. Clients receive treatment services of the intensity and frequency determined by an objective assessment

using national addictions medicine criteria. The services range from intensive treatment in a residential program to weekly treatment sessions in a community-based program and include recovery supports to assist people in lifelong recovery from addiction disorders. The programs effectively restore people to sobriety and improved functioning at home, school, work and to law abiding behavior. Services are delivered by certified professional staff. The programs rely on county-based community nonprofit providers, tribes, and families to achieve successful outcomes.

Major cost drivers in substance abuse disorders include:

- Community norms that minimize the effects of alcohol and drug use by young people leading the underage drinking and risky behaviors and school failure;
- Access to heroin and other opioid drugs drives social problems including death and demand for addiction treatment;
- Individuals entering treatment who have multiple and complex physical and mental health needs;
- The need to serve people being released from prisons and local jails;
- Growth in demand for services as the population has grown and the funding has remained flat; and
- Lack of safe, affordable and drug free housing.

The integration of behavioral health and physical health services in a locally driven, coordinated and evidence-based environment provides opportunities to identify substance abuse disorders and intervene earlier and more effectively. The use of flexible funding with accountability to improved outcomes will support locally determined innovative services that result in more people recovering from these disorders, being healthier, retaining their children in the family, gaining and keeping jobs and avoiding criminal behavior and incarceration.

Program Justification and Link to 10-Year Outcome

Untreated addiction disorders are a major cost driver in health care and in years of life lost. Effective treatment results in improved health, a better experience of health care and in reduced costs to the medical system. National studies indicate that substance use disorders affect 22 percent of those in medical settings. These individuals have higher medical costs and use 8 times more health care services and their families use health care at rates 5 times higher than other families. (Center for Policy Research & Analysis at the Treatment Research Institute 2009)
A recent analysis of a sample of OHP members who accessed addiction treatment found significant cost-offsets in physical health expenditures, most notable in emergency room visits and hospitalization. The cost offsets were over $3,000 per person.

Effective alcohol and drug treatment results in a decrease in criminal activity and recidivism rates for individuals completing treatment. Expanded availability of alcohol and drug treatment will result in improved access to adults at risk of criminal justice involvement due to untreated substance abuse.

Program Performance

Alcohol and drug treatment programs are essential components to individual recovery. The programs insure appropriate treatment, coordinated services between multiple levels of care and agencies, and make sure individuals are prepared for recovery beyond a given treatment episode.

AMH: Substance Abuse Program Performance Overview										
Performance Area	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number of People Served	64,259	65,250	66,328	65,295	64,399	64,489				
Quality of Services: % with Reduced Use of Abused Substance at Discharge	74%	73%	74%	75%	75%	74%				
Timeliness of Services: % of People Seen within Seven Days of Discharge from Residential Care	21%	21%	22%	23%	22%	22%				
Average Cost per Person Served	$1,235	$1,285	$1,412	$1,473	$1,518	$1,640				

Reducing the use of drugs is an essential outcome and indicator of quality for treatment programs. Reducing use increases the likelihood individuals can focus on recovery and improving other aspects of their lives, such was employment and housing. Over the past six years, 73 to 75 percent of individuals have reduced the use of their primary drug by the end of a given treatment episode. This is a good result statewide, however further improvement is warranted.

The timeliness of transitions between residential and outpatient services is a critical element in coordinated care. While residential care gives individuals a chance to stabilize and prepare for return to their homes, outpatient treatment is essential to provide supports for sustained recovery. Follow up within seven days is preferable but not always possible. Over the past six years, 21 to 23 percent of individuals are seen in outpatient treatment within seven days of the completion of residential treatment. There is room for improvement. AMH is working on strategies to increase the number of people accessing timely follow-up.

AMH is working with providers to improve outcomes with the implementation of new data systems that allow for timely use of data to improve the quality of services. The goal is to have the main components of the new system online by the beginning of the 2013-2015 biennium.

Enabling Legislation/Program Authorization

Oregon Revised Statute (ORS) 430.254 through 430.426 and ORS 430.450- 430.590
Federal PL 102-321 (1992) Sections 202 and 1926

Funding Streams

State General Fund: Legislative appropriation for treatment services.

Other Funds: **Beer & Wine -** Statutorily dedicated by ORS 430.345 to 430.380, does require local maintenance of effort and local expenditure of dedicated taxes for state approved services. **Intoxicated Driver Program Fund -** Statutorily dedicated by ORS 813.270, does not require any matching or maintenance of effort. **Miscellaneous -** Contract Settlements, State match from Multnomah Co/DePaul and the Oregon Youth Authority, and Sponsored Travel Reimbursements.

Federal Funds: **Medicaid** requires state matching funds. **Substance Abuse Prevention Treatment grant (SAPT)** requirements are: 20 percent of the grant must be spent on prevention, and service levels must be maintained for specified populations, such as women and women with children. The one qualifying factor for this grant is that the state must expend a minimum of state and local revenues on SAPT-related services to meet the maintenance-of-effort requirement. **Access to Recovery grant (ATR)** includes several unique requirements: nontraditional client-driven services and supports, administration of a voucher system for clients to purchase services, and free and independent choice in the selection of recovery and treatment services, including faith-based options. This grant does not require any matching or maintenance of effort. **Strategic Prevention Framework-State Incentive grant (SPF-SIG)** does not require any matching or maintenance of effort. **Enforcing Underage Drinking Laws grant (EUDL)** does not require any matching or maintenance of effort. **Temporary Assistance for Needy Families grant (TANF)** requires maintenance of effort.

Significant Proposed Program Changes from 2011-13

The 2013-15 Governor's Balanced Budget includes an investment of $14.1 million for Oregon's Alcohol and Drug Treatment program.

- **Intensive Treatment and Recovery Services (IRTS) - $2.6 million**
  Expands the ITRS program that helps reunite and keep families together when parents enter treatment for drug and alcohol addiction. This investment will provide outpatient treatment and recovery services to approximately 607 additional vulnerable adults per biennium.

- **Reinvested savings from 2014 Medicaid expansion - $11.5 million**
  By covering approximately 12,700 additional people through Medicaid, the 2014 Medicaid expansion will result in a savings of $11.5 million in General Funds which will be reinvested into the community addictions system. This provides the opportunity to expand services to individuals who are not receiving services at this time, stabilize and improve the level of service, and leverage Federal and other funds.

Capital Improvements

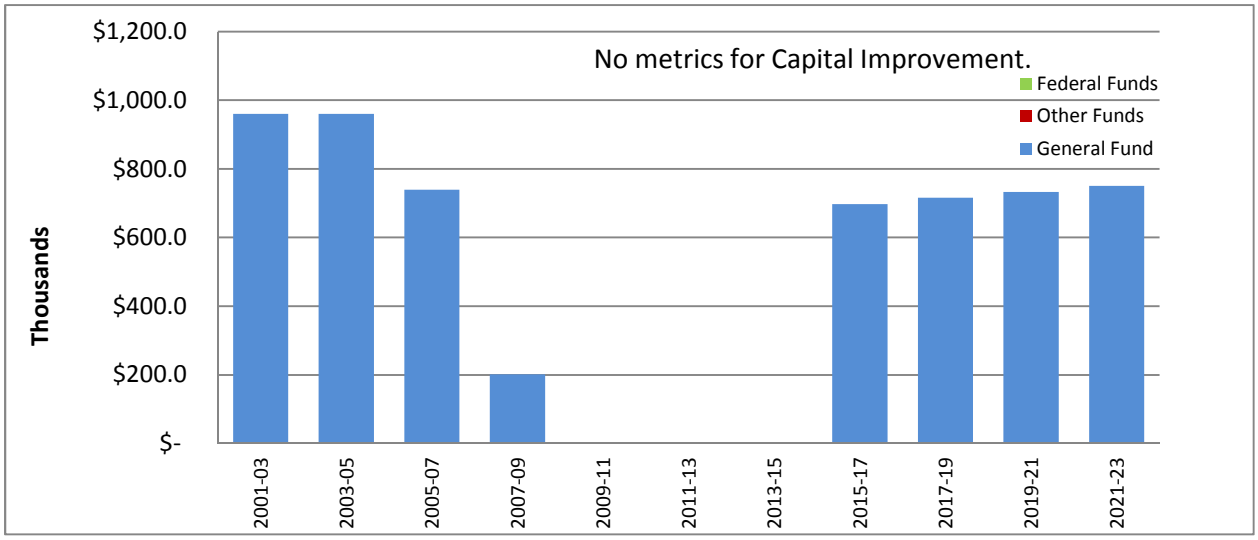
BIENNIUM	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
General Fund	960,000	960,000	739,221	201,014	1,165	-	679,238	697,577	715,714	732,891	750,480
Other Funds	-	-	-	-	-	-					
Federal Funds	-	-	-	-	-	-					
Total Funds	960,000	960,000	739,221	201,014	1,165	-	679,238	697,577	715,714	732,891	750,480
Positions											
FTE											

Program Performance

No metrics available

Agency Name: Capital Improvements

Primary Outcome Area: Healthy People
Secondary Outcome Area:
Program Contact: Linda Hammond 503-480-4786, Linda.Hammond@state.or.us



The budget of $663,318 for 2011-13 and $679,238 was removed as part of reduction options. This chart shows what the amounts would be for future biennia, if the budget is restored in 2015-17.

Executive Summary

This program funds essential health and safety remodels or repairs for the state hospitals. Without these repairs hospital certification and licensure can be jeopardized and patients and staff subject to less than ideal treatment environments.

Program Description

This limited program provides minimal resources to fund minor remodel or repair project costs in the state hospitals. These projects are essential to maintaining a safe and therapeutic environment in which to serve Oregonians with severe persistent mental illness that cannot be safely treated in a community setting. Funds are used to contract with private entities to make needed repairs in fire suppressant systems, remodel kitchens, repair roofs, sidewalks, elevators and other essential components of state hospital treatment facilities. The work is accomplished through a competitive bidding process with the selection of a private company to do the work. The major cost drivers are the age of some of the existing facilities, (e.g., Blue Mountain Recovery Center) and the damage to the buildings by patients who are very ill and whose symptoms sometimes manifest in violence against the environment.

Program Justification and Link to 10-Year Outcome

To achieve the goal of healthy people requires a safe and healthy treatment environment in good repair.

Program Performance

N/A

Enabling Legislation/Program Authorization

This program is not required by statute; however, federal requirements under the Americans with Disabilities Act requires people to be served in a safe, accessible environment.

Funding Streams

100% State General Fund.

Significant Proposed Program Changes from 2011-13

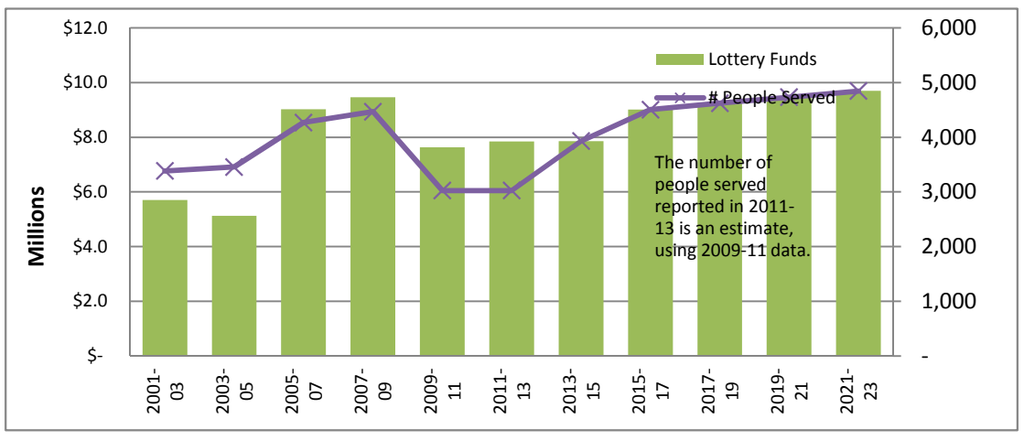
There is no change proposed in the program. The Governor's Balanced Budget continues the base G/F budget support of $679,238.

OHA - Addictions and Mental Health (AMH) Gambling Treatment & Prevention

BIENNIUM	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Lottery Funds	5,704,321	5,126,282	9,018,100	9,466,762	7,627,625	7,849,712	7,857,518	9,009,384	9,243,628	9,465,475	9,692,646
Total Funds	5,704,321	5,126,282	9,018,100	9,466,762	7,627,625	7,849,712	7,857,518	9,009,384	9,243,628	9,465,475	9,692,646
Positions											
FTE											

Program Performance

Quantity Metric											
# People Served	3,383	3,455	4,268	4,467	3,026	3,026	3,929	4,505	4,622	4,733	4,846
Cost Per Unit Metric											
Average Cost per Person Served	Not Available	Not Available	$ 737	$ 1,230	$ 1,762	Not Available					
	0.06%	0.07%	0.05%	0.05%	0.04%	0.04%					



Agency Name: Oregon State Hospital (OSH) & Blue Mountain Recovery Center (BMRC) State Hospitals & State Delivered Secure Residential Treatment Facility (SRTF)

	BIENNIUM	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
70	General Fund	104,025,611	141,754,460	140,736,472	230,318,550	297,753,056	325,922,022	352,248,471	469,288,250	524,676,941	592,884,945	669,959,987
	Other Funds	41,273,388	17,684,263	17,886,026	17,022,174	15,606,497	15,244,658	13,741,618	19,314,385	21,742,496	24,569,021	27,762,993
	Federal Funds	28,964,837	40,517,834	40,767,576	32,311,582	31,709,798	29,858,863	45,207,683	34,585,854	38,423,284	43,418,312	49,062,692
	Total Funds	174,263,836	199,956,557	199,390,074	279,652,306	345,069,351	371,025,543	411,197,772	523,188,489	584,842,721	660,872,278	746,785,672
	Positions	1,378	1,348	1,341	1,656	2,304	2,185	2,404	2,463	2,463	2,463	2,463
	FTE	1,266.74	1,293.39	1,299.94	1,426.81	1,979.21	2,175.93	2,137.00	2,328.21	2,328.21	2,328.21	2,328.21

Program Performance

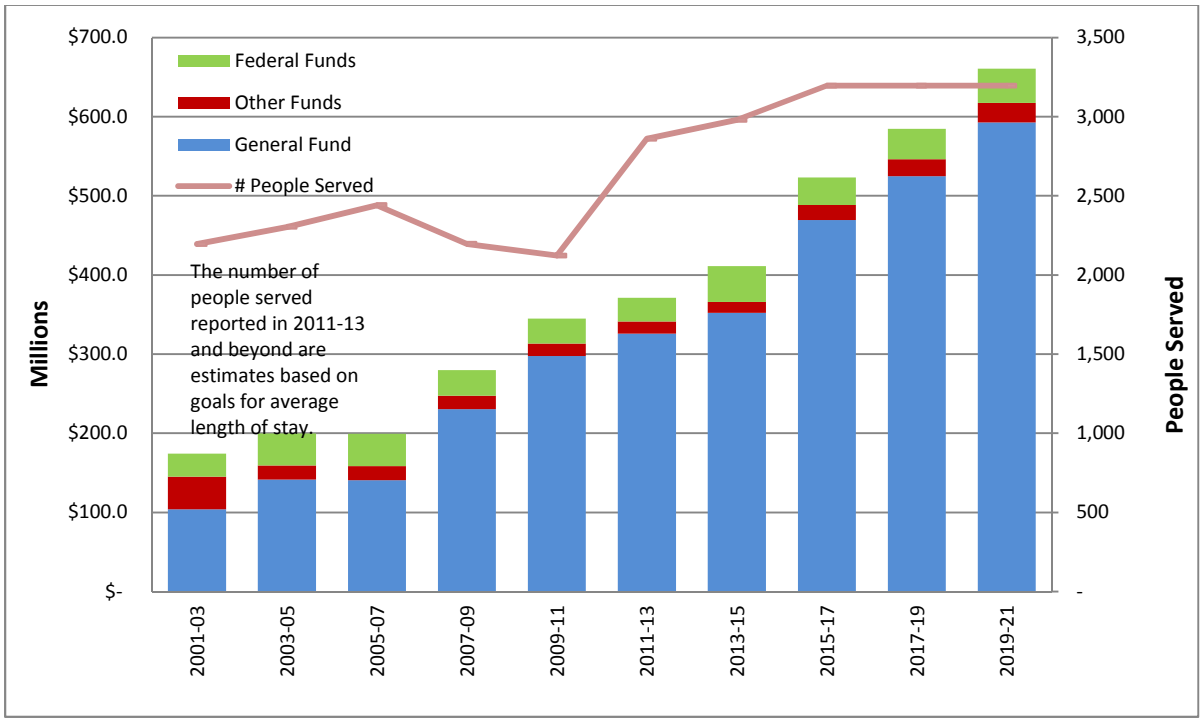
OSH	1,750	1,846	1,951	1,852	1,773		745				
BMRC	445	457	490	328	333						
SDSRTF				16	16						
# People Served	2,195	2,303	2,441	2,196	2,122	2,860	2,980	3,196	3,196	3,196	3,196

Cost Per Unit Metric											
Average Cost per Day of Service											
OSH	Not Available	Not Available	$ 397.14	$ 510.01	$ 568.19	$ 719.19					
BMRC	Not Available	Not Available	$ 826.47	$ 634.21	$ 689.71	$ 628.71					
SDSRTF	N/A	N/A	N/A	$ 499.99	$ 535.72	$ 589.59					

745
2,980

Oregon Health Authority: Oregon State Hospital (OSH) & Blue Mountain Recovery Center (BMRC) State Hospitals & State Delivered Secure Residential Treatment Facility (SRTF)

Primary Outcome Area: Healthy People
Secondary Outcome Area: Safety
Program Contact: Linda Hammond 503-480-4786, Linda.Hammond@state.or.us



Executive Summary

State hospital and state-delivered Secure Residential Treatment are part of a continuum of care for Oregonians living with mental illness. They provide the most intensive health services in the most secure and restrictive environment. These programs work in partnership with community mental health programs to deliver the right care and the right time in the right place.

Program Description

These programs provide intensive psychiatric treatment in a secure setting to treat adults with the most severe and long lasting symptoms of mental illness that, if untreated, make an individual a danger to self or others.

Under this program there are four facilities serving a total of 716 Oregonians. Oregon State Hospital operates 548 beds on the Salem campus and 92 in Portland. Pendleton has two facilities: Blue Mountain Recovery Center with 60 beds in Pendleton and there is also a state-operated 16-

bed secure residential treatment facility. People who receive treatment in these facilities fall into three categories: those who are civilly committed; those who have been arrested but cannot participate in their defense without mental health treatment; and those who have committed crimes and are adjudicated Guilty Except for Insanity. Services are provided 24 hours per day, seven days a week.

Services are provided by psychiatrists, nurses, mental health professionals and include medication, recreational, educational and vocational opportunities. Upon release, people will have skills necessary to understand and manage symptoms, fully participate in their local community and when able, hold down a job.

Partners include the local mental health systems and the Psychiatric Security Review Board. Success for hospital services depends on intensive community services delivered in integrated and independent settings. These services are most effective when they are managed as part of a system of care.

Major cost drivers include:

- Intensity of staffing required to provide services 24/7 in a secure environment;
- The intractable nature of the symptoms of mental illness displayed by people requiring this level of care;
- Responsibility to assure public safety;
- Complex co-occurring disorders including substance abuse and chronic physical ailments;
- Lack of investment in a robust community mental health system; and
- Lack of safe, affordable and drug free housing.

Coordinated Care Organizations will create an opportunity to improve performance through alternative delivery. The integration of behavioral health and physical health services in a locally driven, coordinated and evidence-based environment funded under a global budget provides local communities the opportunity to find innovative and earlier approaches to supporting individuals with severe persistent mental illness. An effective, robust community system is critical to allow the state hospital to function within the capacity created in Salem and the planned Junction City facility from 2015 forward.

Program Justification and Link to 10-Year Outcome

As part of a continuum of integrated care, the programs at the Oregon State Hospital campuses and Secure Residential Treatment Facilities fall under Healthy People Outcome Strategies 1 and 2: Reduce per capita cost, improve patient experience, reduce chronic disease costs, and increase the life expectancy of people who receive substance abuse and/or mental health treatment by 10 years.

Work in 2011 by the Coalition of New York State Public Health Plans concluded that:

- Medicaid enrollees with integrated physical and behavioral health benefits have:
    - Fewer behavioral health admissions.
    - Significantly lower behavioral health inpatient costs.
    - Shorter behavioral health inpatient stays.

- Better quality of care.

Further, research published in the *Journal of Psychopharmacology* (Nov., 2010) concluded that "treatment of medical comorbidity with psychiatric conditions will help to extend life expectancy among individuals with severe mental illness, suggesting that coordinated care organizations can address both psychiatric and medical needs in an integrated manner."

Program Performance

Performance at these facilities is measured by timely service, readmissions and length of stay.

AMH: State Hospitals Program Performance Overview											
Performance Area		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number of People Served	Blue Mtn	288	252	189	191	207	212				
	OSH	1,354	1,371	1,295	1,247	1,215	1,298				
Quality of Services: % Readmitted within 30 Days		7%	4%	4%	2%	1%	0%				
Timeliness of Services: Average Length of Stay (days) on Wait List for State Hospital Services		24	15	24	16	28	25				
Average Cost per Day of Service	Blue Mtn	$426.06	$400.41	$578.71	$689.71	$689.71	$689.71	$628.71			
	OSH	$388.97	$405.30	$451.83	$568.19	$568.19	$568.19	$719.19			

Timeliness, as measured by the average time spent on a waitlist for state hospital services, has ranged from 15 to 28 days. AMH, the community providers, and the state hospitals need to continue to work on this issue. Although individuals are receiving active service while on the waitlist, it is not at the appropriate level of care.

The hospitals have done an excellent job keeping readmissions within 30 days to a minimum. Over the past six years, the readmission rate at 30 days for people who were civilly committed has decreased from seven percent in 2006 to zero percent in 2011. This is a strong indication that the service provided by the hospitals has been successful and appropriate transitions to community care have occurred.

Length of Stay - AMH has two initiatives to strengthen the ability of the community system to discharge hospital patients more timely to the least restrictive, most independent and integrated environments possible.

The Adult Mental Health Initiative (AMHI) has decreased the time that discharge-ready individuals wait to be discharged, and between the last 10 months of 09-11 and the first 8 months of this biennium has increased the rate of discharge. Between September 1, 2010 and March 31, 2012, 1,044 individuals transitioned from the state hospital or licensed residential programs. The second initiative provides flexible funding to the counties to determine the best way to meet community needs for mental health services. The increased flexibility is coupled with increased accountability to discharge county residents from the state hospital within 30 days of being notified the individual is ready or be required to pay for the cost of continued treatment at the state hospital.

Enabling Legislation/Program Authorization

Statutory or legislative provision for this program includes, but is not limited to, that which is cited in:

ORS 179.321 - Responsibility to supervise state institutions
ORS 179.040 - General powers and duties
ORS 426.010 - State hospitals for persons with mental illness
ORS 426.060 - Commitment to Oregon Health Authority
ORS 426.500 - Powers and duties of Oregon Health Authority
ORS 161.370 – Determination of fitness to proceed
ORS 161.390 - Rules for assignment of persons to state mental hospitals or secure intensive community inpatient facilities
ORS 443.465 - Secure residential treatment homes and facilities

Funding Streams

State General Funds: Legislatively appropriated for treatment.
Other Funds: Medicare for covered services, collection from third-party payers (insurance, estates or private pay.
Federal Funds: Medicaid including reimbursement for some patients over age 65 and Disproportionate Share revenue (recognition for treating more people who are poor and unable to pay).

