Department of Human Services
2017 Joint Legislative Committee on Ways and Means
Reference Document
Index

2017-19 Governor's Recommended Budget (GRB)

Oregon Department of Human Services
Message from DHS Director Clyde Saiki

One of Oregon's greatest responsibilities is ensuring the health and well-being of her people, particularly for the most vulnerable populations. While the economy is rebounding, and the state's job growth and unemployment rate are outperforming the national average, there are still families being left behind in the recovery. Hours and wages reflect an uneven pace of recovery, particularly in rural Oregon. Access to affordable housing continues to be barrier statewide. The high cost of child care may prevent families from returning to work or puts undue economic burden on them. Hunger is still an issue for Oregon children and families. For young people, the transition from school to higher education or work is difficult, particularly for people with disabilities. Oregon has a higher rate of youth entering the foster care system and higher-than-average abuse while in foster care.

To address the multitude of issues families face, the state plays a major role in effective interventions with children, youth, and vulnerable adults and families that can prevent or reduce the impact of toxic stress and break the generational cycles of poverty, child abuse, drug and alcohol dependence, and domestic violence.

The mission of the Department of Human Services (DHS) is to help Oregonians in their own communities achieve safety, well-being and independence through services that protect, empower, respect choice and preserve dignity. DHS is responsible for the care of some of Oregon's most vulnerable citizens – children, youth, families, older adults and people with physical, intellectual and developmental disabilities. DHS is also responsible for serving Oregonians at times when they are most in need – when they have experienced abuse, when they are hungry, when they are homeless.

DHS's success in that effort depends upon nearly 8,000 employees across the state, as well as upon thousands of community and service delivery partners, all of whom are dedicated to supporting and improving the lives of Oregonians.

The agency works to achieve the following goals:

- Every Oregon child and youth in our care deserves to grow up safely -- with support for success in school;
- Every Oregon adult deserves to live in safety – free from abuse, neglect and financial exploitation;
- Every Oregonian has the right to live as independently as possible -- with dignity, choice and self-determination;
- Every Oregonian can work to the best of their abilities to contribute to their family and their community; and
- All Oregonians deserve efficient and effective services from DHS.

DHS maintains its commitment to safety, transparency, and improvements that use the state's resources efficiently and effectively. Every year, more than one million people rely on DHS services to meet their most basic needs, to be safe, to live as independently as possible, and to support their efforts to achieve economic independence.

The Governor's Budget for DHS maintains and enhances the Governor's commitments to achieving key outcomes for Oregonians while responsibly managing inflationary growth. Below is a summary of the key program investments proposed by the Governor to balance the DHS budget and meet the needs of Oregon's most vulnerable residents.

Investments in the **DHS Child Welfare Program** will help improve capacity to provide safe and permanent living environments for foster children of all ages. Child Welfare Programs serve children and families when children are subject to abuse and neglect. Child protection workers respond to all reports of child abuse/neglect. If a child cannot be safe at home, a foster care placement is made. Child Welfare has a renewed focus and energy around keeping children safe and reducing its foster care population, by implementing a system that prevents out-of-home placements and increases a timely and safe return to families. The Governor's Budget:

- Adds $7.7 million GF for new staff in Child Welfare. This investment supports additional case worker and screening positions to help ensure safety for children and youth who are victims of child abuse and neglect.
- Adds $4.1 million GF for rate increases for Behavioral Health Service Providers. This package is about child and youth safety as well as maintaining access to this essential part of the system serving Oregon's most needy children. Increases to the rate will help reduce pressure on these important providers as costs increase.
- Adds $7.9 million GF for rate increases for family foster care providers. Families coming forward to provide foster care has continued to diminish over the last 5 years in part due to the low reimbursement rates. Oregon is currently providing only 40-46% of the actual cost of care, and this increase will help Oregon recruit and retain foster families – providing safe, appropriate placements.
- Adds $6.9 million GF to support legal representation for case workers. This investment will provide DHS caseworkers with continuous representation which, in turn, will promote attorney-caseworker collaboration, improve caseworker job satisfaction and retention, avoid the risk for unlawful practice of law by case workers, and improve the overall efficiency and cost-effectiveness of the system.
- Continues funding for other core services in order to keep children and youth safe.