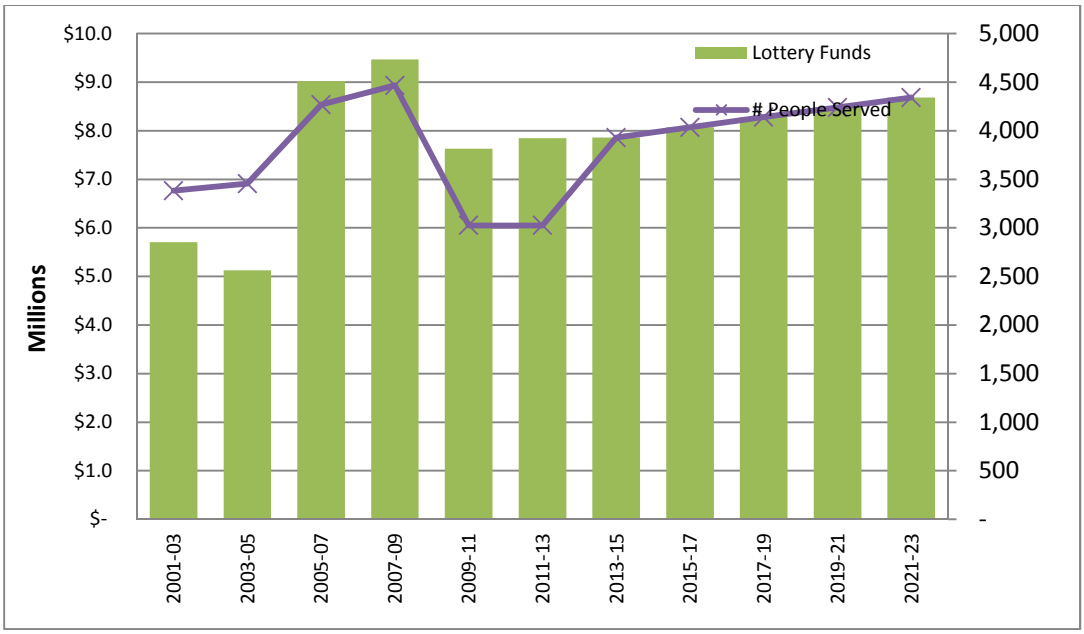
Significant Proposed Program Changes from 2011-13

State hospital system - $3 million
With the restoration of previous one-time reductions and the savings listed below, the state hospital system will see a limited increase of $3 million.

- Continues the $9.7 million savings from non-direct care reductions that Oregon State Hospital (OSH) implemented during 2011-13.
- Realizes a $3 million savings through automation of the OSH pharmacy.
- Closes one 24-bed geropsychiatric ward at the Salem campus for an estimated savings of $8.8 million.
- Closes the 60-bed Blue Mountain Recovery Center facility in Pendleton in January 2014.
- Closes the 92-bed leased Portland campus in March 2015.
- Begins opening the 174-bed hospital in Junction City in April 2015.

Agency Name: Addictions and Mental Health (AMH) Gambling Treatment & Prevention

Primary Outcome Area: Healthy People
Secondary Outcome Area: Safety
Program Contact: Linda Hammond 503-480-4786, Linda.Hammond@state.or.us



Executive Summary

Problem gambling prevention and treatment services prevent people from becoming addicted to gambling and assist people who are addicted in recovering from addictive and pathological gambling. They also assist family members and other significant persons who have been impacted by a gambler. People in recovery find or maintain jobs, repair family relationships and stop committing crimes. Their mental and physical health improves and the potential for suicide decreases.

Program Description

Problem gambling prevention services include evidence-based strategies to ensure all ages will be aware of the addictive nature of gambling, particularly line games available via the internet and video poker, and to help reduce risk. Treatment services include outpatient individual, family and group therapies, intensive therapies, and statewide access to respite and residential treatment for those who are at risk of suicide because of pathological gambling. Services are provided to individuals who exhibit problem or pathological gambling that creates financial, vocational and relationship problems and legal risks. These services are delivered in all Oregon counties through the county-based community mental health programs and by for-profit and nonprofit providers. The counties and local providers are essential partners in delivering these services.

Lottery revenues to support problem gambling services declined in the last two biennia. AMH worked with providers to reduce programs. The method agreed upon delayed all reductions to the second year of the 09-11 biennium. Providers favored this because of the historic growth in Lottery revenues. When the growth failed to materialize, the magnitude of the reductions resulted in the loss of providers in the most populous areas of the state. The loss of providers resulted in fewer people accessing services. The reduction in revenue continues in the 11-13 biennium.

The major cost driver for this program is the availability and easy access to attractive and highly addictive electronic games of chance that are widely advertised on television and in other media.

AMH is changing the contracting and business relationship with the counties for the delivery of mental health, substance abuse and problem gambling services. The inclusion of problem gambling treatment and prevention funds in the flexible budget will encourage the local integration of these services with other addiction services and with mental health services when that is the most effective approach in the local community. The flexibility will be coupled with increased accountability to deliver outcomes.

Program Justification and Link to 10-Year Outcome

Untreated problem and pathological gambling may result in people seeking medical care, which will not be effective until the underlying gambling addiction is treated. Pathological gamblers have a higher incidence of adverse health consequences than low-risk individuals.[1] They experience higher rates of tachycardia, angina, hypertension, cirrhosis and other liver diseases. Gambling severity is also associated with higher rates of medical utilization with pathologic gamblers more likely than low-risk individuals to seek treatment in emergency rooms.[2] Treating and preventing problem gambling will assist in reducing the per capita cost of health care. Effective problem gambling treatment will reduce criminal activity, particularly embezzlement or financial exploitation

Program Performance

Problem gambling treatment programs are essential components to individual recovery. The programs insure appropriate treatment, coordinate services between multiple levels of care and agencies, and make sure individuals are prepared for recovery beyond a given treatment episode.

AMH: Problem Gambling Program Performance Overview										
Performance Area	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number of People Served	1,652	1,941	1,958	1,831	1,455	1,171				
Quality of Services: % with Reduced Use 180 Days Following Discharge	81%	89%	87%	84%	84%	86%				
Timeliness of Services: % of People Seen within Five Work Days of Request for Care	73%	73%	69%	71%	66%	66%				
Average Cost per Person Served	$560	$971	$1,197	$1,371	$1,816	$1,842				

[1] Grinols E. Gambling in America: Costs and benefits. New York: Cambridge University Press,2004.

[2] Petry NM, Grant BF, Stinson FS. Comorbidity of DSM-IV pathological gambling and psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry 2005;66:564–74

Reduced gambling is an essential outcome and indicator of quality for treatment programs, especially once individuals have left treatment for some period of time. Reducing gambling increases the likelihood individuals can focus on recovery by working on other aspects of their lives, such as employment and housing. Over the past six years, 81 to 89 percent of individuals have reduced or no gambling 180 days after the end of treatment episodes. These results are excellent, given the many factors that could influence an individual to return to gambling once treatment is complete.

To take advantage of an individual's commitment to recovery, the timeliness of services is very important. As a general indicator of timeliness, the number of days from service request to actual service is tracked. Over the past six years, 65 to 73 percent of individuals were seen in treatment within five working days of the request for treatment. This is a good result but there is room for improvement. AMH is actively working on strategies to help providers improve this statistic.

In addition to treatment services, the problem gambling program delivered prevention information designed to educate and reduce risk to 1.3 million Oregonians in 2011. Gambling is the risk behavior most often reported among Oregon youth (AMH Student Wellness Survey 2010) so ongoing efforts are made to bring this issue to the attention of parents and teachers and to weave it into existing prevention programs.

Enabling Legislation/Program Authorization

Problem gambling treatment and prevention services are mandated by Oregon Revise Statute (ORS) 413.520, which directs the Oregon Health Authority to develop and administer statewide gambling addiction programs and ensure delivery of program services.

Funding Streams

Lottery Funds: Oregon Revised Statute (ORS) 461.549, dedicates 1% of Lottery revenue for prevention and treatment of problem gambling and does not require any matching or maintenance of effort. In spite of this, these funds are frequently reduced in times of economic decline. The Governor's Balanced Budget adjusts the Lottery Revenue for the latest economic forecast, but provides $10,541,165 in Funding for AMH Problem Gambling services.

Significant Proposed Program Changes from 2011-13

As Oregon continues to recover from the recent recession and population increases, Lottery revenues are likely to rise, which will increase funding to Problem Gambling Services. This will allow an increase in trained gambling addiction counselors and certified prevention specialists throughout the state. We will provide additional services for high-risk populations such as Latinos, Asian-Americans, and military veterans. We will enhance partnerships with the corrections system in order to reduce recidivism by those who have committed gambling related crimes.

Addictions and Mental Health (AMH)
Community Mental Health Services

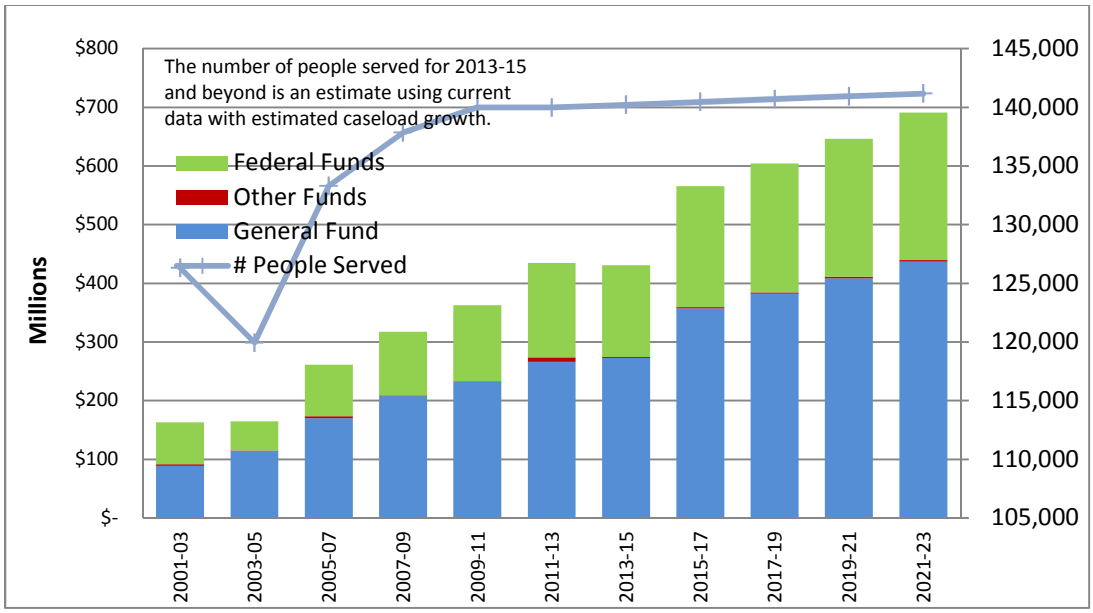
BIENNIUM	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
General Fund	88,585,166	114,701,333	170,131,353	207,722,374	231,690,666	266,123,251	272,489,724	357,417,768	382,047,892	408,401,341	436,600,714
Other Funds	3,002,370	349,510	3,422,882	1,325,927	1,048,225	7,726,955	2,030,357	2,234,830	2,388,835	2,553,616	2,729,939
Federal Funds	71,700,932	49,692,232	87,920,601	108,155,970	129,924,018	160,706,012	156,557,994	205,921,342	220,111,650	235,294,828	251,541,510
Total Funds	163,288,468	164,743,075	261,474,836	317,204,271	362,662,909	434,556,218	431,078,075	565,573,940	604,548,377	646,249,785	690,872,163
Positions											
FTE											

Program Performance

# People Served	126,322	119,941	133,296	137,837	139,980	139,980	140,218	140,456	140,694	140,932	141,170

Oregon Health Authority: Addictions and Mental Health (AMH) Community Mental Health Services

Primary Outcome Area: Healthy People
Secondary Outcome Area: Safety
Program Contact: Linda Hammond 503-480-4786, Linda.Hammond@state.or.us



Executive Summary

Community mental health services are local treatment and intervention services for Oregonians at risk of or who have severe mental disorders such as bipolar, major depression, post-traumatic stress and schizophrenia. 106,000 children and adolescents are diagnosed with a severe emotional disorder in any year; and 157,000 adults are diagnosed with a severe mental illness in any year. Oregon's current system as it is structured is not keeping pace with demand.

Program Description

Community mental health services are organized by county government and one tribe in every county in Oregon for children with mental health disorders and adults with serious mental illness. The services include 24/7 response to mental health crises, screening and assessment to determine the intensity and frequency of service need. Response to mental health crises are brief treatments consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization. These services are mostly received voluntarily but may be involuntarily for those who are a danger to themselves or others and are court committed to service. The frequency and intensity of services is based on the needs of the individual and family. The types of services range from in-school services and supports, supports delivered by peers, (individuals who have experienced mental health problems and who have recovered), residential services,

outpatient therapies and medication prescribing and review. The programs are designed to deliver evidence-based services that restore individuals and their families to the most optimal level of functioning possible. Services are delivered by a range of professionals including psychiatrists, nurses, psychologists, qualified mental health professionals and associates, trained peers and personal care providers. Services are delivered in the least restrictive, most integrated and independent setting possible based on the needs of the individual.

Key partners, in addition to county government, tribes and providers that provide the necessary services and supports are the individuals with these disorders and their families. These partnerships are critical to successfully treating mental health disorders.

Major cost drivers include:

- Identifying the illness late in its course at a point when the individual has experienced untreated episodes of psychoses, mania or depression, homelessness and often incarceration;
- Complicating substance abuse disorders and physical health conditions;
- Severe and untreated trauma in childhood;
- Court mandated treatment – either civil or criminal commitment;
- Growth in demand for services as the population has grown and the funding has remained flat; and,
- Lack of safe, affordable and drug free housing.

Opportunity: To address these drivers the agency can build on the integration of behavioral health and physical health services in a locally driven, coordinated and evidence-based environment provides opportunities to identify symptoms of psychosis and to intervene early and more effectively. The use of flexible funding with greater accountability to improved outcomes will support locally determined innovative services, such as Early Assessment and Support Alliance (EASA), that result in more people recovering from mental illness, finishing school, finding work, creating friendships and staying out of trouble with the law. These flexible and more accountable arrangements also result in more adults living in the most integrated and independent environment with the supports they need to be successful.

Program Justification and Link to 10-Year Outcome

Community Mental Health Programs fall under Healthy People Outcome Strategies 1 and 2 - Reduce per capita cost, improve patient experience, and reduce chronic disease costs, and increase the life expectancy of people who receive substance abuse and/or mental health treatment by 10 years.

Mental health disorders that are unidentified and untreated are a major cost driver in health care and in years of life lost. Effective treatment results in improved health, a better experience of health care and in reduced costs to the medical system. According to several studies cited by the Agency for Healthcare Research and Quality in 2009, Americans with severe mental illness have increased mortality and morbidity rates and people with serious mental illness die, on average, 25 years earlier than the general population. Chronic conditions and multiple co-morbidities among those with severe mental illness are cited as key drivers of increased healthcare utilization and costs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) in their recently published (2012) plan to reduce the impact of substance abuse and mental illness on America's communities found that the annual total estimated societal cost of substance abuse in the United States is $510.8 billion; by the year 2020 behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide and half of all lifetime cases of mental and substance abuse disorders begin by age 14 and three-fourths by age 24.

Program Performance

Mental health treatment programs are essential components to individual recovery. The programs ensure appropriate treatment, coordinate services between multiple levels of care and agencies, and make sure individuals are prepared for recovery beyond a given treatment episode.

AMH: Mental Health Program Performance Overview											
Performance Area		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number of People Served		105,263	109,287	109,724	105,821	107,784	108,553				
Quality of Services: % with Improved Outcomes	children	56%	59%	57%	59%	57%	59%				
	adults	57%	56%	56%	56%	57%	54%				
Timeliness of Services: % of People Seen within Seven Days of Crisis Services	children	19%	21%	22%	19%	19%	19%				
	adults	22%	23%	22%	22%	21%	21%				
Average Cost per Person Served		$2,130	$2,512	$2,785	$3,127	$3,175	$3,082				

An excellent indicator of the quality of services is the individual's own perception of the experience. AMH utilizes standardized surveys for adults and the caregivers of children who receive treatment services. One of the performance domains derived from the surveys is the individual's perception of improved outcomes in critical life areas. For both children and adults, AMH has not seen much change statewide over the past six years with scores ranging from 54 to 59 percent. Some parts of the state do better than others in this area and many other states perform better than Oregon. AMH needs to continue to work with its community providers and begin work with the Coordinated Care Organizations (CCOs) to improve outcomes for members.

Crisis services are too often individuals' introductions to mental health services and it is important that crisis services facilitate the transition into community level services, where appropriate care can be delivered. The timeliness of this transition can be impacted by hospitalization and many other less desirable and costly barriers. Over the past six years roughly 20 percent of individuals (adults and children) transition from crisis services to community services within seven days. It would be desirable to see this improved and AMH will continue to work with its community providers and begin work with the CCOs to improve this statistic.

One way AMH is working with its provider community to help improve outcomes like those described above is to implement new data systems that allow for more timely use of data and a better understanding of components that help to improve or hinder the quality of services. The goal is to have the main components of the system online by the beginning of the 2013-2015 biennium.

Enabling Legislation/Program Authorization

Oregon Revised Statute (ORS) 430.610 through 430.644 set out the requirements for a local mental health authority and the community mental health system. ORS 426 sets out the requirements for involuntary commitment proceedings for allegedly mentally ill persons. ORS 161.295 through 161.400 sets out the requirements for the system to manage and treat people who are found guilty except for insanity. This is a partnership between the Oregon Health Authority and the Psychiatric Security Review Board (PSRB). Federal legislation 1992 PL 102-321 authorized community mental health services funded in small part by the Substance Abuse and Mental Health Services Block Grant.

Funding Streams

State General Funds: Legislative appropriation for treatment services.

Other Funds: Community Housing Trust Funds - This trust fund was established with the sale of the Dammasch hospital property (ORS 413.101). Interest from the fund is dedicated for new housing and facility maintenance to benefit people with mental illness.

Federal Funds: Medicaid (Title XIX) there is matching requirement; Center for Mental Health Services block grant (CMHS) - At least 35 percent of the service funding of each grant must be expended for mental health services for children. There is a Maintenance of Effort (MOE) requirement on this grant; PATH- Projects for Assistance in Transition from Homelessness.

Significant Proposed Program Changes from 2011-13

The 2013-15 Governor's Balanced Budget represents a 43% increase in General Funds for Oregon's community mental health system. This investment will expand essential mental health and addiction services and build capacity by adding 471 beds to the community mental health system.

- **Increase capacity in the community mental health system by 238 beds - $45 million** Helps clients receive the most appropriate level of care by adding capacity to facility, residential and supported housing.
    - Develops 35 beds for people who have civil commitments in seven new facilities to address the needs of:
        - Young adults – 10 beds
        - People with traumatic brain injury – five beds
        - Individuals with severe behavioral issues – 15 beds
        - People with polydipsia – five beds
    - In partnership with Aging and People with Disabilities (APD), develops 40 placements for geriatric patients.
    - Adds capacity to the Adult Mental Health Initiative (AMHI) to serve 148 more clients who need intensive in-home supports.
    - Adds five new beds in a residential treatment setting (RTH) for clients under the jurisdiction of the Psychiatric Security Review Board (PSRB) as called for in the caseload forecast.

- Addresses facility needs to serve 10 youths under the jurisdiction of the Juvenile Psychiatric Security Review Board (JPSRB) as called for in the caseload forecast.

- **Strengthening community mental health services - $10 million**
  - **Oregon Psychiatric Access Line for Kids (OPAL-K) - $1.5 million**
    Gives primary care physicians access to child psychiatric consultation for children up to age 18.
  - **Early Assessment and Support Alliance (EASA) - $1.8 million**
    Expands the EASA program statewide to provide young adults with early identification and treatment for psychotic disorders.
  - **Supported housing and peer-delivered services to 233 clients - $5.2 million**
    Increases supported housing and peer-delivered services for approximately 233 additional clients with major mental illnesses.
  - **Supported employment services - $1.5 million**
    Expand supported employment services statewide.

- **Incentives for coordinated care organizations - $15 million**
  Provides incentives to CCOs to encourage partnerships with community mental health programs and providers.

- **Reinvested savings from 2014 Medicaid expansion - $33.5 million**
  By covering approximately 12,700 additional people through Medicaid, the 2014 Medicaid expansion will result in a savings of $33.5 million in General Funds which will be reinvested into the community mental health system. This provides the opportunity to expand services to individuals who are not receiving services at this time, stabilize and improve the level of service, and leverage Federal and other funds.

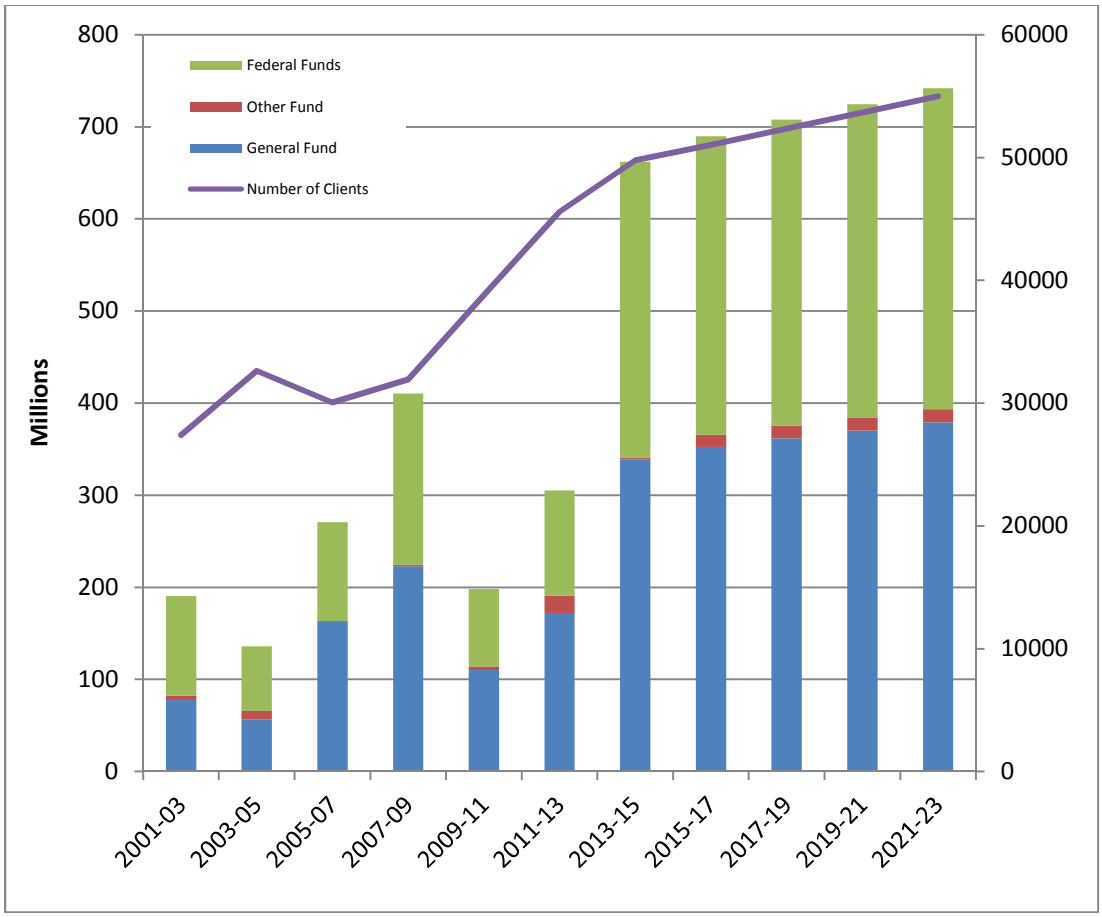
MAP - Admin	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	21,925,753	7,537,423	17,956,535	17,261,982	14,757,261	32,507,264	65,128,931	56,619,633	61,830,274	67,619,982	74,108,393
Lottery Funds											
Other Funds	14,790,212	5,170,105	7,995,289	5,803,324	10,236,083	71,368,673	68,224,147	72,140,055	74,210,145	76,215,139	78,297,367
Other Funds - Nonlimited											
Federal Funds	49,126,982	32,362,532	39,328,780	28,437,656	28,207,040	78,543,362	108,439,183	95,532,423	102,416,864	109,943,172	118,308,992
Federal Funds - Nonlimited											
Total Funds	85,842,947	45,070,060	65,280,604	51,502,962	53,200,384	182,419,299	241,792,261	224,292,111	238,457,283	253,778,293	270,714,752
Positions	170	179	172	179	197	401	478	478	478	478	478
FTE	162.05	165.89	166.83	167.97	185.31	390.24	470	470	470	470	470
Program Performance											
Quantity Metric											
Percentage of Program Support	2.62%	1.25%	1.79%	1.20%	0.97%	2.80%	2.36%	2.60%	2.69%	2.79%	2.91%

MAP Total	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	923,349,244	661,232,331	754,399,364	902,106,664	708,323,085	873,317,476	1,142,849,213	1,885,788,244	1,938,557,268	1,989,388,424	2,041,999,278
Lottery Funds	-	-	-	-	-	-	-	-	-	-	-
Other Funds	417,123,450	694,391,497	698,951,015	690,596,799	982,031,959	1,570,522,725	1,884,802,912	695,039,330	713,304,801	730,648,066	748,436,684
Other Funds - Nonlimited	-	-	-	-	-	-	-	-	-	-	-
Federal Funds	1,938,084,659	2,257,734,820	2,193,867,342	2,688,870,686	3,781,006,856	4,074,009,633	7,208,942,866	6,048,611,739	6,210,276,242	6,364,391,175	6,522,863,748
Federal Funds - Nonlimited											
Total Funds	3,278,557,353	3,613,358,648	3,647,217,721	4,281,574,149	5,471,361,900	6,517,849,834	10,236,594,991	8,629,439,313	8,862,138,311	9,084,427,665	9,313,299,710
Positions	170	179	172	179	197	401	478	478	478	478	478
FTE	162.05	165.89	166.83	167.97	185.31	390.24	469.95	469.95	469.95	469.95	469.95
Program Performance											
Quantity Metric											
Biennial average number of clients receiving services	450,155	423,191	412,624	465,485	561,265	662,589	690,563	708,242	726,372	744,677	763,145

MAP - NON OHP	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	77,491,181	56,325,485	163,451,772	222,874,429	110,229,926	172,085,348	342,552,360	352,470,673	361,634,910	370,314,148	379,201,688
Lottery Funds											
Other Funds	4,965,051	9,345,664	-	1,742,557	3,686,669	18,675,447	12,918,634	13,267,437	13,612,390	13,939,087	14,273,625
Other Funds - Nonlimited											
Federal Funds	107,934,603	70,395,581	107,237,520	185,980,469	84,127,814	114,288,698	326,903,357	324,044,391	332,469,545	340,448,814	348,619,586
Federal Funds - Nonlimited											
Total Funds	190,390,835	136,066,730	270,689,292	410,597,455	198,044,409	305,049,493	682,374,351	689,782,501	707,716,845	724,702,049	742,094,899
Positions											
FTE											
Program Performance											
Quantity Metric											
Biennial average number of clients receiving services	27,402	32,642	30,062	31,920	38,789	45,585	49,769	51,043	52,349	53,669	54,999

OREGON HEALTH AUTHORITY: NON-OHP Medical Assistance Programs

Primary Outcome Area: Healthy People – Non-Oregon Health Plan Programs
Secondary Outcome Area:
Program Contact: Judy Mohr Peterson, (503) 945-5768



Executive Summary

Non-Oregon Health Plan (Non-OHP) programs include those programs not included under the Oregon Health Plan Medicaid demonstration waiver, but included in the Medical Assistance Program budget. The Non-OHP budget includes:

- Citizen-/Alien-Waived Emergency Medical (CAWEM) program
- The Breast and Cervical Cancer Medical program
- The Qualified Medicare Beneficiaries program
- A limited drug coverage program for transplant clients formerly covered by the Medically Needy program
- Payments to the federal government for Medicare Part D coverage for dual-eligible clients (i.e., clients who are eligible for both Medicare and full Medicaid coverage).

These programs either directly or indirectly support health care coverage for low-income Oregonians.

Program Description

CAWEM: This is a mandatory Medicaid program. People who are ineligible for Medicaid solely because they do not meet the Medicaid citizenship or immigration status requirements are eligible for limited medical assistance under CAWEM. The program provides emergency medical services, including labor and delivery services for pregnant women. Most expenditures are for labor and delivery. Clients receive services from medical providers who accept Medicaid fee-for-service payments. For the 2013-15 biennium, the program has a budget of $92 million and serves over 25,000 clients.

Breast and Cervical Cancer Medical: This is an optional Medicaid program providing medical coverage to women who are diagnosed with breast or cervical cancer through Public Health's Breast and Cervical Cancer Program, which helps women gain access to screening for early detection of breast and cervical cancer. For each woman found to need treatment for cancer, the state evaluates eligibility under the Oregon Health Plan programs that provide the OHP Plus benefit package. If not eligible for an OHP Plus program, the woman qualifies for medical assistance through this program and receives coverage consistent with the OHP Plus benefit package. The woman remains eligible until she reaches age 65, obtains other health coverage, or is no longer in need for treatment for her breast or cervical cancer. Clients receive services from medical providers who accept Medicaid fee-for-service payments. For the 2013-15 biennium, the program has a budget of $43 million and serves over 600 women.

Qualified Medicare Beneficiaries: This program pays the Medicare premiums, deductibles, co-insurance and co-payments for clients. (The budget for premium payments is in the Department of Human Services and the budget for the deductibles, co-insurance and co-payments is in the Oregon Health Authority. The agencies will seek to move the budget for premiums to OHA for the 2013-15 budget.) To be eligible, a person must be receiving Medicare Part A (hospital insurance benefits). Income and resources must fall within certain limits. Eligibility extends up to 135 percent of the federal poverty level. For the 2013-15 biennium, the program has a budget of $27,000 and serves almost 19,000 people.

Limited drug coverage program for transplant clients: The authority provides limited drug coverage to transplant clients formerly covered by the Medically Needy program, which the Oregon Legislature ended in early 2003. Since spring 2003, the Legislature has appropriated General Fund dollars to provide coverage for the drugs necessary for the direct support of their transplants, which were originally paid for by Medicaid. Clients remain eligible unless they qualify for the OHP coverage or move out of state. There are no federal matching funds in this program. Clients receive their prescription drugs from pharmacies who accept Medicaid fee-for-service payments. For the 2013-15 biennium, the program has a budget of $110,000 serves about 20 people.

Payments to the federal government for Medicare Part D: The Medicare Modernization Act of 2005 created Medicare Part D under which Medicare beneficiaries became eligible for

Medicare prescription drug benefits beginning Jan. 1, 2006. This was a change for dual-eligible clients (i.e., clients eligible for Medicare and full Medicaid coverage). These clients previously received their prescription drug coverage under Medicaid. The law requires states to pay the federal government for a large portion of the cost of what the state would have paid as the state share for drug costs for dual-eligible clients. When states started paying in 2006, they paid 90 percent of the cost. For the 2013-15 biennium, the program has a budget of $166 million based on an average monthly caseload of 65,000 dual-eligible clients.

Program Justification and Link to 10-Year Outcome

CAWEM: Providing these services improves health outcomes for Oregonians, reduces uncompensated care, and reduces the shifting of costs to Oregonians with private health insurance.

Breast and Cervical Cancer Medical: Since the implementation of the Breast and Cervical Cancer Medical program in 2002, the state has excluded the women in the program from managed care enrollment because managed care organizations were concerned about accepting the financial risk for patients diagnosed with cancer. As a result, the women have been required to find health care providers who are willing to accept their "open card" Medicaid coverage. Enrolling these women in Coordination Care Organizations provides an excellent opportunity for these women to receive appropriate and timely access to integrated care: improving health, improving health care and lowering costs.

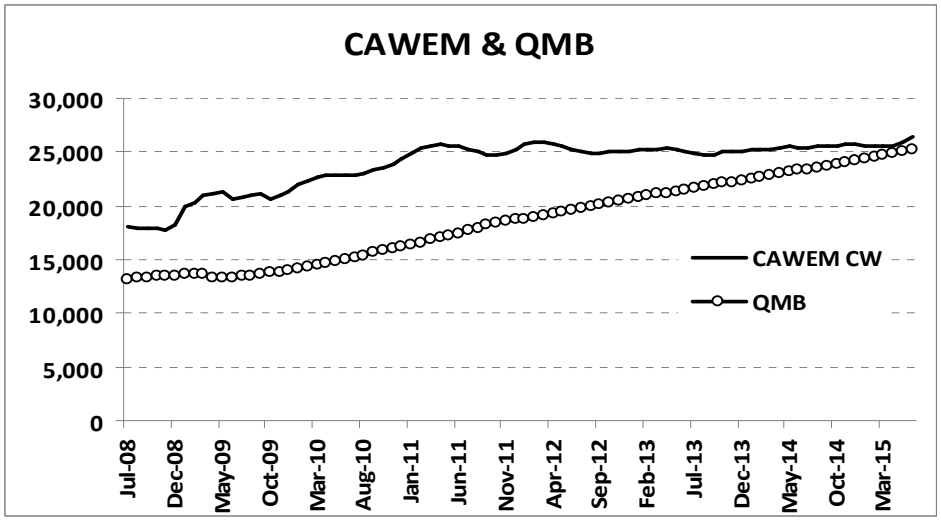
Qualified Medicare Beneficiaries: Providing this coverage alleviates financial concerns for low-income Medicare clients who may otherwise avoid or delay health care treatment, causing adverse health outcomes and increased costs.

Limited drug coverage program for transplant clients: Coverage for this group ensures these individuals, who received a transplant paid by Medicaid, can comply with their regiment of anti-rejection drugs; thereby, avoiding significant health care costs from adverse outcomes.

Payments to the federal government for Medicare Part D: These payments directly support prescription drug coverage for dual-eligible clients in the Oregon Health Plan.

Program Performance

Program performance is primarily measured by the number of clients served. The following are caseloads for CAWEM and BCCM. Data points for February 2012 forward represent caseload forecasts.



Enabling Legislation/Program Authorization

CAWEM: The federal government authorizes the CAWEM program under section 1903(v) of the Social Security Act. The Oregon Legislature provides the authority for covering the program under Oregon Revised Statute (ORS) 414.025.

Breast and Cervical Cancer Medical: The federal government authorizes the Breast and Cervical Cancer Program under section 1902(z)(1)(aa) of the Social Security Act. The Legislature established the program at ORS 414.532 through 414.540.

Qualified Medicare Beneficiaries: The federal government authorizes the Qualified Medicare Beneficiaries program under section 1902(a)(10)(E) of the Social Security Act. Under state law, the Legislature authorizes the program at ORS 414.033 and 414.075.

Limited drug coverage program for transplant clients: There are no federal matching funds in this program. The Legislature created this program with a budget note to Senate Bill 5548 in during the 2003 legislative session.

Payments to the federal government for Medicare Part D: The federal government requires states to pay the federal government for Medicare Part D drug coverage provided to dual-eligible Medicaid clients under section 1935(c) of the Social Security Act.

Funding Streams

CAWEM; Breast and Cervical Cancer Medical; Qualified Medicare Beneficiaries: Oregon qualifies for Medicaid matching funds for these programs under its federally approved Medicaid State Plan. The federal fiscal year (FFY) 2012 match rate is 62.91 percent for CAWEM and Qualified Medicare Beneficiaries. The federal government provides an enhanced Medicaid match rate for the Breast and Cervical Cancer Medical Program, which is 74.04 percent for FFY 2012. Oregon funds the state's share of these programs with General Fund dollars and Other Funds in the form of hospital tax revenue.

Limited drug coverage program for transplant clients: There are no federal matching funds in this program, only General Fund dollars.

Payments to the federal government for Medicare Part D: The state budgets General Fund dollars to make these payments. Because of General Fund reductions, the authority has used Children's Health Insurance Program Reauthorization Act (CHIPRA) performance bonuses to make these payments.

Significant Proposed Program Changes from 2011-13

The 2013-15 funding request for Non-OHP programs is significantly higher than the 2011-13 budget primarily because the 2013-15 request includes cost for the Policy Option Package (POP) to transfer a Medicare-related program from Aged and People with Disabilities (APD) to Medical Assistance Programs. This transfer provides better alignment for delivering health care to OHP clients with Medicare coverage.

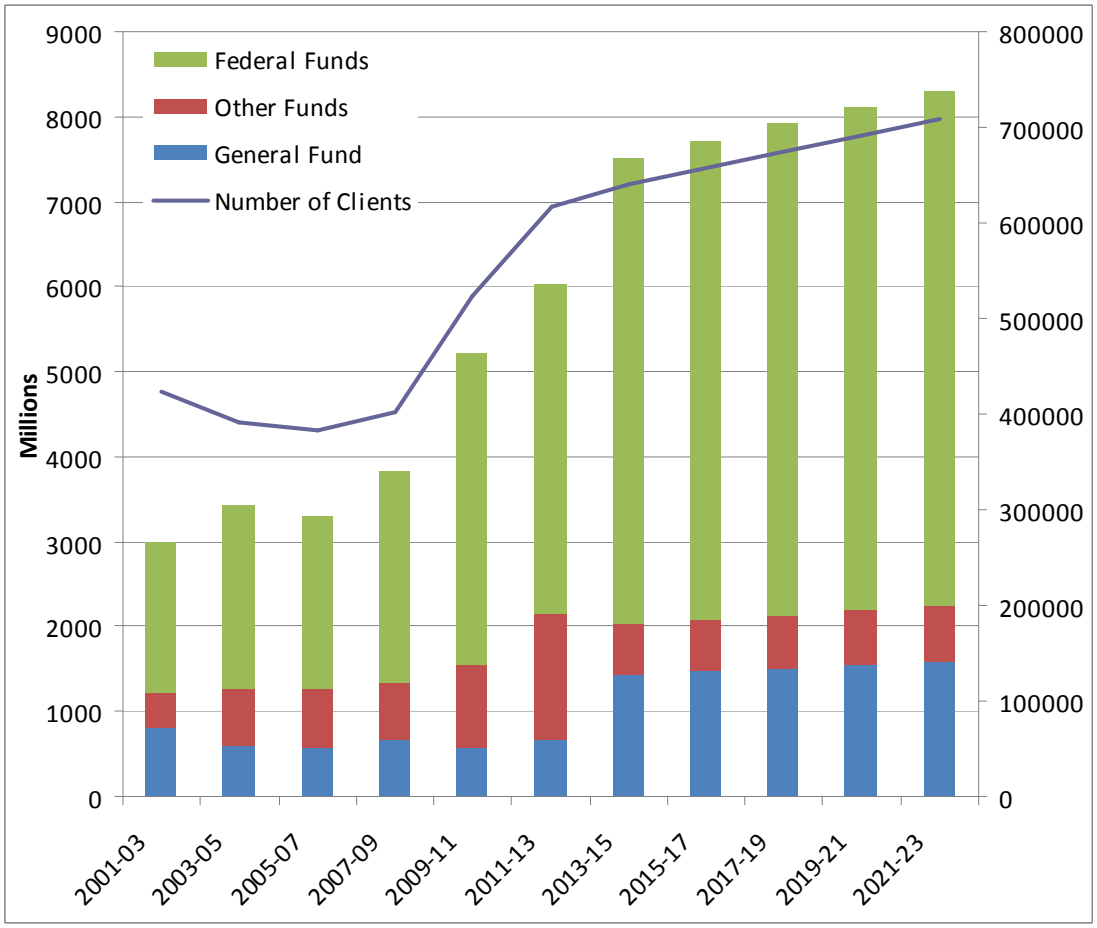
The following is a breakdown (in millions) of the 2013-15 Governor's Balanced Budget for Non-OHP programs:

2013-15 POP - APD transfer:	$332 TF ($119 GF, $0 OF and $213 FF)
2013-15 Non-OHP (without POP):	$330 TF ($220 GF, $2 OF and $108 FF)
2013-15 Non-OHP (with POP):	$662 TF ($339 GF, $2 OF and $321 FF)

MAP - OHP	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	823,932,310	597,369,423	572,991,057	661,970,253	583,335,898	668,724,864	735,167,922	1,476,697,938	1,515,092,084	1,551,454,294	1,588,689,197
Lottery Funds											
Other Funds	397,368,187	679,875,728	690,955,726	683,050,918	968,109,207	1,480,478,605	1,803,660,131	609,631,838	625,482,266	640,493,840	655,865,692
Other Funds - Nonlimited											
Federal Funds	1,781,023,074	2,154,976,707	2,047,301,042	2,474,452,561	3,668,672,002	3,881,177,573	6,773,600,326	5,629,034,925	5,775,389,833	5,913,999,189	6,055,935,170
Federal Funds - Nonlimited											
Total Funds	3,002,323,571	3,432,221,858	3,311,247,825	3,819,473,732	5,220,117,107	6,030,381,042	9,312,428,379	7,715,364,701	7,915,964,183	8,105,947,323	8,300,490,059
Positions											
FTE											
Program Performance											
Quantity Metric											
Biennial average number of clients receiving services	422,752	390,549	382,562	433,565	522,477	617,004	640,795	657,199	674,023	691,009	708,146

Oregon Health Authority: Medical Assistance Programs

Primary Outcome Area: Healthy People – Oregon Health Plan Program
Secondary Outcome Area:
Program Contact: Judy Mohr Peterson, (503) 945-5768



Executive Summary

The Oregon Health Plan (OHP) is Oregon's innovative Medicaid Program that has saved $15.7 billion in state and federal dollars over the past 18 years. Since the Oregon Health Plan was established in 1994, it has provided coverage for over 1.5 million people. Today it serves more than 600,000 low-income Oregonians who would not have care otherwise, more than 50 percent of the babies born in Oregon are covered under OHP and 85 percent of Oregon providers see OHP clients.

Program Description

OHP provides health care coverage to low-income seniors, people with disabilities, children, pregnant women, and adults living at or below 100% of the federal poverty level. Clients receive coverage through two benefit packages, which are based on the prioritized list of health services:

- The OHP Plus benefit package provides a comprehensive set of services to those individuals who qualify under traditional Medicaid and the Children's Health Insurance Program (CHIP) eligibility categories.
- The OHP Standard benefit package provides a limited set of services to uninsured adults who would not otherwise qualify for Medicaid except by virtue of the OHP Medicaid demonstration waiver.

Until recently, most clients of the program received their benefits through different types of managed care organizations. OHA contracted with fully capitated health plans, mental health organizations, and dental care organizations to provide clients with needed services. While these managed care organizations have done a good job in keeping health care costs down, theirstructure limited their ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. The state paid each entity separately to manage elements of a person's health as though they are distinct.

In 2011, the Oregon Legislature and Governor Kitzhaber created Coordinated Care Organizations in House Bill 3650, with the goal of achieving the Triple Aim of improving health, improving health care, and lowering costs by transforming the health care delivery system.

CCOs are local network of all types of health care providers working together to deliver care for Oregon Health Plan clients. Care is coordinated at every point – from where services are delivered to how the bills are paid.

Program Justification and Link to 10-Year Outcome

The innovations happening in the Oregon Health Plan delivery system are at the center of the Healthy Oregon 10-year Outcomes. The implementation of Coordinated Care Organizations provides a direct connection to Oregon's 10-year goals (i.e., outcomes) for achieving:

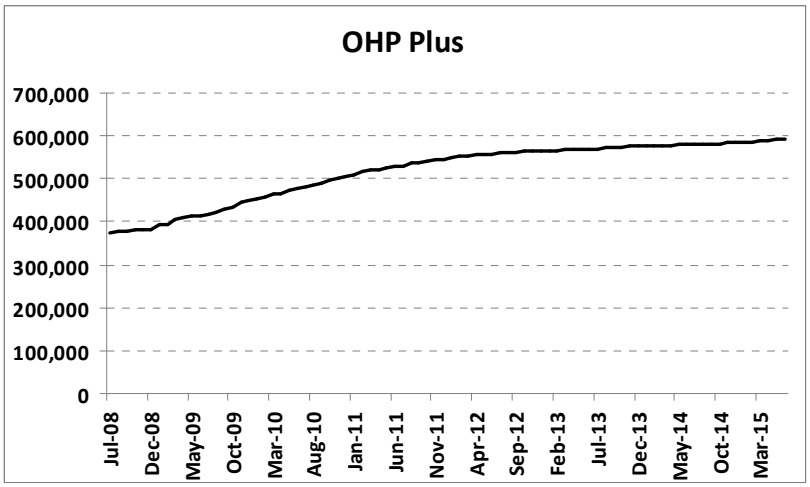
- Improved the health of those on the Oregon Health Plan
    - Decreased chronic disease rates, including mental health
    - Decreased tobacco use rates
    - Improved self-reported health status
- Reduced per capita cost
- Improved the patient experience (in terms of outcomes, safety and satisfaction)

Research shows that some 30-50 percent of health care spending is due to waste and inefficiency and some 80 percent of health care costs are driven by 20 percent of the population. Under an agreement with the federal government, Oregon will reduce the projected growth in health care spending by 2 percentage points in two years through improved health outcomes and reduced

waste and inefficiency. The projected total state and federal savings are $11 billion over ten years. Oregon will achieve this through new Coordinated Care Organizations.

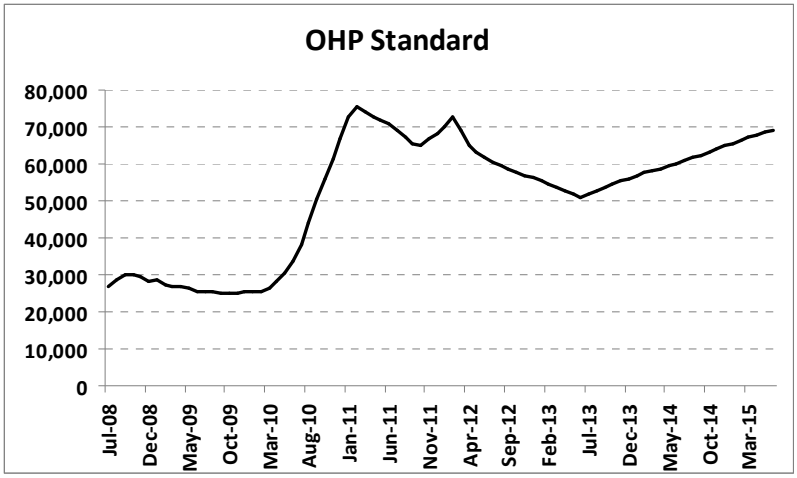
Program Performance

Driven by the recession, there has been a dramatic growth in the number of people eligible for and enrolled in traditional Medicaid and receiving the OHP Plus benefit package. OHP Plus caseloads continue to experience growth with projections indicating a flattened growth pattern through early 2015. For the 2011-13 biennium, the OHP Plus program budget supports an average monthly caseload of 557,000 clients. . The average cost of covering a person on OHP Plus is about $361 a month.



Note: February 2012 forward represents the projected caseload.

By expanding a hospital tax, OHP Standard coverage has expanded, using a reservation list system to add new enrollees, from a low of about 18,000 in early 2008 to over 70,000 by 2011. For the 2011-13 biennium, the OHP Standard budget supports an average monthly caseload of 60,000 clients. The average cost of covering a person on OHP Standard is about $498 a month.



Note: February 2012 forward represents the projected caseload.

According to the Oregon Health Study, a research project designed to evaluate the impact of insuring the uninsured in the United States, the newly covered OHP Standard population in the first year had an increased likelihood of using outpatient care, prescription drugs, and non-emergency hospital admissions. Preventive care such as mammograms increased by 60 percent and cholesterol monitoring increased by 20 percent. According to the research there was a 25 percent increase in people reporting themselves in good health and a 40 percent decrease in people reporting a decline in their health.

Enabling Legislation/Program Authorization

The Oregon Health Plan is not a federally mandated program, but supported by Medicaid and the Children's Health Insurance Program (CHIP). Title XIX and Title XXI of Social Security Act, respectively, provide the federal authorization. Oregon administers the program under the authority of the federally approved Medicaid State Plan, CHIP State Plan, and Oregon Health Plan Medicaid demonstration waiver.

The Oregon Health Plan is established and authorized in Oregon Revised Statute (ORS) 414.018 through 414.760.

Funding Streams

Federal matching dollars (Medicaid and CHIP) are the primary funding streams supporting the program. Oregon qualifies for these federal dollars under its federally approved Medicaid and CHIP State Plans and the OHP Medicaid demonstration waiver. The federal match rate for Medicaid program expenditures and for CHIP program expenditures changes each fiscal year. Oregon funds the state's share of the program with General Fund dollars and a variety of Other Fund sources, (e.g. hospital tax, insurer's tax, tobacco tax, tobacco settlement payments, drug rebates,) and leveraged funds from a variety of sources such as counties and the Oregon Health & Science University.

The Oregon Legislature established the hospital tax in 2003 (Chapter 736, Oregon Laws 2003) to fund the OHP Standard program and enhanced hospital reimbursement. In 2011, the Legislature expanded the use of the tax to support reimbursement rates for other providers, not just those for hospitals. The authority, in consultation with hospital representatives, sets the tax rate by administrative rule (OAR 410-050-0861) to generate the projected revenue needed to meet budget and program objectives. As of January 1, 2012, the tax rate 4.32 percent.

The Oregon Legislature established the insurer's tax in 2009 (Chapter 867, Oregon Laws 2009) to fund the Healthy Kids Program for increased enrollment of children in the Oregon Health Plan. The tax rate is set in statute at one percent.

Significant Proposed Program Changes from 2011-13

By stepping up to this challenge to reduce the growth in spending for CCO enrollees, Oregon will obtain additional federal Medicaid funding for Designated State Health Programs (DSHP) that frees up General Fund dollars to be reinvested in Health System Transformation. While the DSHP dollars provide significant help for Health System Transformation, OHA is still faced with two large funding challenges in its 2013-15 budget. Effective September 30, 2013, the hospital tax and insurer's tax expire. The loss of the Other Fund revenue from these taxes creates a General Fund backfill need. The Governor's Office engaged with stakeholders regarding the funding gap created by the lost revenue and potential options to mitigate the problem. Following stakeholder discussions and after receiving input from Program Funding Teams, the Governor released his 2013-15 Balanced Budget, which extends the current hospital tax, utilizes the $808 million from DSHP funding and $120 million in tobacco master settlement agreement funding.