Investments in the **Intellectual and Developmental Disabilities Services** program (I/DD) will provide support across the lifespan to Oregonians. The I/DD program strives to support individuals with intellectual and developmental disabilities and their families within communities by promoting and providing services that are person-centered, self-directed, flexible, community inclusive, culturally appropriate, and supportive of the discovery and development of each individual's unique gifts, talents and abilities. As a result of the state's adoption of the Community First Choice Option (or K plan), an increased number of children and adults with I/DD are able to access Medicaid funded, community-based services to meet their needs, instead of having to meet crisis eligibility in order to access the appropriate level of support. The Governor had to make difficult choices in this section of the budget:

- Adds $22.3 million GF for rate increases for I/DD Direct Service Providers. This funding will increase safety for individuals with intellectual and developmental disabilities because providers will be better able to hire, train and retain adequate staff to meet individuals' needs and assure their health and safety.
- Continues to protect the eligibility requirements for individuals who qualify for assistance by funding anticipated increases in caseloads and cost per case, including GF backfill of changes in the federal match rate for certain grants.

Investments in the **Aging and People with Disabilities (APD) program** will assist a diverse population of older adults and people with physical disabilities to achieve well-being through opportunities for community living, employment, family support and long term services and supports that promote independence, choice and dignity. The program seeks to achieve the following goals: Ensure the safety and protection of the population we serve with a focus on prevention; Facilitate broad awareness of, and easy access to, services; Invest in preventive services to keep people independent, safe and healthy for longer periods of time; Provide person centered services and supports; and serve people in an equitable and culturally sensitive manner. The Governor also had to make difficult choices in this budget:

- Continues funding for Service Priority Levels 1-13. This investment will continue current Medicaid service levels for all clients.
- Protects current caseload and eligibility criteria.
- Supports a staffing level of a net 90.4 percent of the workload model by the end of the biennium, based on the fall 2016 caseload forecast.

Investments in the **Self-Sufficiency Program** help DHS meet the emotional and material needs of program participants, and ensure that every family has an educational or career pathway to economic security before leaving SSP. SSP is designed to provide low-income Oregonians with services to create stability and prepare participants for employment so they are equipped to work their way out of poverty. The programs emphasize the safety and healthy development of children, and often serve to prevent abuse or neglect that may lead to out-of-home placement in the more expensive foster care program. The Governor's Budget maintains current eligibility, timeline and benefit standards for Self-Sufficiency programs:

- Funds the Temporary Assistance for Needy Families time limit at 60 months. TANF is one of the most important programs for stabilizing families, assisting them in returning to work keeping children safely at home with families (and out of the child welfare system).
- Invests $20.5 million GF into the TANF re-investment initiative (started in 2015-17) under HB 3535. This is a package of policy and program changes to increase family engagement and stability.

The 2017-19 GRB investment for **Vocational Rehabilitation** is $114 million total funds ($27 million GF). These services assist Oregonians with disabilities to achieve and maintain employment and independence through a variety of services, and employees provide direct services through a network of local offices across Oregon.

Investments in **DHS Central and Shared Services** will support important programs that assist the Department of Human Services and the Oregon Health Authority, as well as other state programs. The Central Services program provides the leadership and business supports necessary to achieve the mission of the agency. The Governor's Budget:

- Adds $6.1 million General Fund (GF) to increase staffing for the Background Check Unit. The result of this investment will be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for Oregonians.
- Adds $9.5 million GF (not including debt service) for two important technology systems, Integrated Eligibility and Centralized Abuse Management. The Integrated Eligibility Project will automate eligibility for non-MAGI Medicaid, ERDC, SNAP and TANF -- modernizing parts of our systems and improving the ability for Oregonians to have a single process of applying for these benefits. The Centralized Abuse Management

System will replace a patchwork of haphazard solutions for records related to adult protective services, mental health investigations and more.
- Adds $10 million GF Special Purpose Appropriation funding for salaries for non-state employee bargaining

The Governor's Budget includes the following **program reductions** for the Department of Human Services:

- Eliminates the General Assistance program that was passed earlier in 2016 in HB 4042 - $1.9 million GF.
- Eliminates the Live-In Program in Aging and People with Disabilities as of 7/1/2017 - $20.8 million GF. The program will convert most clients to the in-home hourly program.
- Eliminates Oregon Project Independence for people with disabilities; in addition, it reduces the remainder of the program expenditures by 75% - $22 million GF total.
- Holds Nursing Facility rates at the 6/30/2017 level - $18.3 million GF.
- Implements a partial reduction (50%) in the complex medical add-on for nursing facilities - $6.6 million GF.
- Eliminates the Family to Family Network for I/DD - $1.3 million GF.
- Eliminates funding for Regional Programs for I/DD - $4.8 million GF.
- Expends $6 million in funding from the Fairview Housing Trust and makes a one-time investment in the DHS I/DD program's K-Plan services.
- Reduces Brokerage and Community Developmental Disabilities Programs (CDDP) equity funding from 95% to 91% - $3.5 million GF.
- Eliminates the Oregon Enterprise Data Analytics program - $1 million GF.
- Provides only flat funding for most Services and Supplies (eliminates inflation)
- Reduces DHS Personal Services funding by $7 million GF.
- Transfers some Information Technology Security positions to the Office of the State Chief Information Officer, based on the Governor's cyber security executive order - $0.4 million GF.

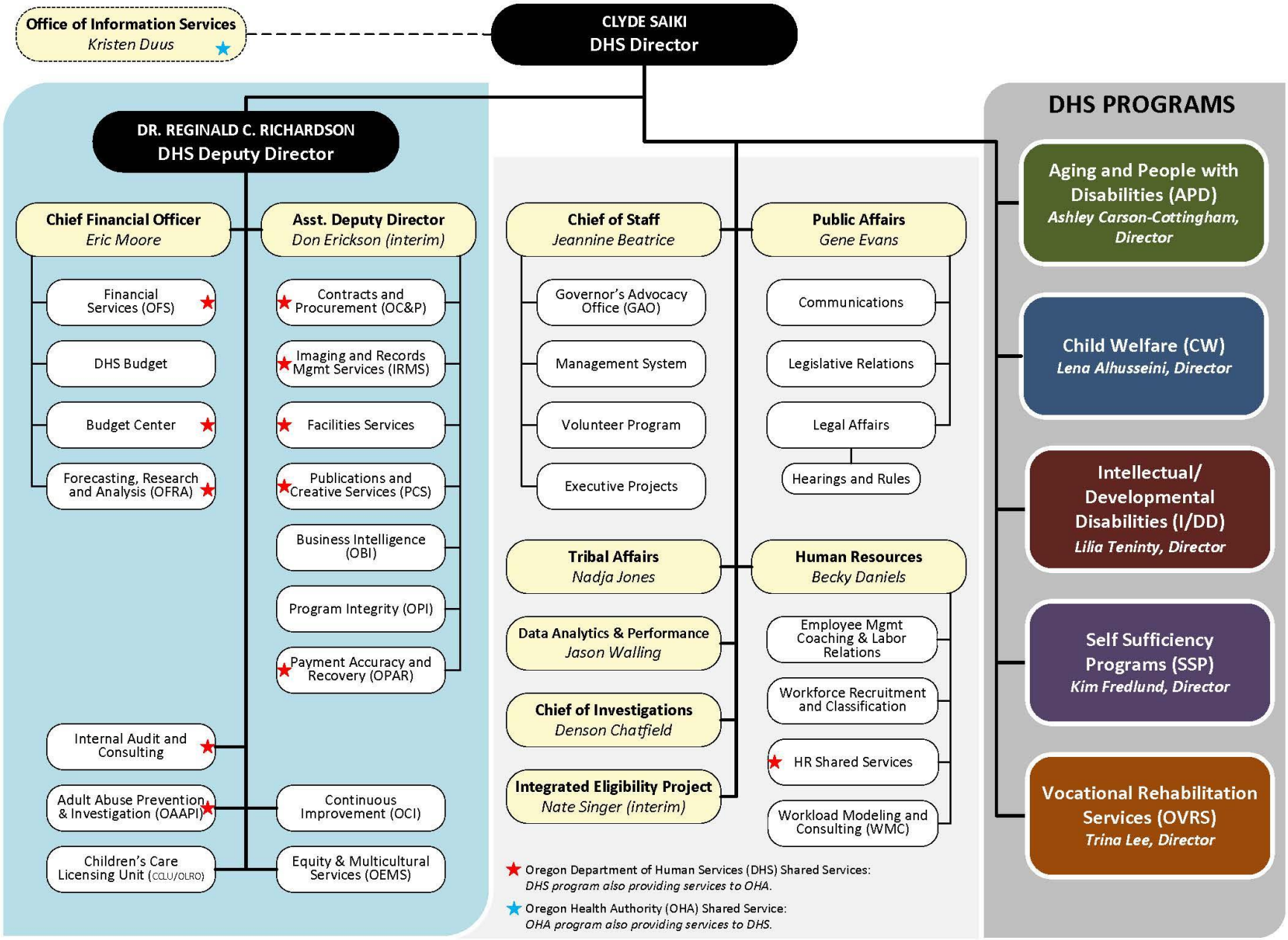
At the Oregon Department of Human Services, we are serious about our commitment to the clients and customers we serve, as well as our responsibility to be good stewards of taxpayer resources. Governor Brown's Recommended Budget provides investments that will help the agency to put our efforts into strategies that better anticipate and address the needs of the children, youth, families, vulnerable older adults, and people with disabilities we serve.