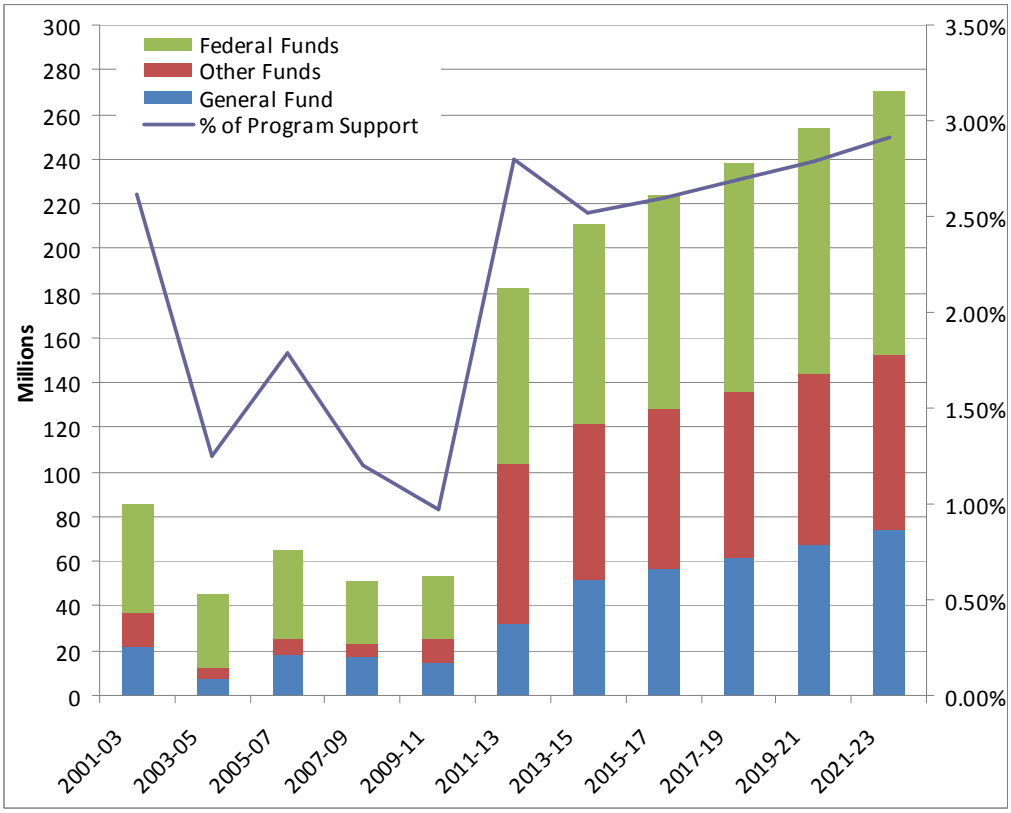
Independent of Health System Transformation, OHA anticipates the expansion of Medicaid eligibility in January 2014, as provided by the Affordable Care Act. While estimates for various sources vary widely on how many more Oregonians will qualify for Medicaid, the federal government will pay 100% Medicaid match for those who are "newly eligible" under the expansion through calendar 2016.

Below is a comparison of the 2011-13 OHP budget compared to the 2013-15 OHP budget provided by the Governor's Balanced Budget (in millions):

2011-13 budget for OHP programs: $6,030 TF ($669 GF, $1,480 OF and $3,881 FF)
2013-15 request for OHP programs: $7,513 TF ($1,438 GF, $594 OF and $5,481 FF)

Oregon Health Authority: Division of Medical Assistance - Other Programs & Support

Primary Outcome Area: Healthy People
Secondary Outcome Area:
Program Contact: Judy Mohr Peterson, (503) 945-5768



Executive Summary

This is the administrative office for programs that fall in the Division of Medical Assistance Programs: the OHP Processing Center; Pharmacy Programs; Law Enforcement Medical Liability Account; and the Medicaid Director's office. Through these offices, The Oregon Health Authority is implementing Health System Transformation through Coordinated Care Organizations (CCOs). CCOs will serve more than 600,000 Oregonians who receive health care services through the Oregon Health Plan. These offices also process applications and pay for services delivered and medical claims for individuals injured as the result of interactions with law enforcement.

Program Description

MAP program & support: The Medical Assistance Program (MAP) includes the Medicaid Director and program staff needed to administer the Oregon Health Plan (OHP)—Oregon's version of Medicaid and Children's Health Insurance Program (CHIP). This office manages all

aspects of health care operations for medical assistance programs, such as enrolling providers in the program, staffing call centers to resolve provider coverage and payment questions, and overseeing the budget and federal financing processes. Most coverage is provided through contracts with managed care organizations that are responsible for providing access to high quality care for their members. MAP is now focused on the implementation of Health System Transformation through Coordinated Care Organizations (CCOs). The primary cost drivers are the number of clients, the number of programs and initiatives, and the number of contracts for services.

Processing Center: The OHP Processing Center provides daily service to members, prospective members and community partners. The purpose of the program is to process medical applications, including enrollment into the appropriate programs, for eligible Oregonians. The Processing Center relies on state medical policy analysts, Centers for Medicare/Medicaid and the Legislature for guidance on eligibility and enrollment. Major cost drivers are the number of eligible Oregonians who apply and enroll in the program and the efficiencies of the various systems and processes that assist the workers in processing applications and providing member support.

Pharmacy Programs: The Oregon Prescription Drug Program (OPDP) is a drug pool that allows Oregon to bargain for prescription drugs for approximately 850,000 members. The program is currently providing drugs for OEBB, SAIF, OHSU, Salem Hospital and other private groups. OPDP also joined with Washington's WPDP to form the Northwest Prescription Drug Consortium.

CAREAssist program purchases health insurance for 2,700 persons with HIV who earn less than 300% of the federal poverty level with the intent to keep clients healthy and reduce the risk of spreading the disease. It also uses revenues earned from drug rebates to purchase drugs through a network of pharmacies providing the lowest price.

LEMLA: The LEMLA program pays medical claims for individuals who sustain injuries resulting from interactions from law enforcement. Law enforcement agencies submit claims to OHA when efforts to recover costs from the individuals or their insurance companies fail.

Program Justification and Link to 10-Year Outcome

MAP program & support: The work of the MAP is essential for achieving the 10-year goals. Achieving the Triple Aim—improving health, improving health care, and lowering costs—is dependent on implementing Health System Transformation through CCOs. For example, staff have developed and are putting into action delivery system transition plans, client transition plans, communication plans, operational supports. Ongoing work has involved: CCO Request for Application (RFA) review and evaluation; CCO contract development, federal negotiations for financing and waiver terms and conditions; and CCO global budget modeling.

Processing Center: Processing Center staff will have a key role in enrolling Oregonians into more efficient and effective CCO care. The ability to do this in a more efficient and consistent

manner will assist in addressing costs associated with application processing for the additional 230,000 lives that will become eligible in 2014, which is in addition to the 600,000+ lives that are currently enrolled and will need on-going support through redetermination processes to remain enrolled in the appropriate medical programs.

Pharmacy Programs: OPDP has developed new price reduction programs including a point-of-sale Group Purchase Organization (GPO). The GPO eligible employer group pilot, implemented with OEBB, has savings more than $3 million since inception on top of the rebates collected on their behalf. OPDP is a self-funded program that produces tens of millions of dollars in savings for state purchasers as well as for uninsured residents.

CAREAssist purchases insurance for its clients thus having the insurance company pay for the cost of HIV drugs, some of which are new and very expensive virus-suppressing retroviral medications that have rendered the disease a chronic condition. The program also helps patients understand their disease and how to prevent spreading it.

LEMLA: The program provides a means to use Other Funds revenue to reimburse medical providers for claims they would not otherwise receive payment. Although most claims are small in nature, there is the potential for very large claims, such as those for surgeries, intensive care and extensive emergency room services. Payment for these claims avoids uncompensated care and the shifting of cost by providers to other payers.

Program Performance

MAP program & support: Just as MAP is working to transform the health care delivery system, it is evaluating its needs and functions in order to best support the integration and coordination of health care. MAP is mapping out its core functions and processing in order to more effectively align itself to achieve the Health System Transformation. This alignment is not just within MAP, but looking across the Oregon Health Authority to identify efficiencies.

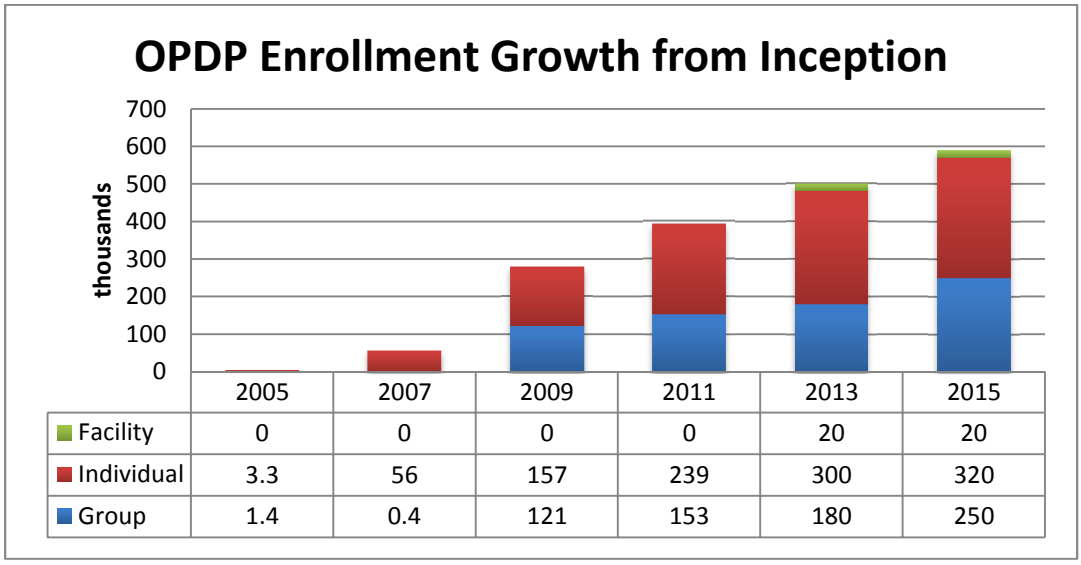
Processing Center: The Processing Center (Referenced as 5503 in the table below) is responsible for processing medical applications received via the mail, on-line and through DHS field offices. The center is also responsible for processing redeterminations for programs where members are seeking continued enrollment or re--enrollment.

Number of People Served

Year	Total applications	Total Average individulas in state	Ave % cases held at 5503	Approx. people served	
2007	129,933	393,373	36%	141,614	
2008	149,148	416,443	34%	141,591	
2009	98,377	468,436	28%	131,162	
2010	138,092	543,577	26%	141,330	
2011	143,880	629,759	27%	170,035	
Total	659,430				
Average	131,886	490,318	30%	145,146	

* Based on the number of applications assigned not by individual. Indiviual people served is approximately 30% greater than the number of application assigned.

Pharmacy Programs:



	2005	2007	2009	2011	2013	2015
Facility	0	0	0	0	20	20
Individual	3.3	56	157	239	300	320
Group	1.4	0.4	121	153	180	250

Between inception in 2005 and April 2012, OPDP has grown to provide coverage to 152,506 employer group members and discounts to 248,225 uninsured residents of Oregon resulting in over $50 M savings for the users of the program.

CAREAssist has grown from 1222 in 2005 to 2852 in 2012 and is projected to grow to almost 3,500 by 2015.

LEMLA: For the 2009-11 biennium, the program has paid $754,000 for 620 claims. From July 2011 through April 2012, the authority has paid $184,432 for 159 claims.

Enabling Legislation/Program Authorization

MAP program & support and Processing Center: The Oregon Health Plan is not a mandatory program, but it is supported federally by Medicaid and the Children's Health Insurance Program (CHIP). Title XIX and Title XXI of the Social Security Act, respectively, provide the federal authorization. Oregon administers the program under the authority of the federally approved Medicaid State Plan, CHIP State Plan, and Oregon Health Plan Medicaid demonstration wavier. The Oregon Health Plan is established and authorized in Oregon Revised Statute (ORS) 414.018 through 414.760.

Pharmacy Programs: OPDP was authorized in the 2003 legislation through Senate Bill (SB) 875. Ballot Measure 44 of 2006 opened the uninsured discount program to all residents. SB 362 of 2007 extended the discount program to underinsured and group business to the private sector. Also in 2007, SB 735 authorized Group Purchasing Organizations for all groups in OPDP.

CAREAssist is authorized by the federal Ryan White Act. This act provides funds to states to purchase drugs or health care insurance that provides a drug benefit for HIV positive individuals.

LEMLA: The Oregon Legislature authorizes the program under Oregon Revised Statute (ORS) 414.805 through 414.815.

Funding Streams

MAP program & support and Processing Center: Medicaid and CHIP federal matching dollars are the primary funding streams for MAP program and support. The federal match rate is determined by the number of enrollees in each federally matched program. Oregon qualifies for these federal dollars under its federally approved Medicaid and CHIP State Plans. Oregon funds the state's share of MAP with General Fund dollars and Other Funds, including hospital tax revenue, insurer's tax revenue, and audit recoveries. The budget also includes leveraged funds from Commission on Children and Families to match with Medicaid.

Pharmacy Programs: The OPDP became self-funded at the beginning of the 2009-2011 biennium through per claim assessments of $.60. In addition, OPDP retains rebates collected from manufacturers for the discount program purchases, and any contractor performance penalties. CAREAssist is funded through General Fund dollars, federal grant funds, and rebate revenues. Additionally, CAREAssist purchases drugs at discounted prices and collects from insurance companies the cost of these drugs. General Fund dollars are necessary to meet the match requirement of the federal Ryan White Program.

LEMLA: The LEMLA account is funded with Other Fund revenue from assessments added to fines and bail forfeitures issued by the courts. The Oregon Legislature allocates money to the account from the Criminal Fine Account established in ORS 137.300.

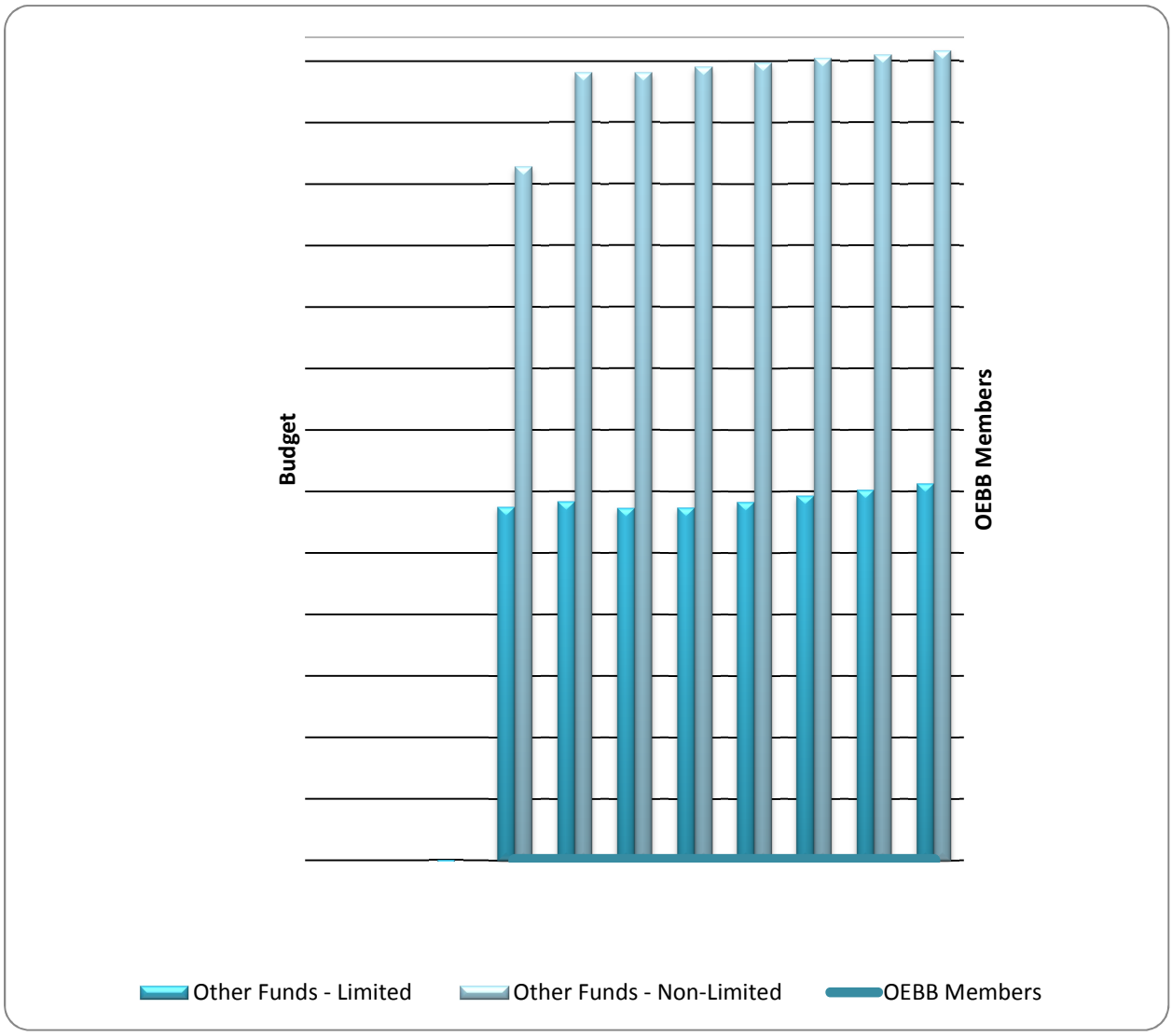
Significant Proposed Program Changes from 2011-13

The 2013-15 Governor's Balanced Budget for Other Programs and Support for 2013-15 includes:

- $8 million (TF) for additional (6.2%) inflation for Pharmacy Programs

Oregon Health Authority: Oregon Educators Benefit Board

Primary Outcome Area: Healthy People
Secondary Outcome Area: Livable Communities
Program Contact: Denise Hall, 503-378-5133



Executive Summary

The Oregon Educators Benefit Board (OEBB) provides value-added medical, dental, vision and disability benefit plans that support improvement for nearly 146,000 members' health in educational entities (including school and education service districts, community colleges and some charter schools) in Oregon. The OEBB also offers life, accidental death and dismemberment and long term care insurance coverages, as well as a health savings account (HSA), flexible spending accounts (FSAs) and an employee assistance program (EAP) to participating entities. The OEBB was established in 2007 under SB426. The OEBB's goal is to

provide high-quality benefits for eligible employees and early retirees at the lowest cost possible and to work collaboratively with members, educational entities and insurance carriers to offer value-added benefit plans that support improvement in members' health while holding carriers accountable for outcomes.

Program Funding Request

The proposal submitted by OEBB requests the Program be funded at the 2011-13 biennium level with allowed inflation factors included. In keeping funding intact for OEBB, the Program can continue to achieve the goals set forth in the Guiding Principles adopted by the OEBB Board. The Program goals are described in detail under the Program Description section. Estimated costs through the 2019-21 biennium are trended forward using inflation factors prescribed by DAS, Budget and Management. Performance through the 2019-21 biennium, OEBB anticipates this funding level will allow it to continue to provide its members with a high level of customer service and continued access to quality health care, as well as the means to promote continued improvement in employee health, at a cost that is affordable to districts, members and Oregon taxpayers.

Program Description

The statutes governing OEBB (ORS 243.860 to 243.886) outline specific criteria that OEBB must follow in considering whether to enter into a contract for a benefit plan and are the basis for OEBB's guiding principles.

Guiding principles adopted by the OEBB Board:

- OEBB will offer employees a range of benefit plans that provide high-quality care and services.
- OEBB will encourage competition in the marketplace in the areas of quality, outcomes, service and cost.
- In making its decisions, OEBB will consider plan performance in quality, administrative processes, costs and outcomes. It will promote system-wide transparency that provides comprehensive information on these issues.
- OEBB will offer a range of benefit plan designs that provide educational entities with the flexibility to choose options that meet their and their employees' financial and health needs.
- OEBB will encourage benefit plans and providers to offer members consistent access to care and services; integrated care systems that provide effective treatment; and personal and prompt service that meets customers' needs.
- OEBB will seek plans and providers that use creative and innovative methods and practices that are evidence-based or otherwise measurable.
- OEBB will recognize the impact of its decisions on employees' total compensation.
- OEBB will promote employee health and wellness through plan design components, disease and case management, and consumer education.
- OEBB will take into account the total costs of benefit plans, as well as employee cost-sharing for services, in offering a range of benefit plan designs.

OEBB staff and consultants work with the Board to ensure the adopted guiding principles are the foundation for all benefit plan and program decisions. The contracted carriers and vendors also

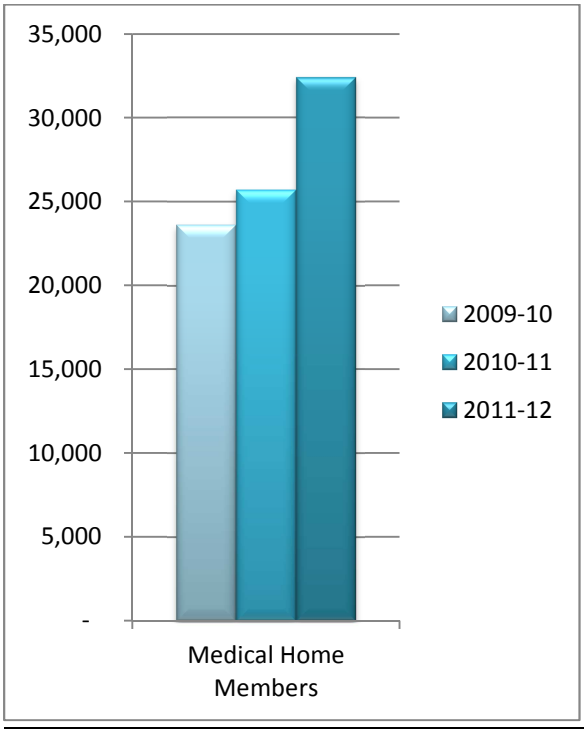
work closely with the OEBB staff, consultants and Board to ensure plans and benefits support the OEBB goal and guiding principles as well as the Oregon Health Authority mission, vision and goals.

OEBB serves more than 146,000 members (employees, early retirees and their family members) in 237 educational entities located throughout Oregon including school districts, education service districts, community colleges and some charter schools. OEBB maintains an online benefit enrollment system (MyOEBB), provides benefit plan and eligibility information to entities and employees, collects premiums from educational entities and individuals participating through self-pay groups, reconciles premiums collected and transfers premiums to the carriers and vendors providing benefit plans to OEBB members. OEBB staff also perform many other related activities and functions including policy development, contract monitoring and management, preparing and providing reports and reporting tools that allow education entities to manage their employees' benefits, and assisting members and entities with yearly enrollment and with eligibility and benefit coverage questions or issues on an ongoing basis.

The major cost driver that affects this program is premium increases related to health care costs. OEBB continues to work with carrier partners to pilot and develop alternative delivery and payment methods that align with the OEBB goals and guiding principles outlined above.

Program Justification and Link to 10-Year Outcome

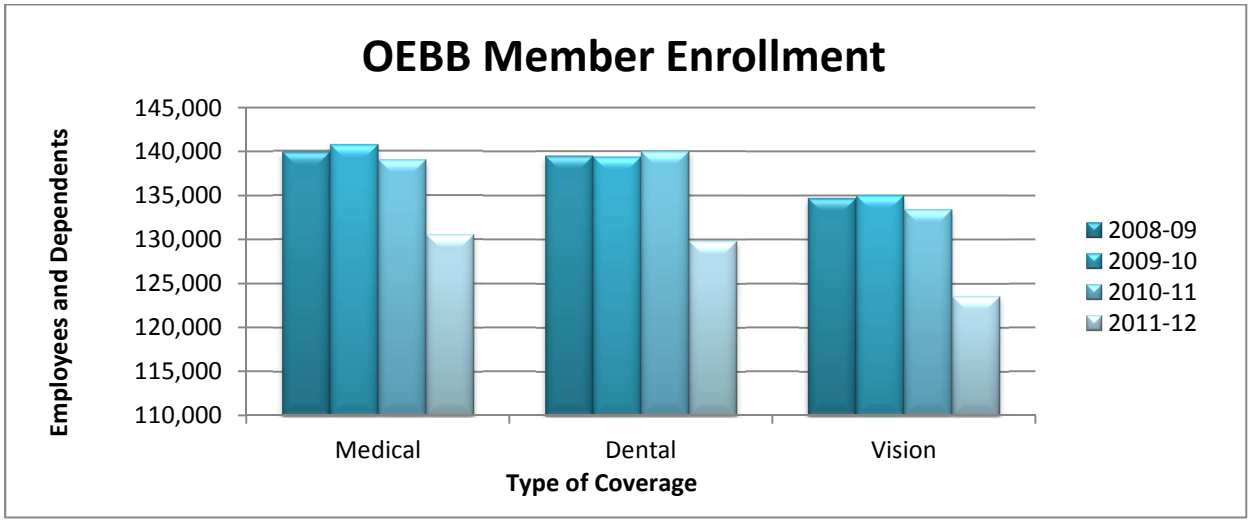
OEBB offers and encourages the use of medical homes and organized systems of care. OEBB has also moved toward aligning payment methodologies with the OHA Patient-Centered Primary Care Medical Home and Diagnosis-Related Group methodologies. OEBB's value-based benefit designs encourage members through lower cost sharing to use high value preventive services and prescription drugs. Value-based benefit designs are becoming more popular among private and public sector health care purchasers seeking to improve the health of their members while controlling health care costs. Currently, OEBB provides low or no cost access to all recommended preventive services, specific prescription drugs for chronic disease management, and participation in a weight management and tobacco cessation program.