We look forward to the work ahead to better achieve our mission of safety, well-being and independence for all Oregonians. If you have questions about the GRB, please send them to communications.dhs@state.or.us.

Respectfully submitted.
Clyde Saiki, Director Department of Human Services.

OREGON DEPARTMENT OF HUMAN SERVICES - *Organizational Structure*

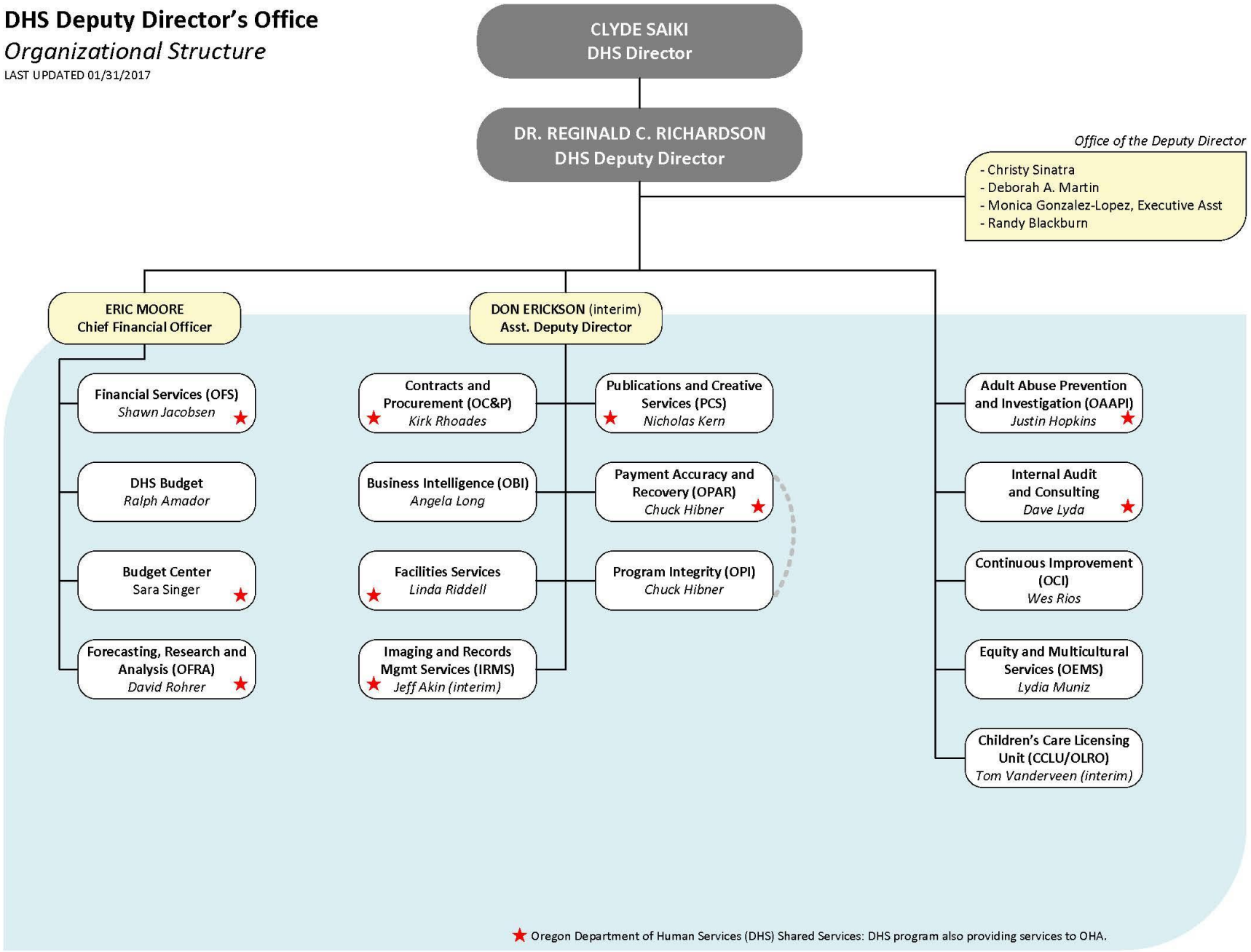
LAST UPDATED 01/31/2017



DHS Deputy Director's Office

Organizational Structure

LAST UPDATED 01/31/2017



Oregon Department of Human Services

Overview

The mission of the Department of Human Services (DHS) is to help Oregonians in their own communities achieve safety, well-being and independence through services that protect, empower, respect choice and preserve dignity. As described in more detail in the DHS Director's Letter the following DHS budget is based on the following guiding principles:

- Safety for Children and Vulnerable Adults
- Independence, Dignity, Choice and Self-Determination for Older Adults, People with Disabilities
- Reducing Families and Individuals in Poverty
- Employment for People with Disabilities, and
- Program Performance and Operational Efficiency and Effectiveness

Funding

The DHS Governor's Budget recommends an investment of $3.17 billion General Fund and $11.3 billion Total Funds for the 2017-19 biennium.

DHS TOTAL	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 2,778,650,152	$ 539,197,645	$ 7,318,100,627	$ 10,635,948,424	8,061	7,908.29
GB 17-19	$ 3,173,736,725	$ 554,442,828	$ 7,536,336,144	$ 11,264,515,697	8,294	8,076.56
Difference	$ 395,086,573	$ 15,245,183	$ 218,235,517	$ 628,567,273	233	168.27
Percent change	14.2%	2.8%	3.0%	5.9%	2.9%	2.1%

Major changes from LAB to GB are driven mainly by:

- Roll up of 15-17 investments
- Standard inflation though most inflation on S&S was removed