In addition, OEBB charges additional copays on nine procedures where evidence shows there are alternatives that are as effective or more effective, cost less, and/or are safer to encourage patients to consider those alternatives.

Program Performance

Who we serve:

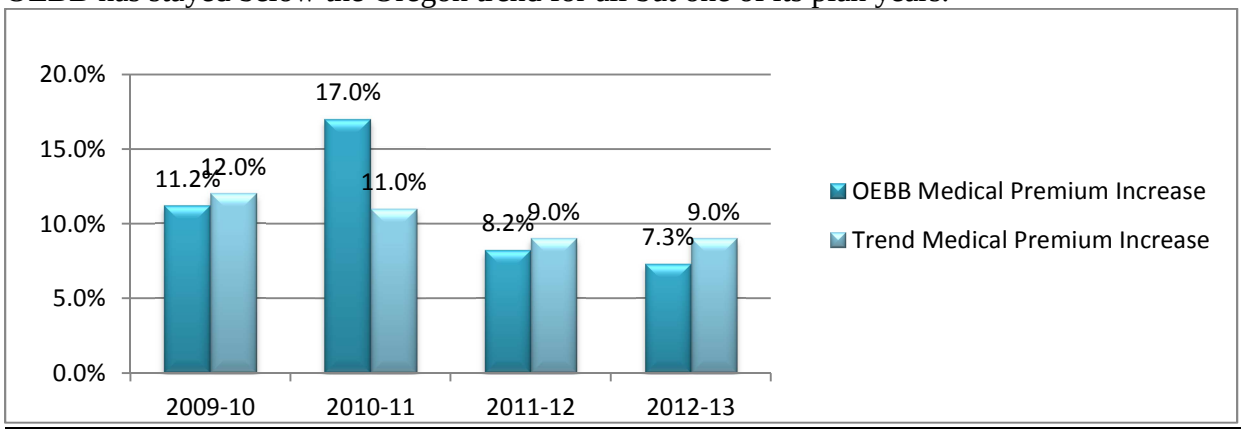


*Plan Year 2011-12 - Medical Opt Outs increased during the 11-12 plan year and layoffs reduced the number of employees in many of the entities. Members also elected to discontinue vision and dental plans due to pay freezes and mandatory furloughs.

OEBB offers various types of benefits and plans to members that include medical, dental, vision, life, accidental death and dismemberment, short- and long-term disability, a health savings account, flexible spending accounts, long term care and an employee assistance program. Members can choose from the plans available through their educational entity and select the benefit or coverage that best meets their or their family's needs and lifestyle. OEBB is committed to ongoing process improvement and continually identifying and implementing administrative efficiencies. The strategic plan for improving quality and efficiency provides for:

- Gathering information, data and input from OEBB's various partners and stakeholders, including members, educational entities, employee representatives, carriers and consultants to develop or modify plan designs for medical, dental, vision and optional benefit plans.
- Reviewing and evaluating proposals and existing contracts and negotiating rates to provide high-quality plans at the lowest possible cost to members and taxpayers.
- Identifying potential policy and plan design changes to improve outcomes, quality of care and members' health status.
- Measuring provider performance based on improved quality of health services to members and outcomes, and minimizing avoidable costs.

OEBB has stayed below the Oregon trend for all but one of its plan years.



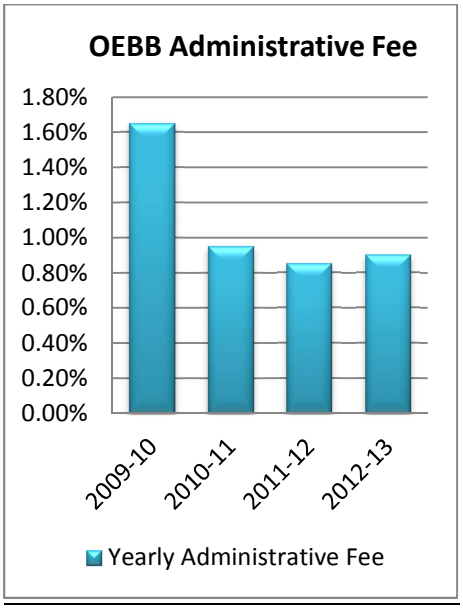
Enabling Legislation/Program Authorization

OEBB was established under Senate Bill 426 in 2007. The OEBB Board, functions and responsibilities are authorized under ORS 243.860 to .886.

Funding Streams

ORS 243.880 authorizes the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated through an administrative assessment included in premiums for OEBB benefits. The administrative assessment cannot exceed two percent of total monthly premiums and is the sole source of revenue for the OEBB benefits program. OEBB is funded entirely with Other Funds.

ORS 243.884 authorizes the Oregon Educators Revolving Fund to pay premiums, control expenditures, provide self-insurance and subsidize premiums.



Significant Proposed Program Changes from 2011-13

OEBB will begin focusing on expanding opportunities for Oregon's educational entities, including schools, education service districts and community colleges, to provide wellness activities and programs for employees and their families. These opportunities will allow Oregon to continue to create and support a culture of health in public schools and community colleges. Programs and activities will allow members to make changes in their lifestyles to improve their health. Improved member health will have a positive impact on members' lives and lead to reduced use of leave, increased productivity and reduced claim costs. Reduced claim costs have a direct impact on employee and employer budgets through decreased premiums. OEBB intends to

work with other stakeholders to expand the reach of its wellness efforts to benefit students and communities whenever possible and feasible.

OEBB has been working with current carriers to promote patient centered primary care homes (PCPCH). ODS Health Plan is promoting and incenting medical providers and clinics to become accredited by the Oregon Health Authority as a PCPCH and is expanding its Community Care Plan network to include health systems and providers outside the Portland and Salem areas and into regions of the state that have had few or no organized systems of care available in the past.

The 2011-12 and 2012-13 plan designs included reduced or no barriers for services and medications related to certain chronic diseases and increased cost share for services for which other less-costly, safer, or more effective services are available. The ODS Health Plan's formulary has a low $4 member cost share for medications found to be beneficial in reducing or delaying the onset of chronic diseases and is used for all medical plan options available through ODS including the option qualifying as a high deductible health plan (HDHP).

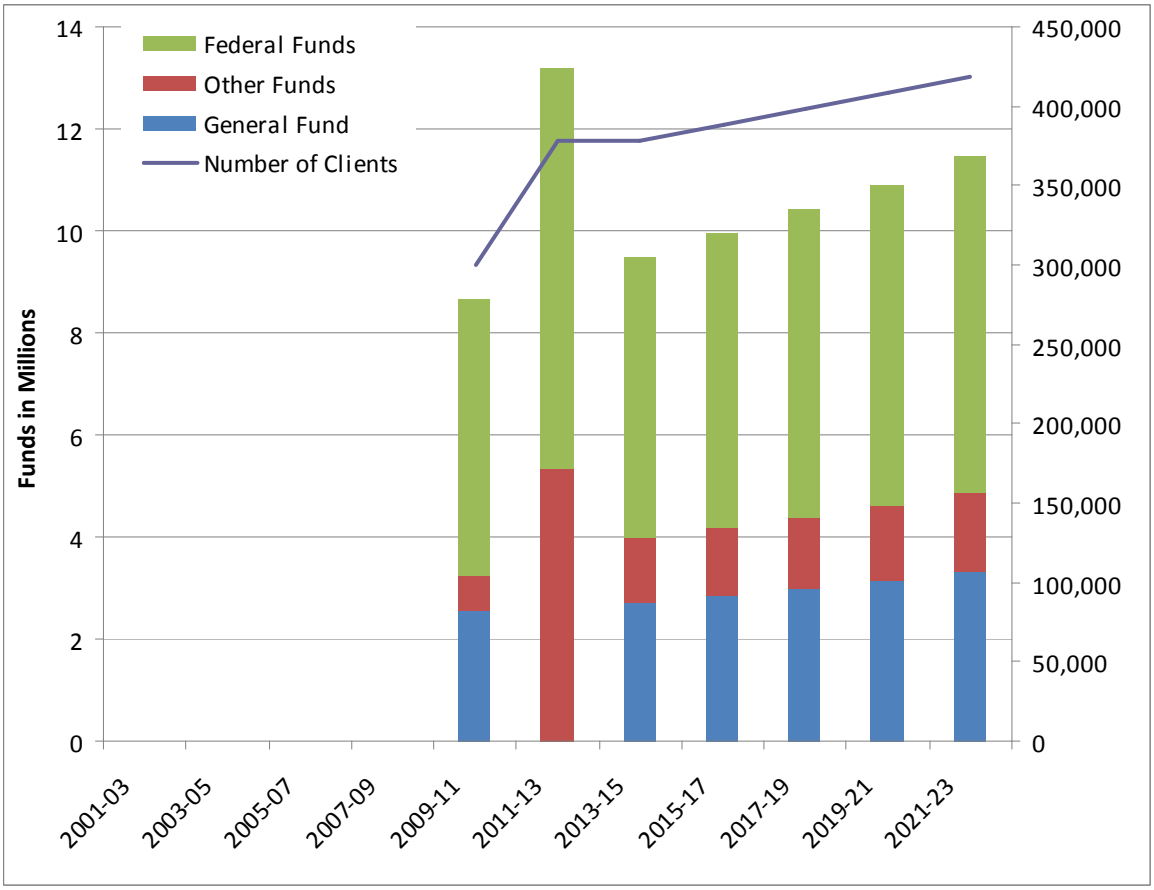
Options for educational entities participating in OEBB will expand with the opening of the Exchange. The OEBB Board will work closely with the Exchange on implementation of House Bill 4164 (2012).

OEBB	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15 *	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund											
Lottery Funds											
Other Funds			136,847	10,775,664	11,443,209	10,639,511	10,707,519	11,424,137	12,208,947	13,063,755	14,012,112
Other Funds - Nonlimited				500,000,000	1,438,000,000	1,438,000,000	1,542,974,000	1,613,950,804	1,686,578,590	1,759,101,470	1,834,742,833
Federal Funds											
Federal Funds - Nonlimited											
Total Funds	-	-	136,847	510,775,664	1,449,443,209	1,448,639,511	1,553,681,519	1,625,374,941	1,698,787,537	1,772,165,225	1,848,754,945
Positions			4	19	22	22	21	21	21	21	21
FTE			0.34	15.63	22.75	22.00	21.00	21.00	21.00	21.00	21.00
Program Performance											
Quantity Metric											
1.Average Number of members (active,early retiree, & dependents) OEBB Serves.				135,714	135,077	128,079	128,079	128,079	128,079	128,079	128,079
Quality Metric											
2. Appropriate use of asthma medications (HEDIS)				OEBB-specific results for 2009 were not available due to continuous	OEBB-specific results for were not available due to continuous enrollment requirements	HEDIS 2011 Kaiser 94% ODS 93% Providence 90%					
3. HbA1c controlled in diabetics (HEDIS)				OEBB-specific results for 2009 were not available due to continuous	HEDIS 2010 Kaiser 80% *ODS NA Providence 85%	HEDIS 2011 Kaiser 79% *ODS NA Providence 84%					
4. BRFSS results comparing overweight and obesity rates from 2009 to 2011.					BRFSS 2009 Obese - 28% Overweight - 34%	BRFSS 2011 Obese - 22% Overweight - 34%					
5. BRFSS redults comparing tabacoo usage rates from 2009 to 2011.					BRFSS 2009 Current Smoker - 5%	BRFSS 2011 Current Smoker - 5%					

OHK (rounded millions)	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	-	-	-	-	2,558,092	-	2,711,310	2,849,249	2,997,189	3,154,187	3,326,012
Lottery Funds											
Other Funds	-	-	-	-	69,754	5,348,601	2,874,330	1,337,079	1,396,937	1,459,364	1,527,047
Other Funds - Nonlimited											
Federal Funds	-	-	-	-	5,419,396	7,846,271	6,502,221	5,766,083	6,030,113	6,306,262	6,606,124
Federal Funds - Nonlimited											
Total Funds	-	-	-	-	8,047,242	13,194,872	12,087,861	9,952,411	10,424,239	10,919,813	11,459,183
Positions					16	14	9	9	9	9	9
FTE					13.62	11.08	8.90	8.90	8.90	8.90	8.90
Program Performance											
Quantity Metric											
Total Enrollment					300,545	378,221	378,221	387,903	397,834	407,859	417,974

Agency Name: Office of Healthy Kids

Primary Outcome Area: Healthy People – Other Programs & Support
Secondary Outcome Area:
Program Contact: Karen House, Administrator
503-945-6254



Executive Summary

Office of Healthy Kids: The Office of Healthy Kids provides outreach and education statewide to ensure all Oregonian children have access to no cost or low cost health care coverage. Healthy Kids provides education and support to DHS field offices, community organizations and partners for Health Systems Transformation implementation.

Program Description

The Office of Healthy Kids exists to increase the number of children with health care coverage. Since the creation of the Healthy Kids program, working in tandem with community partners through targeted enrollment grants, the uninsurance rate for children has been reduced from 11% to 5.6%. Success has depended on a strong focus on Oregon's most fragile and difficult to reach

populations. The program also works to keep children and teens enrolled in health care coverage once they receive it, and focusing on the small percentage of children and teens who are eligible but who are not currently enrolled in a health care program.

The Office of Healthy Kids also provides key support to OHA's Health Systems Transformation in many ways. Outreach coordinators are developing and will deliver training and support tools to the DHS field offices, community outreach organizations and partners that work with Oregon Health Plan members. This will assist in a much smoother transition for our communities as CCOs are brought up in each region. OHK's outreach and training now includes many topic areas including Health System Transformation, Patient-Centered Primary Care Homes, health care for children, teens and adults (OHP Standard), and soon it will include information about the Oregon's Health Exchange, Cover Oregon. The office is currently funded by revenue generated by the state's Insurer's tax and matched with federal Medicaid/CHIP funds. In the last six months of 2011-13 biennium, the office will also receive funding from Cover Oregon to begin Outreach activities for the exchange. With another 230,000 newly eligible Oregonians anticipated for Medicaid/CHIP coverage in 2014, the office is poised to provide application training and program support with the many changes coming as a result of the Affordable Care Act.

Program Justification and Link to 10-Year Outcome

The Healthy Kids Program is critical to the success of the 10-year goals and outcomes for Healthy People. The office provides education to communities around the state about the importance of health care for children, as well as helping families enroll their children in health care programs. It is important that the office continues its education and outreach efforts so that eligible children remain enrolled in these programs and have continued access to health care until they reach adulthood. Achieving the Triple Aim—better health, better care, and lower costs, begins with providing health care to Oregon's children. When children are healthy and able to focus on education and understand the importance of a healthy lifestyle is where Oregon's health status begins to dramatically improve. The Office of Healthy Kids embraces these concepts and ties them directly to all areas of the program.

Program Performance

To date, Healthy Kids outreach and marketing efforts have resulted in a net enrollment increase of over 110,000 children into health coverage. A statewide survey conducted in early Spring 2011 (the Oregon Health Insurance Survey) showed Oregon's child uninsurance rate to be at 5.6%, a significant decrease from the 11.3% rate found by the American Community Survey conducted two years prior. Healthy Kids 22 outreach grantees and 99 Application Assistor organizations have provided direct application assistance to 12,120 families from inception. Their efforts through the end of the biennium will allow Oregon to continue to reach out to uninsured children and help keep eligible children enrolled when they come up for their annual redetermination of eligibility and families must resubmit application information. In addition to the direct application assistance that these organizations provide, it is the additional community based outreach and ongoing education that connect and support all families to the health care coverage that their children need. The current forecast (Fall 2012) anticipates a growth in

Poverty Level Medical Children and CHIP caseloads of approximately 6,500 clients between May of 2012 and the end of the 2013-2015 biennium (June of 2015).

Enrollment by Program

								Healthy Kids Baseline		
	Apr-12	Mar-12			Apr-11			Jun-09		
Program	Current Month	Previous Month	Change	% Change	Previous Year	Change	% Change	Baseline	Change	% Change
Oregon Health Plan	**373,376**	**372,614**	**762**	**0.20%**	**353,512**	**19,864**	**5.62%**	**267,843**	**105,533**	**39.40%**
Medicaid (Title XIX)	*302,829*	*302,426*	*403*	*0.13%*	*287,660*	*15,169*	*5.27%*	*221,095*	*81,734*	*36.97%*
CHIP (Title XXI)	*70,546*	*70,188*	*358*	*0.51%*	*65,852*	*4,694*	*7.13%*	*46,748*	*23,798*	*50.91%*
Medicare (Title XVIII)	*0*	*0*	*0*	*0.00%*	*-*	*0*	*-*	*-*	*0*	*-*
Healthy KidsConnect	**6,662**	**6,597**	**65**	**0.99%**	**4,732**	**1,930**	***40.79%***	**-**	**6,662**	**-**
Private Market Option	*6,653*	*6,588*	*65*	*0.99%*	*4,725*	*1,928*	*40.80%*	*-*	*6,653*	*-*
ESI	*9*	*9*	*0*	*0.00%*	*7*	*2*	*28.57%*	*-*	*9*	*-*
FHIAP	**2,002**	**2,013**	**-11**	**-0.55%**	**2,158**	**-156**	**-7.23%**	**2,230**	**-228**	**-10.22%**
TOTAL	**382,040**	**381,224**	**816**	**0.21%**	**360,402**	**21,638**	**6.00%**	**270,073**	**111,967**	**41.46%**

***** Healthy KidsConnect beginning in March 2012 counts only children actively enrolled. Prior Healthy KidsConnect enrollment figures counted actively enrolled plus enrollees with future start dates. This change moves the Healthy KidsConnect enrollment methodology closer to how the other Healthy Kids programs enrollment figures are constructed. Due to this change, care in interpreting enrollment change for the Healthy KidsConnect program should be taken.

Enabling Legislation/Program Authorization

Oregon is not required to administer the Oregon Health Plan, but it is supported federally by Medicaid and CHIP. Title XIX and Title XXI of the Social Security Act, respectively, provide the federal authorization. Oregon administers the program under the authority of the federally approved Medicaid State Plan, CHIP State Plan, and Oregon Health Plan Medicaid demonstration wavier. The Oregon Health Plan is established and authorized in Oregon Revised Statute (ORS) 414.018 through 414.760.

Funding Streams

The insurer's tax, Medicaid, and CHIP federal matching dollars, are the primary funding streams for the Office of Healthy Kids program and support. After the sunset of insurer's taxes, general funds will replace insurer's taxes. Oregon qualifies for these federal dollars under its federally approved Medicaid and CHIP State Plans.

Proposed Program Changes from 2011-13

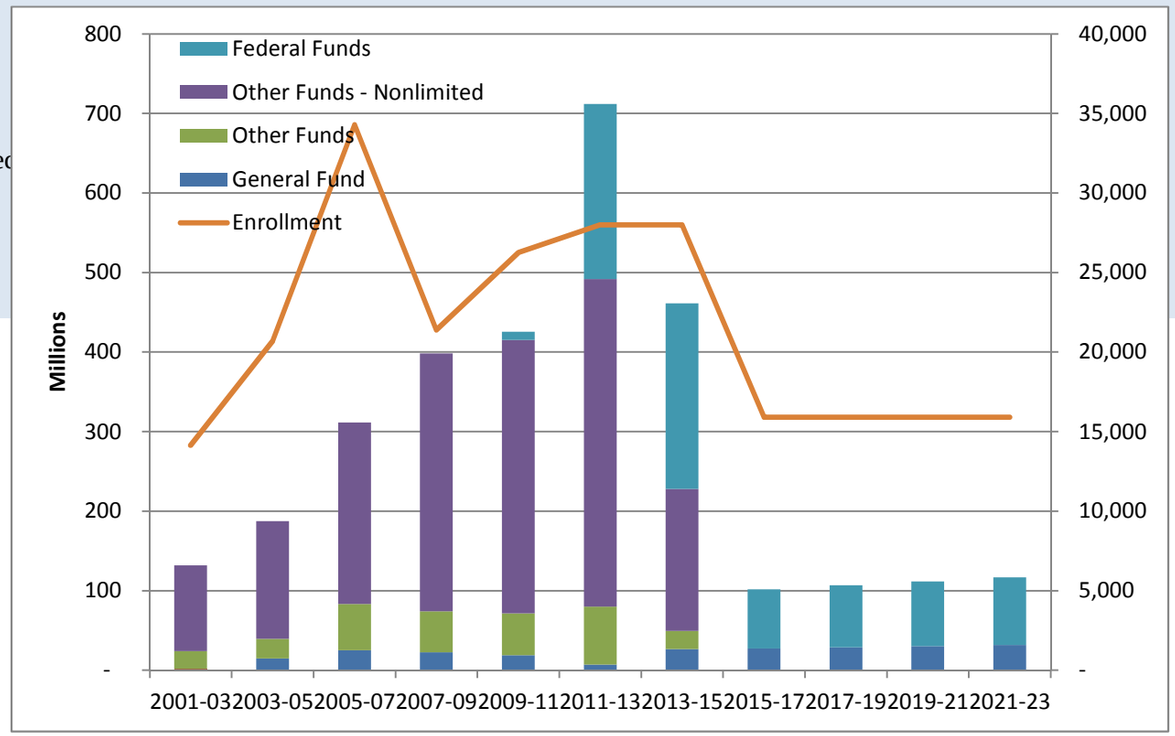
The Office of Healthy Kids will increase its service levels by providing outreach in partnership with the Cover Oregon. The office will provide support through outreach coordination staff, outreach grants and community partner training for those enrolling in Medicaid, CHIP and Advanced Premium Tax Credit health care programs.

The Governor's Balanced Budget for Office of Healthy Kids includes an increase in Other Fund Limitation resulting from the partnership between OHK and Cover Oregon. This will support work to achieve enrollment for 95% of the eligible Medicaid population by the end of the 2013-15 biennium. Healthy Kids will maintain enrollment at or above an estimated 95% of those eligible for Medicaid through the 2019-21 biennium at current FTE and funding levels.

The program office is currently budgeted at $2.7 million General Funds, $2.8 million Other Funds and $6.5 million Federal Funds, totaling $12 million total funds at 2013.

OPHP	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget	actuals	actuals	actuals	actuals	actuals	leg approved	governor's balanced	estimated	estimated	estimated	estimated
General Fund	423,222	14,770,356	25,075,821	22,575,786	18,888,853	7,002,275	26,499,939	27,457,269	28,812,214	30,189,579	31,644,483
Other Funds	22,496,590	24,729,275	58,153,766	51,384,983	52,726,732	73,049,970	22,945,607	-	-	-	-
Other Funds - Nonlimited	108,022,757	147,907,884	228,129,425	324,383,338	343,770,156	411,670,261	178,636,928	-	-	-	-
Federal Funds	-	-	-	-	10,184,071	220,095,929	233,085,130	74,378,822	77,873,260	81,393,664	85,088,940
Federal Funds - Nonlimited	-	-	-	-	-	-	-	-	-	-	-
Total Funds	130,942,569	187,407,515	311,359,012	398,344,107	425,569,812	711,818,435	461,167,604	101,836,091	106,685,474	111,583,243	116,733,423
Positions	83	60	67	62	91	43	61	22	22	22	22
FTE	47.79	59.50	65.80	60.92	83.70	42.36	59.75	22.00	22.00	22.00	22.00
Program Performance											
Quantity Metric											
Program Enrollment	14,142	20,691	34,294	21,386	26,244	27,992	27,992	15,900	15,900	15,900	15,900
Quality Metric	not quantified - measured by level and breadth of service received by enrollees										
Timeliness Metric											
Survey respondents ratings satisfaction 'good' or 'excellent' customer service, including timeliness (did not start tracking till mid-2005-07 bie)	n/a	n/a	n/a	95	95	n/a	n/a	n/a	n/a	n/a	n/a
Cost Per Unit Metric	not relevant - vast majority of costs driven by rates in commercial market and are not under control of program										

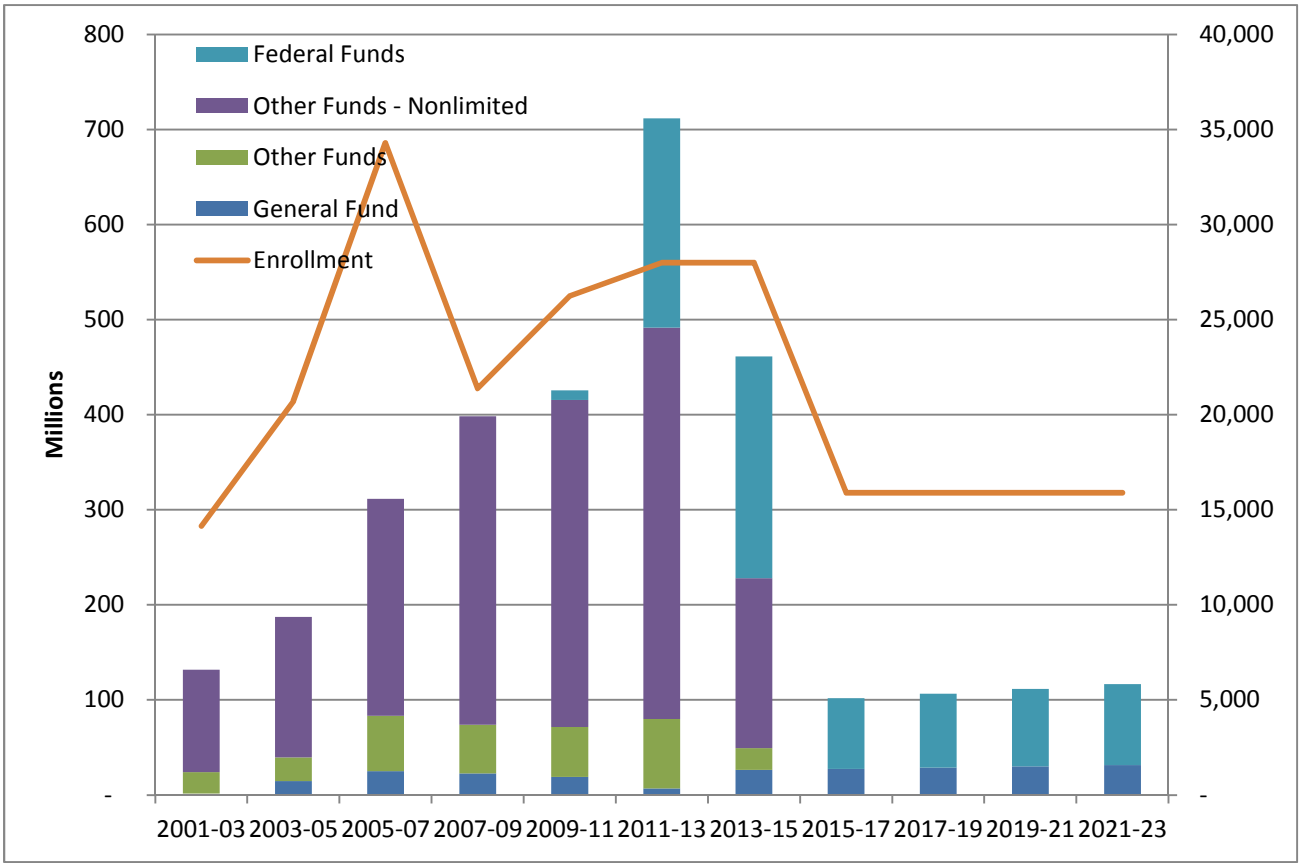
Bid Form Narrative Chart Source



General Fund	26	27	29	30	32
Other Funds	23	-	-	-	-
Other Funds - Nonlimited	179	-	-	-	-
Federal Funds	233	74	78	81	85
Enrollment	27,992	15,900	15,900	15,900	15,900

Oregon Health Authority: Office of Private Health Partnerships

Primary Outcome Area: Healthy People
Secondary Outcome Area: N/A
Program Contact: Don Myron, Administrator (503) 378-4025



Executive Summary

The Office of Private Health Partnerships (OPHP) administers five programs that work to break down barriers to access, assist with health care costs, preserve the participation of insurers in the children's insurance market, and educate program members and the general public about the changes in the health care system that affect them – helping support the goal of a Healthy Oregon. These five programs are closely connected, and they work across program lines to share talent, technologies, and other resources to accomplish the shared mission of the organization. The programs are the Family Health Insurance Assistance Program (FHIAP); two programs for high risk uninsurable individuals, the Oregon Medical Insurance Pool (OMIP), and the Federal Medical Insurance Pool (FMIP); a Children's Reinsurance Pool (CRP) administered within the OMIP program; the Healthy Kids Connect (HKC) program, and an Information, Education and Outreach (IEO) program that supports all of the others.

Program Description

OPHP's programs offer consumer health plan coverage through the commercial insurance market and provide eligible individuals premium assistance. They also provide access to health care information and resources, allowing the enrollees to make informed decisions about their health care options.

These programs create a three-way partnership between government, the private market and the insured. Since its inception, OPHP has designed, contracted, managed and administered programs that provide health care access to eligible individuals and families, to those who have been declined coverage due to pre-existing health conditions and those who have no portability insurance options in the private insurance market. Approximately 85 percent of OPHP's members do not qualify for other state health programs.

Combined, OPHP's programs provided access to health insurance coverage for approximately 26,000 Oregonians in August 2012. Once individuals enroll in health insurance coverage, they continue the coverage as long as they pay premiums or find other coverage. Individuals receiving premium assistance in FHIAP or HKC continue to receive it as long as they meet the income requirements. Program expenditures are driven by the ever-increasing cost of medical services as well as by increases in enrollment.

Program Justification and Link to 10-Year Outcome

There is a direct link between OPHP programs and the intent of the Healthy People program to improve access to health insurance coverage and produce outcomes that promote lifelong health.

The availability of health insurance coverage and access to premium subsidies through OPHP programs ensure access to a range of health care benefits ranging from preventive services through medical procedures needed by people with severely debilitating chronic illnesses. This access would not be available without these OPHP programs and these individuals would not be insured at all.

- FHIAP offers subsidy assistance for individual and employer-sponsored coverage for 50%, 70%, 90% or 95% of premiums based on enrollee federal poverty levels (FPLs) below 200%. Subsidies are 100% for children up to 19 years of age below 200% FPL.
- Healthy KidsConnect offers subsidy assistance to children up to 19 years of age between 200% and 301% FPL. Subsidies are available at either 85% or 90% for eligible children.
- OMIP and FMIP provide access to comprehensive health insurance coverage for people with chronic health conditions who cannot obtain commercial or public sector coverage, along with those who have not access to private sector portability coverage.
- The CRP provides a reinsurance option for insurers under the guaranteed issue requirement for covering children to control their risk against catastrophic losses and to ensure a healthy children's insurance market remains viable.

By reducing cost, improving access, and sharing health information, OPHP programs help to increase each member's health security. Through a sliding scale for premium subsidy payments, where a member subsidies decrease as their incomes increase, OPHP programs provide a means for each member to be as healthy as possible.

Program Performance

OPHP partners with private market health insurers to help reduce the state's uninsured rate by providing insurance options to people who otherwise would be without health coverage. Program performance can be measured by the percentage that programs have reduced the state's uninsured rate through increasing enrollment. However, limited funding in the FHIAP program has resulted in enrollment caps (resulting in enrollment reductions in 2007-09, for example) that make this measure less than illustrative of program performance because the caps artificially mask the true potential of FHIAP.

Costs for the programs are determined primarily by the commercial insurance market, but OPHP ensures quality and timely service delivery for members through the following actions:

- Assistance managing health care and benefits;
- Expanding the range of diagnoses addressed by disease management programs;
- Enhancing promotion of no-cost classes for smoking cessation and self-management of chronic diseases;
- Promoting use of websites for enrollees to access a wide range of information about managing diseases and lifestyle, general knowledge about medical conditions and medication alternatives and history of claims;
- Promoting healthy lifestyles by offering paid weight loss programs through Weight Watchers;
- Increasing the number of available generic prescriptions from 59 to 72 percent of covered medications, thereby controlling the rate of increase in drug expenditures.

Enabling Legislation/Program Authorization

OPHP programs are governed by a series of Oregon Revised Statutes: FHIAP – ORS 414.841 through 414.872; HKC – ORS 414.231, 414,826, and 414,828; OMIP and FMIP – ORS.735.600 through 735.650; and OPHP as a whole – ORS 735.700 through 735.714.

The FHIAP program is matched with federal Medicaid funds, and is therefore subject to the maintenance of effort established in the state's Section 1115 waiver. Both the FHIAP and Healthy Kids Connect programs are matched by federal Children's Health Insurance Program (CHIP) funds, and are therefore governed in part by the CHIP State Plan.

Funding Streams

OPHP programs are supported by a variety of funding sources and leveraged funds:

- The Federal Health Insurance Assistance Program is supported by a combination of General Fund, Insurers Tax, and leveraged federal match through Medicaid (63%) and CHIP (74%).
- Healthy Kids Connect is supported by Insurers Tax and leveraged federal funds (CHIP only [74%]). Following the sunset of the Insurers Tax at the end of September 2013, support shifts to the General Fund.

- The Oregon Medical Insurance Pool is supported by statutorily dedicated (see ORS reference above) non-limited Other Funds generated by enrollee premiums and assessments on the licensed Oregon commercial health insurers.
- The Children's Reinsurance Program is funded by assessments on the licensed Oregon commercial health insurers.
- The Federal Medical Insurance Pool is funded by enrollee premiums and an allotment of special funds under the federal PCIP program.

Significant Proposed Program Changes from 2011-13

The OHA 2013-15 funding proposal for the Governor's Balanced Budget (GBB) reflects the operation of all programs largely unchanged for the first six months of the biennium, followed by the closure of four of five OPHP programs in 2014. The only OPHP program that is scheduled to operate for the duration of the 2013-15 biennium in the GBB is Healthy Kids Connect.

Additionally, please note that a primary source of revenue for the FHIAP and HKC programs, the Insurers' Tax, is scheduled to sunset as of September 30, 2013. The HKC and FHIAP current service level budgets were adjusted to reflect the elimination of this fund source following the sunset, with the difference replaced by an increased General Fund appropriation.

The following is a brief overview of the impacts of the ACA implementation on OPHP programs as incorporated in the GBB budget:

FHIAP. Expansion of Medicaid up to 138% of the federal poverty level (FPL) and the shift of federal subsidies to the health insurance exchange, Cover Oregon, will make the Family Health Insurance Program (FHIAP) unnecessary, and the program is scheduled to close in January 2014 in the 2013-15 GBB budget. The FHIAP GBB budget for special payments is abolished as the program closes in January 2014, while program positions remain budgeted for the entire 2013-15 biennium in the GBB budget. The same ACA provisions that caused the closure of the FHIAP program are also increasing the workload for staff elsewhere in OHA, in some cases serving the same enrollees that were served in FHIAP. FHIAP staff has the skills, training, and experience necessary to meet this increased workload, and OHA leadership is working to identify programs most impacted by changes driven by the ACA implementation. FHIAP positions will be transferred to other OHA program areas later in the 2013-15 budget process as transition plans are formalized.

HKC. The only OPHP operational program scheduled in the 2013-15 GBB budget to remain open after January 2014 is the Healthy Kids Connect (HKC) program. The federal Maintenance of Effort (MOE) provisions in the ACA specifies that existing coverage for children under both Medicaid and the Children's Health Insurance Program (CHIP) remains in place through federal fiscal year 2019. HKC provides coverage for children in the 200% to 300% FPL range utilizing federal CHIP matching funds, and is classified as a discretionary group insurance product. Cover Oregon sells only individual and small employer group products. However, Cover Oregon does not sell discretionary group products, and as a result the HKC program is planned to continue operating in OHA for the 2013-15 biennium in the GBB.

FMIP. The FMIP program is available until 2014. Beginning January 1, 2014, federal law will prohibit insurance companies from refusing to sell coverage or renew policies because of a person's pre-existing condition. Also starting in 2014, individuals whose employers don't offer them insurance will be able to buy insurance directly in Cover Oregon. As a result, the FMIP program will close in January 2014, and the federal government is expected to release plans for transitioning federally funded high-risk pool program enrollees shortly.

OMIP. The OMIP program is also impacted by the prohibition in 2014 of insurance companies from refusing to sell coverage or renew policies because of a person's pre-existing condition. Like the FMIP program, the OMIP program is scheduled in the GBB to close in 2014 as these provisions in the ACA are implemented. OMIP positions remain budgeted for the entire biennium for reasons described above in the FHIAP section, and will be transferred to other OHA program areas later in the 2013-15 budget process as transition plans are formalized.

IEO. The IEO program is scheduled to close in January 2014 as many of the operational programs it serves close, and enrollees move to an expanded Medicaid program, the new Cover Oregon, or to the commercial market. The IEO position remains budgeted for the entire biennium for reasons described above in the FHIAP section, and will be transferred to another OHA program area later in the 2013-15 budget process as transition plans are formalized.

PEBB	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund											
Lottery Funds											
Other Funds	3,072,255	3,863,506	6,116,430	7,016,200	18,495,736	8,715,361	9,266,004	9,936,309	10,674,001	11,482,257	11,616,582
Other Funds - Nonlimited	48,557,206	28,448,793	21,340,455	125,365,000	1,017,616,000	1,405,241,260	1,712,335,080	1,791,102,494	1,871,702,106	1,952,185,296	2,036,129,264
Federal Funds											
Federal Funds - Nonlimited											
Total Funds	51,629,461	32,312,299	27,456,885	132,381,200	1,036,111,736	1,413,956,621	1,721,601,084	1,801,038,803	1,882,376,107	1,963,667,553	2,047,745,846
Positions	14	17	17	19	20	19	20	20	20	20	20
FTE	13.68	16.68	16.83	18.83	19.08	18.50	19.50	19.50	19.50	19.50	19.50
Program Performance											
Quantity Metric											
Biennial average number of active members	45,148	45,474	45,640	46,437	47,269	47,496	48,792	48,292	48,695	49,101	49,510
Quality Metric											
Appropriate use of asthma medications (HEDIS)				Kasier 95% Regence 92%	Kasier 92% Providence 96%	Kaiser 93% Providence 92%					
HbA1c controlled in diabetics (HEDIS)				Kaiser 78% Providence 84%	Kaiser 80% Providence 83%	Kaiser 78% Providence 85%					
Trying to quit smoking (self-reported)				53%	65%	Survey to be completed this summer					
Trying to lose weight (self reported)				57%	90%	Survey to be completed this summer					
Excellent health status (self reported)				54%	25%	Survey to be completed this summer					

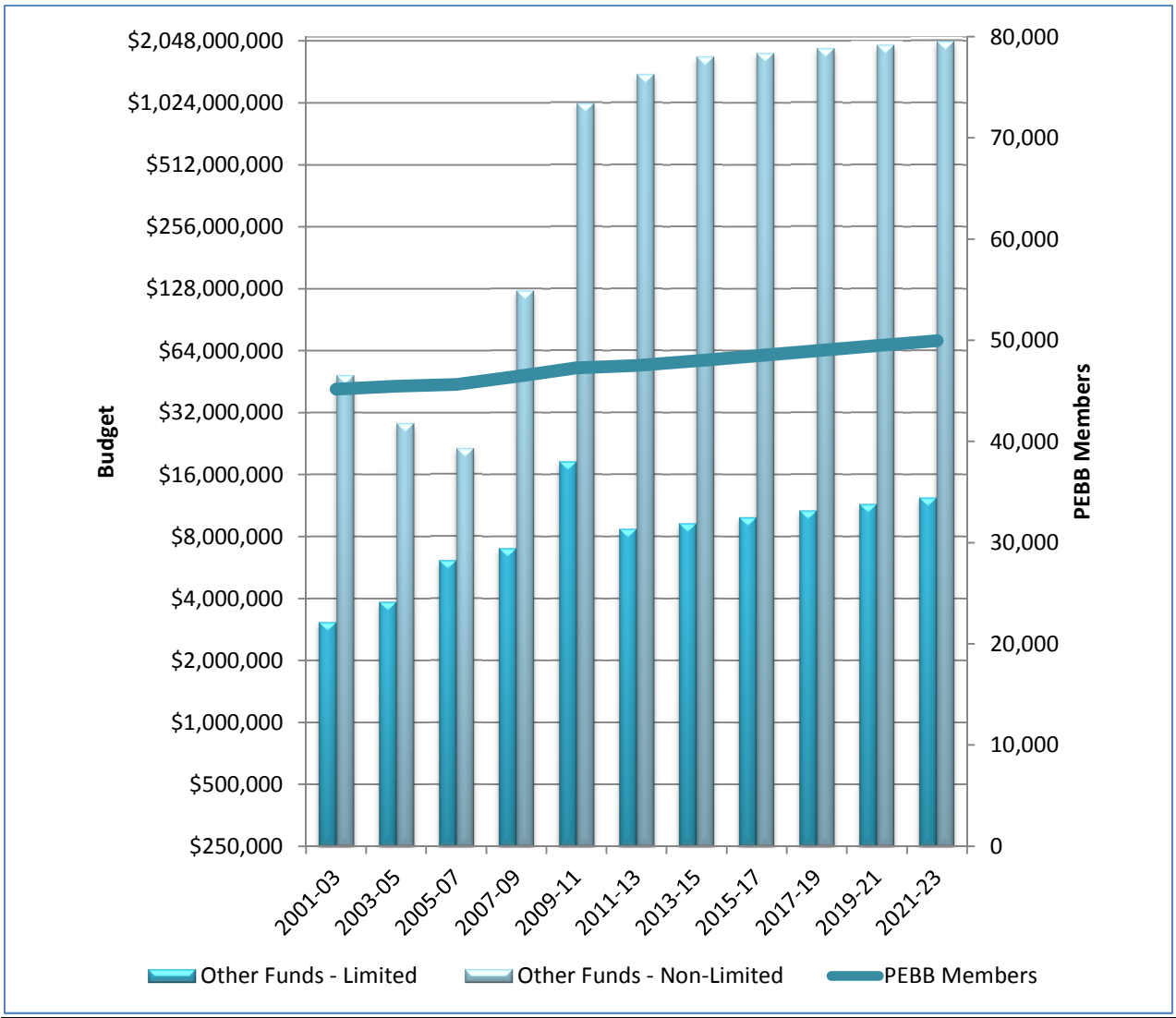
Agency Name: Public Employees' Benefit Board

Primary Outcome Area: Healthy People
Secondary Outcome Area: Livable Communities
Program Contact: Kathy Loretz, 503-373-0800

Executive Summary

The Public Employees' Benefit Board (PEBB) provides high-quality medical, dental, vision, life, disability, accidental death and dismemberment, and long term care insurance benefit options at a cost affordable to employees and the state. Insurance benefits are a part of state employees' total compensation package and an important tool in hiring and retaining quality personnel.

Program Funding Request



Program Description

PEBB's goals are to design, contract and administer high-quality medical, dental, life, accident, disability and long-term care insurance, and flexible spending accounts for state employees and their dependents that are affordable for the state as the employer and employees. Key elements used in the decision making process include:

- An innovative delivery system that uses evidence-based medicine to maximize health and use dollars wisely;
- A focus on improving quality and outcomes, not just providing healthcare;
- Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place;
- Accessible and understandable information about costs, outcomes and other health data for informed decision making; and
- Affordable benefits for the state and the employees.

PEBB seeks optimal health for its members through a system of care that is patient-centered, focused on wellness**,** coordinated, efficient, effective, accessible and affordable. The system emphasizes the relationship among patients and providers, their community and primary care. PEBB takes an integrated approach to health by treating the whole person.

PEBB serves its members and customers through six central functions:

- Financial oversight of PEBB accounts, including the Revolving Fund and its subaccounts;
- Program development through collaboration with agencies, universities, health plans and other benefit purchasers on programs to implement elements of the PEBB vision;
- Regulatory compliance to ensure the benefit program meets all state and federal regulations;
- Enrollment accuracy through the use of a benefit management system to ensure the accuracy of benefit-related data shared among state and university payroll systems, health plans and other vendors;
- Accurate and timely contract services; and
- Communication services to engage employees in the benefit program, health improvement and the PEBB vision.

The most valuable benefit in the program is health care coverage. The cost of health care continues to increase without evidence of a commensurate increase in measurable quality. The PEB Board reviews and adjusts benefit designs to best meet the needs of the employees and the employer.

Medical and dental premium costs are impacted by utilization of services and the cost of services. PEBB has implemented evidence-based plan designs to help drive members to lower cost, equally effective services; reduced or removed barriers for medications and office visits that help the chronically ill stay healthier and those at risk avoid developing chronic illness; and worked with carriers to develop and implement alternative ways to pay for services, such as the medical home model and the use of global rates in the near future.

Program Justification and Link to 10-Year Outcome

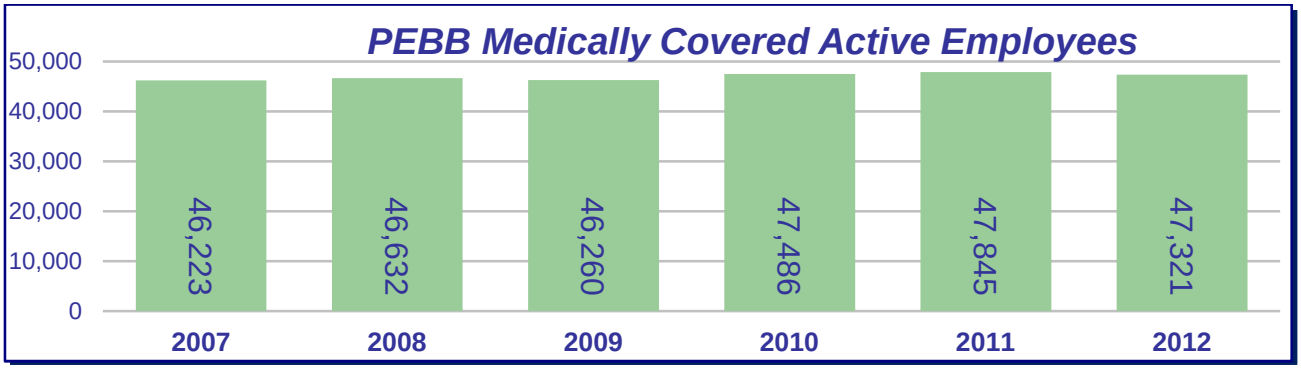
In 2010, PEBB began to self- insure 85 percent of members. Self- insuring gives the board more flexibility in plan design to meet specific goals and has been very successful in keeping premium increases at a reasonable level.

PEBB actively promotes enrollment into medical homes, implements value based designs and participates in other OHA-wide initiatives:

- In 2012, 33 percent of PEBB members are enrolled in either Kaiser or Providence Choice medical home model plans;
- PEBB members with chronic diseases are participating in the High Value Medical Home pilot;
- PEBB offers no-cost maintenance medications;
- The PEBB Statewide and Providence Choice plans have no cost sharing associated with office visits for diabetes, asthma, heart disease and coronary artery disease;
- Members and their dependents have access to no-cost tobacco cessation and weight management benefits; and
- Low value, highly utilized procedures have a higher copayment than more effective and less cost alternatives.

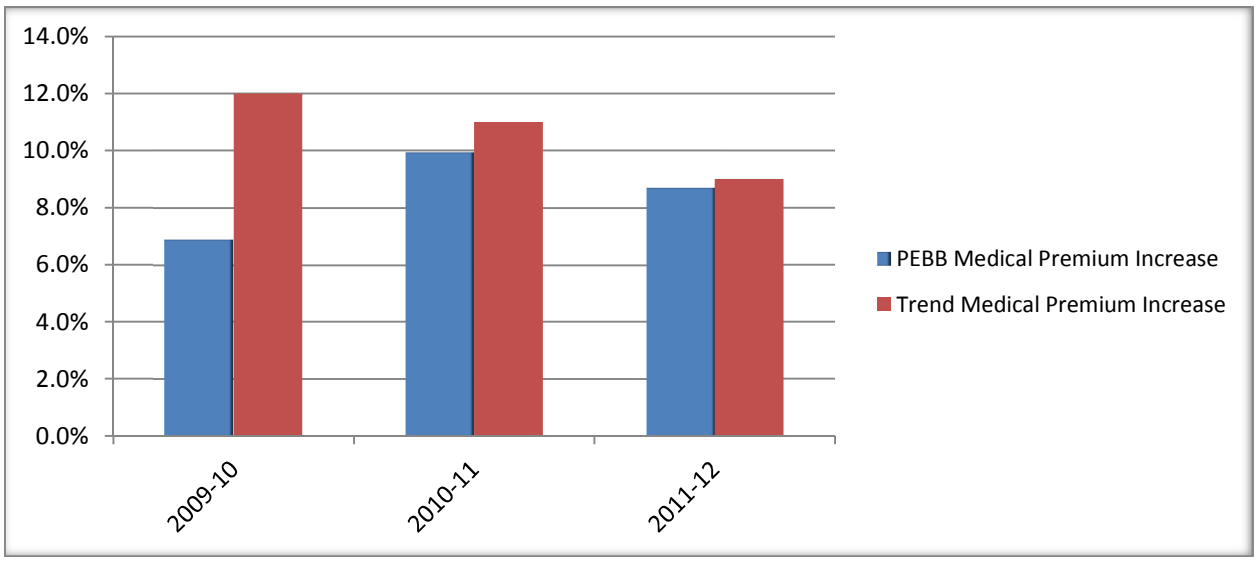
Program Performance

Who we serve:



In addition to employees of state, university and semi-independent agencies and their dependents, PEBB members include retirees, self-pay and COBRA participants and their dependents. Currently, 46 percent of PEBB's active employee population is age 50 or older.

PEBB has stayed at or below the Oregon premium trend level for the past three years:



PEBB's focus over the past few years has been on creating plan designs that foster better care, wellness programs to improve the overall health of members and controlling costs. PEBB has increased the number of members in a patient-center primary care home, reduced barriers to preventive and maintenance care, such as maintenance medications and tobacco cessation, partnering with the Office of Public Health to support worksite wellness, implemented a plan design to promote direct member engagement in improving their health, conducted a dependent verification to maintain enrollment integrity and achieved better cost control through direct contracting with medical, vision and dental plans.

Enabling Legislation/Program Authorization

The Public Employees' Benefit Board authority lies in ORS 243.061 through ORS 243.302.

Funding Streams

PEBB receives other fund dollars from agencies, universities and self- pay members to directly cover the costs of self- insured members. The dramatic increase in other funds over the past three years (see first chart) are directly related to the increase in self- funded plans. PEBB now self-insures 85 percent of members for health coverage. These monies are used to pay member medical, vision and dental claims, dollar for dollar, and for insurance carriers' administrative fees. In 2011, the average administrative fee for self- funded plans was 5.02 percent.

By statute, PEBB can collect up to two percent of premium to meet administrative and operational costs. For the past two years, PEBB has collected 0.4 percent of premium.

Significant Proposed Program Changes from 2011-13

In 2012, PEBB introduced a wellness program called the Health Engagement Model to incent members to make changes in their lifestyles to improve their health. Improved member health will have a positive impact on members' lives and lead to reduced use of leave, reduced claim costs and increase productivity. Reduced claim costs have a direct impact on employee and employer

budgets through decreased premiums. PEBB intends to continue to adjust this program going forward based on information gathered through an evaluation process.

PEBB has been working with current carriers to promote patient centered primary care homes (PCPCH). Providence is promoting and incenting medical providers and clinics to become recognized by the Oregon Health Authority as a PCPCH. PEBB is adjusting benefits for 2013 to incent members through a reduced coinsurance for services provided by OHA recognized PCPCH providers.

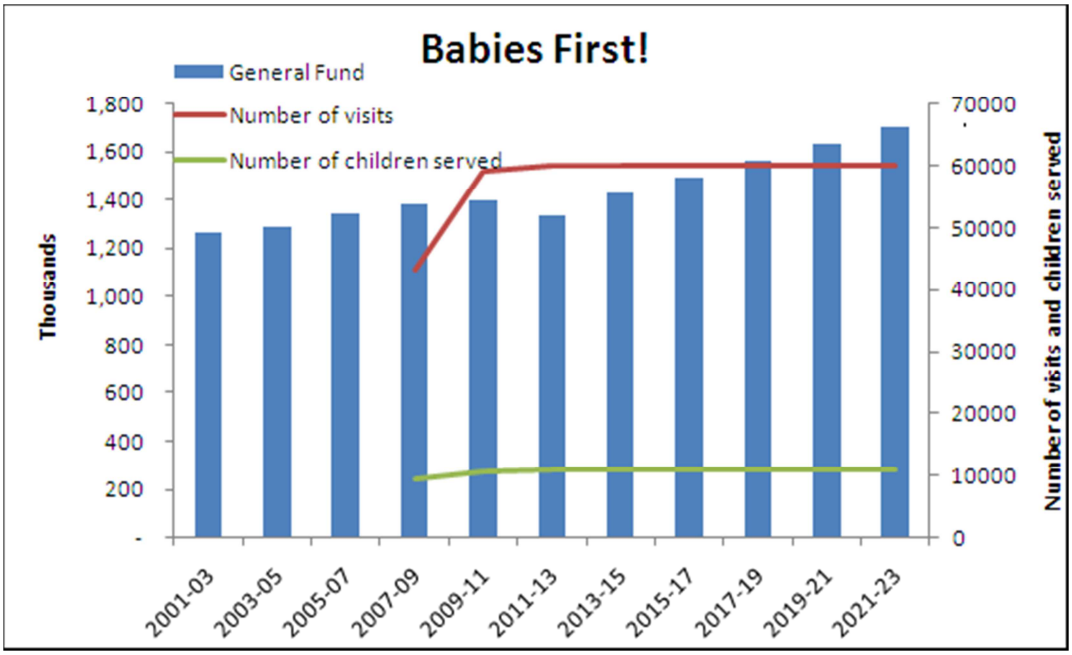
The 2011 and 2012 plan designs included reduced or no barriers for services and medications related to chronic diseases and increased cost share for services for which other, less costly services are available. The Providence formulary has a $0 member cost share for medications found to be beneficial in reducing or delaying the onset of chronic diseases.

PEBB is releasing a request for proposals for insurance carriers for the 2014 plan year. The PEB Board is currently preparing a request for proposal for 2014. All bidders that meet specifications including CCOs will be encouraged to respond to the RFP. Language to advance the use of OHA recognized PCPCH providers, a benefit design based on evidence and value based purchasing will be included in the RFP.

In the Governor's Balanced Budget, PEBB will maintain 2011-13 funding levels plus allowed inflation. Maintaining current funding level into the next biennium will ensure PEBB complies with statutory requirements while meeting the goals and vision of the PEB board. PEBB cost through the 2019-21 biennium have been trended forward using appropriate inflation factors as described by the DAS Budget and Management division. The ten year funding level will allow PEBB to provide high quality health and wellness benefits to members at a cost that is affordable to the members and the employer.

Oregon Health Authority: Public Health - Babies First!

Primary Outcome Area:	Education
Secondary Outcome Area:	Healthy People
Program Contact:	Melvin A. Kohn, MD, MPH Director, Public Health Melvin.A.Kohn@state.or.us Phone: 971-673-1300



Executive Summary

Home visiting is an evidence based approach to ensuring that children are healthy and ready to learn when they reach school-age. Oregon's home visiting system includes a spectrum of services for families with different levels of risk for poor outcomes. Babies First! provides services to those families at highest risk for developmental, social, medical or emotional problems. In contrast to other home visiting services, it is delivered by a public health nurse, rather than a peer or para-professional, and is more intensive. This program is delivered by county health department-based public health nurses. Babies First! has performed extremely well, demonstrating improvements in many important health outcomes for families served. This state investment leverages substantial county general fund and federal Medicaid match, enabling state dollars to be stretched to serve as many people as possible.

Program Description

Babies First! is a public health nurse home visiting program that provides preventive nursing interventions in the home for infants and children under age 5 years and their families. Program eligibility is based on well-defined, evidence-based medical and social risk factors. During these home visits, county health department public health nurses provide evidence-based assessments

of mother and infant attachment and the home environment; screening and referral for developmental delays, vision and hearing; and case management, advocacy and education for the families.

Currently about 7,000 children receive this service each year and this number represents only a small portion of the total number of children with potential health and development risks that would be eligible for the services.

Program Justification and Link to 10-Year Outcome

Because Babies First! is delivered by public health nurses rather than peers or para-professionals, and because it is more intensive than other home visiting approaches, it is more expensive to deliver on the front end. However, the program costs are justified because of the very high-risk that these families have for poor outcomes and the very strong research that demonstrates that Babies First! is a very powerful tool to significantly increase the chance that the high risk children in the program will grow up healthy and ready to learn. Provision of these services when infants are young avoids much more expensive provision of social and educational services later in life, as well as the human costs associated with poor outcomes.

The Babies First! program contributes to three of the 10-Year Outcome goals: Healthy Oregonians at all stages of life, Oregon's children are ready to enter kindergarten, and shift resources to focus on prevention. Compared to high-risk children who do not receive nurse home-visiting services, children in this program are healthier because they receive important health interventions at a higher rate, including regular well-child visits, immunizations, developmental screening, nutrition assessments, and breastfeeding support for mothers. Nurse home visiting also has been linked to improved school readiness and performance including improvements in cognitive and language development and higher scores on achievement test scores in reading and math. Because the program is a preventive one, it also contributes to the Healthy People goal of shifting resources to focus on prevention.

Program Performance

In the two year period July 2008-June 2010, Babies First! served 13,136 children and provided 50,116 home visits.

Research has demonstrated that the larger the number of home visits and the earlier they start, the greater the positive impact on health and educational outcomes. Seventy percent of Babies First! children received an average of six 60-minute home visits over 7 months, and 70 percent were under one year of age.

Seventy percent of children enrolled in Babies First! Also received age-appropriate developmental screens—primarily using the Ages and Stages Questionnaire-3 (ASQ3). This screen addresses the following domains: communication, gross motor skills, fine motor skills, problem solving and personal-social development.

Babies First! Mothers were more likely than other women with similar risk factors to breastfeed at a rate equal to the general population. Breastfeeding reduces the rates of ear infections, diarrhea, chronic conditions such as asthma, obesity and Type 2 Diabetes, and lower respiratory infections, all of which impact a child's ability to effectively learn and develop.

More than ninety percent of Babies First! clients were assessed for healthy nutrition. Ninety-eight percent of those with an identified need received an intervention to correct nutritional issues.

Children continuously enrolled 2 to 3 years in Medicaid who received Babies First! services had at least one dental visit and had a visit with a primary care practitioner, at significantly higher rates than Medicaid-enrolled children who had not received Babies First! services.

Enabling Legislation/Program Authorization

Babies First! is authorized under ORS 431.416(b). Payments are authorized under OAR410-138-000 through 410-138-0080,covering Targeted Case Management and Medicaid State Plan Amendment (SPA) Targeted Case Management. Title 42 of the US Code authorizes federal Medicaid spending.

Funding Streams

The Babies First! program is funded through state and county General Funds together with federal Medicaid Targeted Case Management match. The state and county General Fund dollars are used as match to draw down Medicaid dollars at various rates from 60:40 (FF to GF) to 70:30 (FF to GF), depending on the Babies First! client's coverage in SCHIP, CHIP and OHP. This means that for every state dollar invested $1.5-$2.3 federal dollars are drawn down.

Significant Proposed Program Changes from 2011-13

As the Coordinated Care Organizations and the Early Learning Council hubs develop, Babies First! will work to ensure full coordination with and leverage of those efforts to deliver the highest quality services to as many Oregonians as possible. Babies First! will also continue to collaborate with other programs providing home visiting to ensure efficient use of resources and service delivery.

The Governor's Balanced Budget includes $1,429,981, which represents funding at the 2013-15 current service level for Babies First!

	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	1,261,638	1,287,042	1,343,200	1,383,745	1,396,225	1,336,889	1,429,981	1,493,103	1,559,891	1,629,540	1,705,048
Lottery Funds											
Other Funds											
Other Funds - Nonlimited											
Federal Funds											
Federal Funds - Nonlimited											
Total Funds	1,261,638	1,287,042	1,343,200	1,383,745	1,396,225	1,336,889	1,429,981	1,493,103	1,559,891	1,629,540	1,705,048
Positions	1	1	1	1	1	1	1	1	1	1	1
FTE	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

Babies First	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Performance											
Quantity Metric				7/2008-6/2010*							
Number of visits *(Source: ORCHIDS - Babies First! Program; data are for July 1, 2008 - June 30, 2010)*	NA	NA	NA	43,137	59,167	60,000	60,000	60,000	60,000	60,000	60,000
Number of children served	NA	NA	NA	9,406	10,571	11,000	11,000	11,000	11,000	11,000	11,000
*alignment with Multnomah County data has been a challenge due to inconsistencies of data systems and measures. Therefore, the most accurate 2-year period to date is July 2008-June 2010											
Quality Metric											

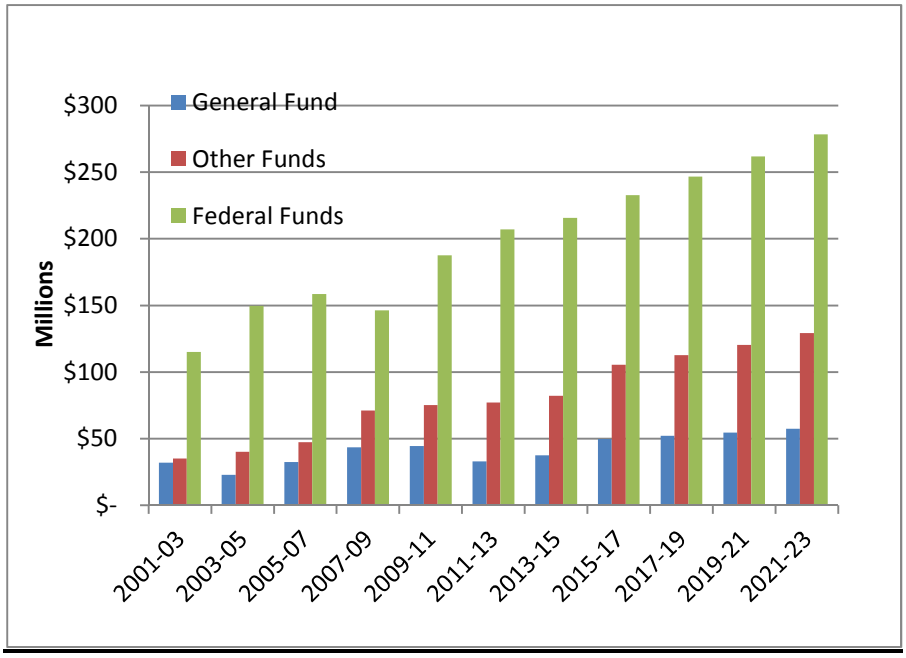
Babies First	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Percent of mothers who receive information from their nurse home visitor when their child is assessed as having a need related to growth and development *(Source: ORCHIDS - Babies First! Program; data are for FY 2010 only)*	NA	NA	NA	NA	90.95%	90.95%	90.95%	90.95%	90.95%	90.95%	90.95%
Percent of mothers who are assessed with a need for parenting education that receive a related intervention from their nurse home visitor *(Source: ORCHIDS - Babies First! Program; data are for FY 2010 only)*	NA	NA	NA	NA	97.00%	97.00%	97.00%	97.00%	97.00%	97.00%	97.00%
Percent of mothers who breastfeed *(Source: ORCHIDS - Babies First! Program; data are for FY 2010 only)*	NA	NA	NA	NA	89.00%	89.00%	89.00%	89.00%	89.00%	89.00%	89.00%
Percent of enrollees 25 months - 6 years of age who had a visit with a primary care practitioner *(Source: MMIS - DMAP medicaid data; calendar year 2010)*	NA	NA	NA	NA	92.34%	92.34%	92.34%	92.34%	92.34%	92.34%	92.34%

Babies First	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Percent of continuously enrolled members 2 to 3 years who had at least one dental visit during the measurement year *(Source: MMIS - DMAP medicaid data; calendar year 2010)*	NA	NA	NA	NA	43.36%	43.36%	43.36%	43.36%	43.36%	43.36%	43.36%

Timeliness Metric	NOT AVAILABLE
Cost Per Unit Metric	NOT AVAILABLE

Oregon Health Authority: Public Health

Primary Outcome Area:	Healthy People
Secondary Outcome Area:	None
Program Contact:	Melvin A. Kohn, MD, MPH, Director, Public Health
	Melvin.A.Kohn@state.or.us, Phone: 971-673-1300



Executive Summary

Public Health is a cost-effective means to promote health, improve care and lower or contain health care costs bypreventingthe leading causes of death, disease and injury in Oregon. Today, medical care accounts for only about 10% of our health status, while lifestyle, behavior, environmental and social and genetic factors account for the rest.

Public health programs address behavioral and social drivers of health by working to ensure physical and social environments that promote health and make it easier for people to make healthy choices. Public health programs complement and amplify investments in health care programs, By focusing on prevention, they have the potential to reduce the need for health care and ultimately, may help in containing health care costs. Public health also directly helps clinical healthcare providers, including Coordinated Care Organizations, adopt evidence-based best practices for the delivery of clinical preventive health services.

Program Description

The Public health mission is to promote health and prevent the leading causes of death, disease and injury in Oregon. In addition to addressing the drivers of chronic illness such as tobacco and obesity, and among other services, the divisionensures the safety of drinking water in public water systems, investigates disease outbreaks, responds to public health emergencies, licenses hospitals, andprovides services to prevent unintended pregnancies.These programs and services serve all people in Oregon.

The vision is lifelong health for all people in Oregon.To achieve this vision, Public Health has identified two main goals: 1) to make Oregon one of the healthiest states; and, 2) to transform the public health system in the state into a national model of excellence.

To make Oregon one of the healthiest states, Public Health is focusing on areas where there is the potential to make significant progress to improve the health of the population.Tobacco and obesity prevention have been prioritized. Public Health is directly working to achieve outcomes identified in the 10 year plan, including supporting the achievement of 100 percent tobacco-free state properties and in the implementation of a statewide nutrition policy for all state agencies and statewide nutrition standards in procurement contracts by 2015.

Other areas of focus include reducing the incidence of heart disease and stroke and increasing survivability of stroke patients; decreasing suicide (which kills more people than motor vehicle crashes in Oregon); preventing family violence, which causes a wide range of physical and mental health problems, and also is a major factor in the development of chronic disease later in life for children exposed to violence; and, increasing community resilience to public health emergencies.

To create a public health system that is a national model of excellence, Public Health is preparing for a time when nearly all people are covered by health insurance by developing its capacity to support Coordinated Care Organizations with technical assistance around prevention and community health assessment; carry out health impact assessments; achieve excellence in the assessment and monitoring of the health of the public through epidemiology and surveillance; and, collaborate with other state agencies to ensure that health is considered in policymaking across state government as appropriate.

OHA;s Public Health carries out population health assessment and assurance functions, and serves a vital link to services and supplies that keep people healthy and safe, providing Oregon with the backbone for a strong economy and education system.

OHA's Public Health works as a partner in a national system of local public health agencies, other state agencies, and federal partners. Partnerships with local public health, Coordinated Care Organizations, transportation, education, federal partners, and health care providers are essential to the work.

Program Justification and Link to 10-Year Outcome

These programs provide cost-effective ways to meet the goals in the 10-year Outcome Plan. Public Health programs fundamentally changing how health care is delivered, shift resources toward the prevention of chronic disease, and ensure access to sufficient, affordable, and nutritious food. Every successful public health program helps with key outcome measures. For example, the division issupporting the achievement of 100 percent tobacco-free state properties and the implementation of a statewide nutrition policy for all state agencies and statewide nutrition standards in procurement contracts by 2015. Public Health is designing strategies to decrease obesity among adults and children, and is actively engaged in measuring and increasing the percent of Oregonians consuming five or more servings of fruits and vegetables a day.

Program Performance

Public Health has a system of performance measurement and quality improvement to address its programs, including data related to the return on investment for many of these programs.Performance and return on investment data is available for the full range of public health programs, however, performance outcomes for key areas—tobacco, family planning, and epidemiology -- are listed below.

The Tobacco Prevention and Education program delivers community-based interventions to control tobacco. The program has averted $3.8 billion in future health care costs since 1997, a return of $45 for every dollar invested in the program.[i] As a result of theprogram,cigarette consumption has declined in Oregon from 92 packs per capita in 1996 to 47 packs per capita in 2011.[ii]

Family planning programhas served more than 100,000 clients per year for each of the past 5 years, providing free or low cost birth control options to men and women without other sources of coverage. The total savings from unintended births averted in 2011 was more than $28 million dollars for the State of Oregon and more than $81 million federal Medicaid dollars.The rate of teen pregnancy among women ages 15 to 17 in Oregon has dropped from 23.8 percent in 2004 to 22.4 percent in 2009.

Epidemiology and data collection are critical to Oregon's ability to measure the health status of its citizens, and to identify trends in infectious diseases, chronic diseases and injuries. This capacity is essential for policymakers and critical for tracking how well community prevention, Coordinated Care Organizations and other changes yet to come in the health system affect the health of the population.

Key areas of improvement:
Increasedfocus on reducing tobacco use and second-hand smoke exposure for low-income Oregonians and vulnerable populations.CDC and state data show that smoking rates for low-income Oregonians are substantially higher than the general population.

Obesity prevention and treatmentAccording to a Northwest Health Foundation study, between 1999 and 2005 one third of the increase in health care expenditures in Oregon can be attributed to the increased prevalence of obesity. Obesity rates have jumped 121 percent among adults since 1990. Today,more than 60% of Oregon adults are overweight or obese. Childhood obesity is a particular area of concern. The rate of overweight or obese youths rose from 22.3% in 2004 to 26.4% in 2009.

Enabling Legislation/Program Authorization

The Oregon Health Authority plays a central role in ensuring the health of all people in Oregon. The power and duty to promote and protect the public's health is reserved to the states under amendment X of the U.S. Constitution. Title 42, among other titles, of the US Code authorizes federal funding for numerous public health programs carried out at the state level. Chapters 431 and 433 of the Oregon Revised Statutes set forth hundreds of code sections enabling and mandating a wide range of public health activities carried out by Public Health Division and its county partners.

Funding Streams

For the 2011-2013 biennium, Public Health's budget is comprised of 10% General Fund, 66 % Federal Funds and 24% Other Funds, (excluding Women, Infants and Children's Program (WIC), Maternal Child Health Title V (MCH) and Babies First!, which are covered in separate bid forms.)For every dollar of General Fund invested in Public Health's budget that dollar yields approximately $43 dollars of Federal and Other Fund revenue for the State of Oregon.The federal revenue includes not only entitlement grants such as Medicaid (with 90-10 match for Contraceptive Care) but over 120 grants which are categorically dedicated to Public Health programs such as Emergency Preparedness and Hospital Preparedness Cancer Prevention and Control, and safe drinking water.

In addition, Public Health's Other Fund revenue sources include fees for activities in such areas as newborn screening tests (including test services for eight other states);licensing of facilities including Hospital and Special Inpatient Care Facilities; registration inspection and testing of X-ray equipment; testing and certification

of Emergency Medical Technicians; registration of medical marijuana card holders/growers;fees for issuing certified copies of vital records; and, statutorily dedicated funds to the Tobacco Use Reduction Account. Other fund fees are generally dedicated to entirely support the program which assesses the fee, except Medical Marijuana program funds which were legislatively approved to support additional programs.

Significant Proposed Program Changes from 2011-13

Public Health has carried out a statewide health assessment, developed a strategic plan, and is engaging in planning with partners to focus its work around the leading causes of disease, injury, and death in AY2013-15. Public Health has also reorganized its programs effective July 1, 2012 into three Centers—Center for Health Protection, Center for Prevention and Health Promotion, and a Center for Public Health Practice.

The Governor's Balanced Budget includes $342,498,031, which continues funding for Public Health programs at the current service level for 2013-15.

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[i] Inflation-adjusted to 2009 dollars. ROI estimates are based on 182,000 fewer adult smokers in Oregon since TPEP began. Since 1997, cigarette consumption in Oregon has tracked closely with TPEP funding. Health care savings accumulate over many years, as smokers' lifetime health care costs average $21,000 more than non-smokers (Hodgson, 1992).

[ii] Orzechowski and Walker (2011).

	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund	32,127,324	22,838,921	32,475,830	43,646,170	44,457,739	32,871,387	37,154,630	49,693,320	52,087,569	54,636,904	57,421,999
Other Funds	35,080,117	40,223,183	47,502,455	71,077,565	75,195,168	77,138,535	80,987,756	105,393,533	112,605,073	120,507,640	129,285,462
Federal Funds	115,041,777	149,744,197	158,606,109	146,441,307	187,659,404	207,086,693	224,355,645	232,757,710	246,750,141	261,830,559	278,465,947
Total Funds	182,249,218	212,806,301	238,584,394	261,165,042	307,312,312	317,096,615	342,498,031	387,844,563	411,442,783	436,975,103	465,173,408
Positions	486	502	560	586	668	625	618	618	618	618	618
FTE	453.40	478.67	538.44	556.38	621.82	617.65	641.35	641.35	641.35	641.35	641.35

Program Performance

Quantity Metric

Example: Biennial average number of students receiving grants

Quality Metric

Example: % of students graduating within 5 years

Timeliness Metric

Example: % of awards picked up within 2 weeks

Cost Per Unit Metric

Example: Biennial Average Award

	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund											
Lottery Funds											
Other Funds											
Other Funds - Nonlimited											
Federal Funds	8,893,110	9,083,141	9,187,910	8,577,897	8,062,065	8,326,371	8,326,371	8,797,811	9,307,949	9,855,432	10,458,186
Federal Funds - Nonlimited											
Total Funds	8,893,110	9,083,141	9,187,910	8,577,897	8,062,065	8,326,371	8,326,371	8,797,811	9,307,949	9,855,432	10,458,186
Positions	20	21	24	28	30	30	30	30	30	30	30
FTE	16.03	19.50	16.67	24.88	26.65	26.65	26.65	26.65	26.65	26.65	26.65

MCH Grant	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Performance											
Quantity Metric											
Number of births (Source: Center for Health Statistics) Two years added together.	91,104	91,125	91,565	98,057	96,305	89,752	89,000	89,000	89,000	89,000	89,000
Number of children ages 0-9 (Source: Or. Population Report, PSU). Two years added togeher	940,083	939,995	938,351	954,146	951,468	951,000	951,000	951,000	951,000	951,000	951,000
Number of adolescents ages 10-24 (Source: Or. Population Report, PSU). Two years added togeher	1,477,642	1,505,975	1,536,688	1,539,999	1,515,915	1,516,000	1,516,000	1,516,000	1,516,000	1,516,000	1,516,000
Quality Metric											
Infant mortality rate per 1000/ births. (Source: Center for Health Statistics); data is for odd-number years only.	5.3	5.8	5.6	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2

Percent of live births that are low birth weight (weighing 2500 grams or less). (Source: Center for Health Statistics); data is for odd-number years only.	6.1%	6.1%	6.1%	6.2%	6.2%	6.2%	6.1%	6.1%	6.1%	6.1%	6.1%
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (Source: Center for Health Statistics); data is for odd-number years only.	81.1%	81.0%	78.4%	71.3%	73.2%	75.0%	77.0%	80.0%	81.0%	82.0%	83.0%
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Polio, Diptheria, Tetanus, Pertusis, Haemophilius Influenza, and Hepatitis B. (4:3:1:3:3). Data is odd-number years only. (Source: Nat'l Immunization Survey; NOTE: NIS stopped reporting for series 43133 in 2008; starting in 2009, reporting is for only series 431331, addingVaricella vaccines to the series).	76.5%	72.9%	72.4%	64.8%	69.3%	73.0%	74.0%	75.0%	76.0%	77.0%	78.0%
Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (Source: Smile Survey, conducted every 5 years)	50.8%	50.8%	50.8%	42.7%	42.7%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%

Pregnancy rate per 1000 females ages 15-17. (Source: Center for Health Statistics); data is for odd-number years only.	26.4	24.2	25.7	22.5	16.6	16.2	15.8	15.4	15.0	14.6	14.2
Death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. (Source: Web-based Injury Statistics Query and Reporting System); data for odd number years only.	25.4	23.7	24.1	13.6	13.0	13.0	13.0	13.0	13.0	13.0	13.0

Timeliness Metric
Example: % of awards picked up within 2 weeks

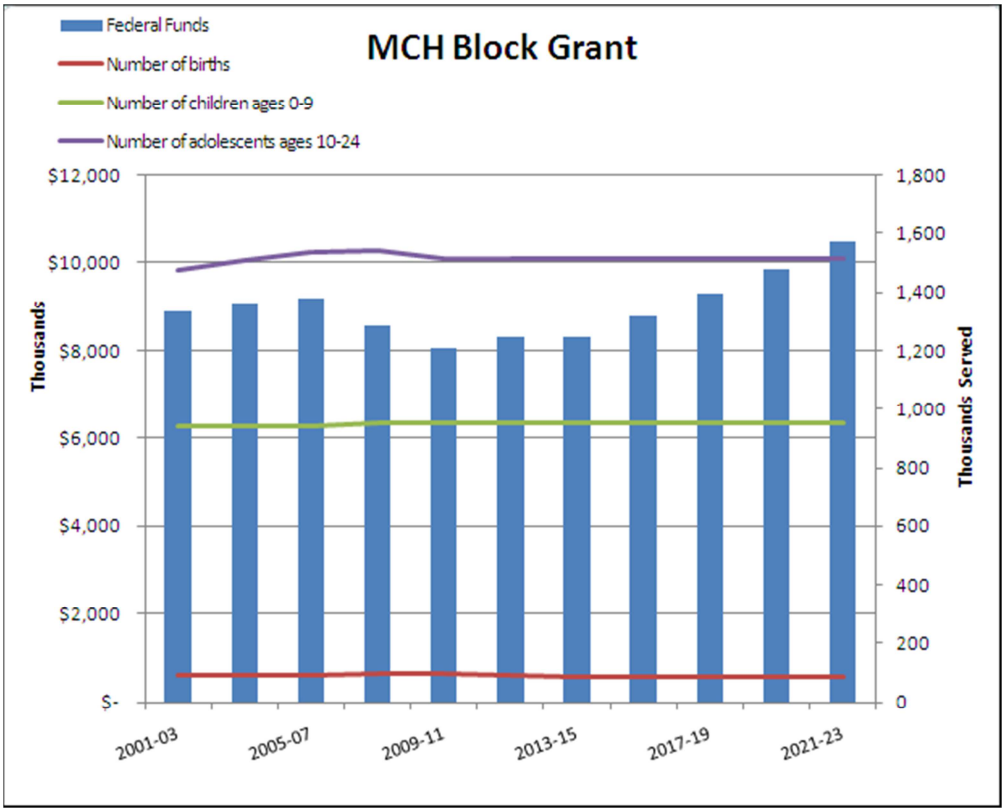
NOT APPLICABLE

Cost Per Unit Metric
Example: Biennial Average Award

NOT APPLICABLE

Oregon Health Authority: Public Health - Maternal and Child Health Block Grant

Primary Outcome Area:	Education
Secondary Outcome Area:	Healthy People
Program Contact:	Melvin A. Kohn, MD, MPH Director, Public Health Melvin.A.Kohn@state.or.us Phone: 971-673-1300



Executive Summary

The Title V Maternal, Child and Adolescent Health Federal Block Grant is a federal program that provides funding to states' lead health agencies to provide preventive and primary care health services for pregnant women, children, adolescents, and children and youth with special health needs. Activities include health needs assessments (for individuals or at a population health level), health outcomes, priority setting, and collaborative leadership in maternal and child health policy and program development, implementation and evaluation.

Program Description

In Oregon, the Title V MCH Block Grant partially funds a wide range of activities at the state and local level intended to develop, strengthen and evaluate state and local systems of care. Grant requirements include the following:

- At least 30% is earmarked for child and adolescent health prevention and health services;
- At least 30% is earmarked for health services for children with special health care needs;
- Any balance may be used to provide services and supports for any MCH population group.
- The State must match $3.00 state or local funds for every $4.00 of Title V funds
- MCH Block Grant Funds may not be transferred to other federal block grants.
- The grant must be administered by the lead state health agency.

Funds that support health services for children with special health care needs are required by Oregon law to be administered by Oregon Health and Sciences University.

There is a Maintenance of Effort (MOE) requirement, which public health meets by matching all non-federal revenue included in the county and tribal health department contracts from the OHA Public Health and in the Oregon Center for Children and Youth with Special Health needs.

Funds are used to monitor population-level maternal and child health outcomes; to fund technical assistance on health policies and evidence-based community practices related to maternal and child health needs, and to promote coordination of health and supporting services for women, children and adolescents. In addition these funds help support delivery of perinatal care; early childhood oral health; maternity case management for non-Medicaid pregnant women; early childhood home visiting, and teen pregnancy prevention. County health departments partner with a range of organizations in their communities to carry out this work.

Program Justification and Link to 10-Year Outcome

The Oregon Title V Program supports the Healthy People goal of prevention of chronic disease strategies as well as the 10 Year Education goal of *being ready for school* and *on track to earn a diploma*. Reduction in maternal depression and family violence promotes healthy infant attachment and experiencing safe, stable, and nurturing relationships, which impacts a child's ability to develop appropriate social, emotional and behavioral skills. Preventing early use of alcohol, obesity and dental cavities decreases subsequent development of chronic disease and school absenteeism, while positively impacting cognitive function and a child's ability to succeed in school. Providing parents and families the supports they need improves their ability to ensure their children's health and mental health needs are met, they are ready to learn at kindergarten and are successful throughout their school years.

Program Performance

Under federal law, the recipient of this grant must show progress related to 10 measures related to prevention:

1. ***Family violence –*** Screening and healthy relationship skill-building in preventive care visits in family planning clinics
2. ***Lifetime use of alcohol –*** Health prevention education and screening in adolescent well-visits by primary care providers
3. ***Maternal depression –*** Timely screening and referrals for pregnant and postpartum women
4. ***Early childhood oral health –*** Annual preventive dental visits for children under age four

5. ***Parent skills and education*** – Parenting resources and education to support young children's health, development, safety, and socio-emotional health
6. ***Healthy weight children and adolescents –*** Promote nutrition, physical activity, and reduced screen time to improve healthy weight among youth
7. ***Preventive health and mental health of adolescents –*** Promote strategies that increase access to periodic preventive health and mental health screening and services
8. ***Link Children with Special Health Needs to mental health services –*** Educate health providers and parents on effective navigation and referral of mental health services appropriate for children and youth with special health needs
9. ***Children and Youth with Special Health Needs access to special services –*** Promote policies that improve access to specialized health and related services for children and youth with special health needs in all geographic areas in the state
10. ***Family support services –*** Promote and develop policies and services for family-centered support for children and youth with special health needs

Three of the above measures (maternal depressions, early childhood oral health and lifetime use of alcohol) strongly link to a child's ability to be ready to learn upon kindergarten entry and succeed in school:

- Maternal depression impacts healthy mother-infant attachment, a driver in subsequent social, emotional and behavioral development. Nationally, 10 to20 percent of all women experience depression during pregnancy or in the first year postpartum. In Oregon, 24 percent of new mothers report they were depressed during, or after pregnancy. This rate has been consistent since we started measuring it in 2004.
- Childhood dental cavities affect a child's speech, eating habits, nutrition, communication, self-esteem and school performance. Cavities are a chronic health condition. From 2002 to 2007 Oregon's school children's oral health worsened in every major measurement. One in five school children now have cavities in seven or more teeth. Prevention must start during infancy. In 2009, 17.6 percent of Medicaid enrolled children ages birth to 48 months received preventive dental services.
- Youth who initiate alcohol use before age 14 are at four to five times greater risk for lifetime dependency. In 2009, approximately 80 percent of Oregon 11th graders who ever drank alcohol reported first drinking at age 14 or younger, compared to 57 percent in 2004. Thirty-one percent of 11th graders who first drank at 14 or younger reported binge drinking one to five days in the past month, compared to 23 percent of youth who first drank between 15 and 17. Fifteen percent of youth who first drank at 14 or younger reported drinking six to-19 days in the last month, compared to 6 percent of youth who first drank between 15 and 17.

Enabling Legislation/Program Authorization

Title 42 of the US Code authorizes the grant and 45 Code of Federal Regulations 96 lays out detail regarding its implementation. Chapters 431 and 433 of the Oregon Revised Statutes set out code sections enabling and mandating public health activities, including activities carried out under the grant.

Funding Streams

The Block Grant is a non-competitive, 100% federal funds grant, allocated to all U.S. States and Territories on an annual basis using a per capita funding formula.

Significant Proposed Program Changes from 2011-13

At this time, Public Health assumes that The MCH Block Grant will likely continue to be funded at the 2011–13 award level during 2013-15. Activities during 2013-15 will continue to focus on the systems, policies and programs that improve health outcomes for women, children, adolescents and families across Oregon. In fiscal years 2013-15, the State MCH Block Grant Office will establish partnerships with new Coordinated Care Organizations and their providers, as well as the Early Learning regional agencies. And the program will focus its work on the priority areas identified in the Public Health's strategic plan, and particularly those that improve educational outcomes.

The Governor's Balanced Budget includes funding at the anticipated grant award level for 2013-15 for the MCH Block Grant.

WIC Program

	2001-03	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15	2015-17	2017-19	2019-21	2021-23
Program Budget											
General Fund-Farmer's Marke	52,212	157,267	161,142	219,212	219,596	202,039	206,900	212,486	218,011	223,243	228,601
Lottery Funds	-	-	-	-	-	-	-	-	-	-	-
Other Funds	-	-	-	-	-	-	-	-	-	-	-
Other Funds - Nonlimited	27,361,262	27,385,390	31,931,072	38,384,054	33,313,520	40,000,000	40,000,000	40,000,000	40,000,000	40,000,000	40,000,000
Federal Funds-WIC Admin.	18,973,169	30,990,624	35,982,691	35,118,868	34,332,681	34,959,969	36,680,119	38,322,900	40,063,685	41,882,550	43,856,522
Federal Funds - Nonlimited	79,060,549	89,823,899	87,273,226	101,996,686	98,525,707	102,729,051	102,729,051	102,729,051	102,729,051	102,729,051	102,729,051
Total Funds	125,447,192	148,357,180	155,348,131	175,718,820	166,391,504	177,891,059	179,616,070	181,264,437	183,010,747	184,834,844	186,814,174
Positions	26	28	36	36	39	39	39	39	39	39	39
FTE	25	27	34	34	38	38	38	38	38	38	38
Program Performance											
Quantity Metric											
WIC Total Biennial Visits (unduplicated client data not available) Source: TWIST WIC Client data	2,322,187	2,435,140	2,479,923	2,654,978	2,708,085	2,789,328	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000
Pregnant or postpartum women	561,730	601,676	629,601	653,705	630,201	649,107	650,000	650,000	650,000	650,000	650,000
Infants or children under 5	1,760,457	1,833,464	1,850,322	2,001,273	2,077,884	2,140,221	2,150,000	2,150,000	2,150,000	2,150,000	2,150,000
Farm Direct Nutrition Participants - Biennial annual individuals	44,725	69,609	54,915	52,263	55,065	56,717	58,418	60,171	61,976	63,835	65,750
Quality Metric											
Percent of mother-infant pairs who initiate breastfeeding (Source: TWIST - WIC Program); data are combined 2 years.	Not available	Not available	90.30%	91.20%	91.60%	92.60%	93.60%	94.60%	94.60%	94.60%	94.60%

Percent of children with low hemoglobin/hematocrit (Source: TWIST - WIC Program); data are combined 2 years.	11.40%	11.30%	14.90%	14.10%	12.90%	12.90%	12.90%	12.90%	12.90%	12.90%	12.90%
Percent of women with a greater than ideal pregnancy weight gain (Source: TWIST - WIC Program); data are combined 2 years.	Not available	Not available	Not available	46.20%	50.50%	49.50%	48.50%	47.50%	46.50%	45.50%	44.50%
Timeliness Metric											
Example: % of awards picked up within 2 weeks	Not available										
Cost Per Unit Metric											
Example: Biennial Average Award	Not available										

Oregon Health Authority: Public Health – Women Infants & Children

Primary Outcome Area: Healthy People
Secondary Outcome Area:
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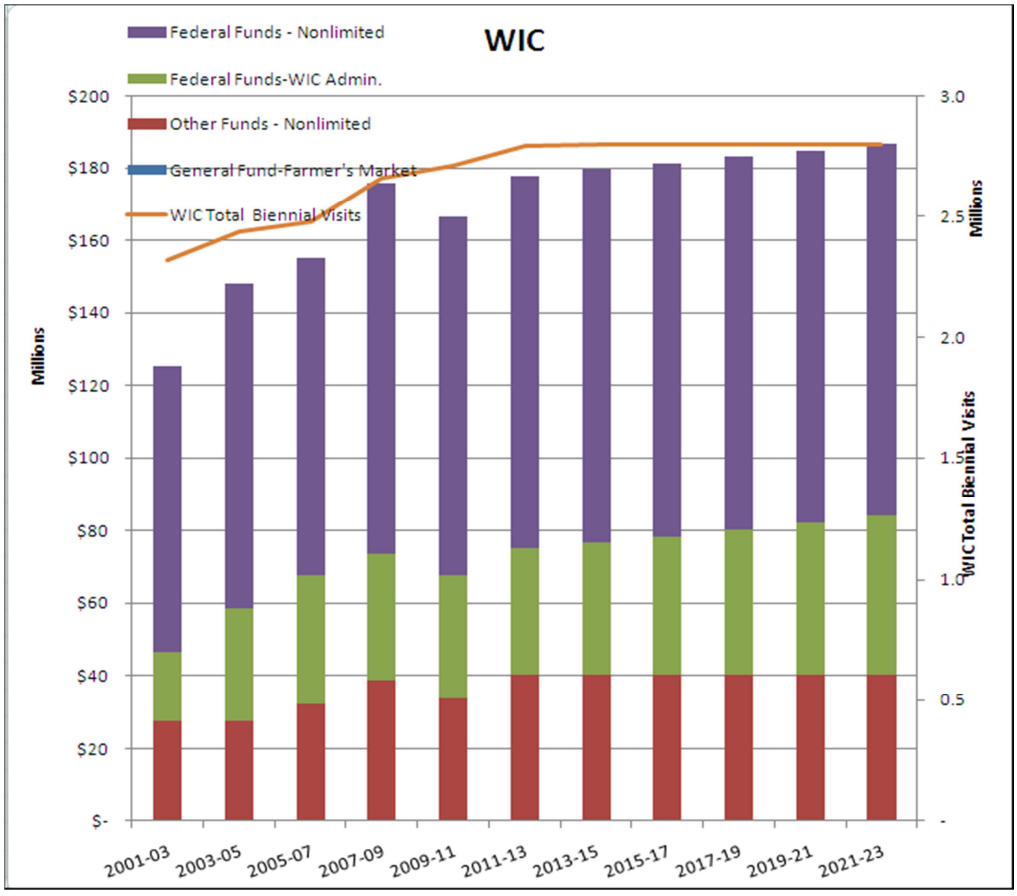

Executive Summary

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program provides vouchers for healthy foods for pregnant women, postpartum women and children under age 5 years in 106 clinic locations across Oregon. WIC visits also provide important assessments and referrals for a variety of health services for women and children, including screening for development delays, growth problems, anemia, family violence and substance abuse; nutrition education, and breastfeeding promotion and support. During 2012, Oregon WIC served 46% of women who gave birth in Oregon and 63% of women giving birth in rural counties. WIC funding comes almost entirely from the US Department of Agriculture, which has strict guidelines about which foods may be purchased with WIC vouchers and how USDA funds may be spent.

Program Description

WIC is a public health nutrition program designed to improve the nutritional health of low-income pregnant women and children. Eligibility criteria include: pregnant, postpartum or breastfeeding women, infants and children up to the age of five who have a health or nutrition risk as defined by United States Department of Agriculture (USDA);a household income of less than185 percent of federal poverty level; and live in Oregon. In December 2012, Oregon provided WIC benefits to 11,189 pregnant women, 15,117 postpartum and breastfeeding women, 23,723 infants and 63,502 children.

Participants receive program benefits at an initial visit where they are "certified," and afterwards must be seen at least quarterly and "recertified" according to a schedule required by USDA. At each certification visit a participant receives health screening, nutrition education and appropriate referrals as necessary. Visits include:

- Measurement of height and weight and calculation of BMI and assessment of growth patterns
- Blood sample taken to check for iron deficiency
- Health history and dietary screening to determine nutritional risk using nationally defined, evidence-based risk categories
- Individualized nutrition counseling; high-risk participants see a Registered Dietitian
- Immunization screening and referral
- Screening and referral (as needed) to domestic violence, alcohol, drug and/or tobacco intervention services
- Referral to Oregon Health Plan or Healthy Kids, prenatal care, patient-centered primary care homes

The largest cost driver for the WIC program is retail food costs: 73 percent of the WIC grant is spent on food. Contracted local agency program operations costs for 106 sites across the state account for most of the remaining budget impact.

A network of over 600 retail grocery stores and pharmacies are authorized to accept WIC vouchers from WIC participants. An additional 700 local farmers accept the Farm Direct Nutrition Program checks.WIC partners with hospitals, healthcare providers, Head Start, SNAP, and many non-profit agencies and other groups to conduct outreach to potentially eligible families and to provide referrals for needed services.

Program Justification and Link to 10-Year Outcome

The WIC Program supports Healthy People strategies 1 and 4: Shift resources to focus on prevention and ensuring access to nutritious food.WIC participation has been shown to reduce health care costs. For every dollar spent on a pregnant woman in WIC, up to $4.21 is saved in Medicaid for her and her newborn baby because WIC reduces the risk for preterm birth and low birth-weight babies by 25 percent and 44 percent, respectively. WIC also increases breastfeeding rates. Breastfeeding decreases a baby's risk of infections, diarrhea, Sudden Infant Death Syndrome (SIDS), childhood leukemia and chronic diseases such as obesity, diabetes, and asthma; and decreases a Mother's risk of breast and ovarian cancers and chronic diseases such as diabetes, high blood pressure, high cholesterol, and cardiovascular disease. Women on WIC breastfeed at a higher rate than income–eligible women who are not participating in WIC. WIC decreases the risk of developmental delays in young children. WIC has the most protective effect on children younger than 12 months of age, when their brains more than double in

size if the nutritional building blocks are provided. WIC improves the diet of families; positively influences the nutrient intakes of children; and the nutrition education leads to an increased consumption of whole grains, fruits and lower-fat milk among the entire family. WIC participation dramatically improves Healthy Eating Index scores for the household. WIC participation has also been shown to reduce the risk of child abuse or neglect.

Program Performance

In 2012, WIC served 49,798 pregnant or postpartum women, and 126,218 Oregon Children. The average monthly food benefit received by a participant was $51.90. Oregon scores better than the national average on most health indicators for the WIC child population. In particular, Oregon's rate of low birth weight, underweight, and iron deficiency anemia are significantly better (i.e. lower) than the national rates. Oregon is among the highest in the nation for the number of mothers who begin breastfeeding (91percent in Oregon vs. 62 percent nationally) and continue to nurse at six months and beyond (43 percent in Oregon vs. 27 percent nationally). Oregon also enjoys the smallest disparity between WIC mothers and non-WIC mothers in relation to breastfeeding. Nationally, the difference in breastfeeding initiation is about 20 percent, while in Oregon it is less than one percent. As breastfeeding is associated with a reduced risk of many negative health conditions for both mother and infant (e.g., ear infections, diabetes and breast cancer), Oregon WIC is focused on making breast milk the foundation of a baby's early preventive care.

Enabling Legislation/Program Authorization

Title 42, Section 1786, of the US Code authorizes federal funding for the WIC program, providing that "the Program shall serve as an adjunct to good health care during critical times of growth and development, in order to prevent the occurrence of health problems" and prohibiting any charge to participants in the program. Chapters 431 and 433 of the Oregon Revised Statutes set forth hundreds of code sections enabling and mandating public health activities, including WIC, and OAR 333-053-0030 to 0110, OAR 333-054-0000 through 0070, and OAR 333-052-0030 through 0110 set out the regulations that govern administration of the program in Oregon.

Funding Streams

The WIC Program is funded primarily by Federal Funds and Other Funds. The program has the following five primary funding streams: 1)WIC Food Funds – 100 percent Federal – discretionary (not entitlement) funding (does not require legislative approval to revise the amount); has no state match requirement; 2) WIC Infant Formula Rebates – 100 percent Other Fund – non limited –Rebates from infant formula manufacturers resulting from WIC Food Vouchers spent on formula; 3) WIC Administration – 100 percent Federal Funds for state and local agency operations, nutrition education and breastfeeding peer counseling; 4) WIC Farmer's Market – 100 percent Federal funds – requires 30 percent General Fund Match; and 5) General Fund – match only for administration of Farmer's Market and additional FDNP checks.

Significant Proposed Program Changes from 2011-13

Oregon WIC is actively involved in a system modernization project that will replace paper checks with Electronic Benefit Transfer (EBT) cards. This will increase the ease of shopping while decreasing stigma for participants, simplify and streamline the WIC transaction for the grocery retailers and provide the state office with detailed data on participants' food buying choices.

The Governor’s Balanced Budget includes $179,616,070, and continues funding for the WIC program at the current service level for 2013-15 ($139,409,170 FF, $206,900 GF, $40,000,000 OF).