- Forecasted Cost per Case and Caseload changes including Child Welfare, state and AAA staffing
- Changes in Federal Fund Match Rates
- Investment in rate increases for certain providers
- Investments in two information technology projects
- Program reductions or flat funding in certain programs

Strategic Funding Investments and Reductions

The following investments and reductions are proposed in the DHS Governor's Budget:

DHS GB - POPS	GF	OF	FF	TF	Pos	FTE
TOTAL	**59,238,738**	**27,733,872**	**173,917,222**	**260,889,832**	**65**	**43.12**
102 - Centralized Abuse Management	1,920,186	2,207,072	215,911	4,343,169	4	2.83
105 - Stable and Competent Workforce	22,281,720	0	49,045,426	71,327,146	1	1.00
108 - Family Foster Care Rate	7,926,190	0	4,857,987	12,784,177	0	0.00
109 - BRS Rates	2,116,547	0	3,823,804	5,940,351	0	0.00
110 - Legal Representation in Child	6,916,041	0	12,957,561	19,873,602	0	0.00
201 - Integrated Eligibilty	11,959,788	18,275,000	101,794,707	132,029,495	38	28.29
205 - Background Check Unit Workload	6,118,266	7,251,800	1,221,826	14,591,892	22	11.00

Reduction Total	(154,228,624)	(10,440,713)	(118,099,073)	(282,768,410)	(2)	(115.37)
Use one time ReAllotment revenues to backfill CSL GF	(7,400,000)	0	7,400,000	0	0	0.00
1% Additional Vacancy Savings	(6,440,675)	(1,233,888)	(6,154,259)	(13,828,822)	0	0.00
Remove inflation from S&S	(3,045,922)	(1,198,069)	(3,842,276)	(8,086,267)	0	0.00
Disallowed Backfill for Federal Grants	(13,774,880)	0	0	(13,774,880)	0	0.00
Statewide Reduction to S&S	(5,314,639)	(603,356)	(5,248,419)	(11,166,414)	0	0.00
Staffing Workload Reduction CW Delivery	(6,400,817)	0	(4,393,470)	(10,794,287)	0	(67.00)
Reduce the complex medical add-on for nursing facilities by 50%. APD	(6,590,582)	(1,339,048)	(20,969,352)	(28,898,982)	0	0.00
Eliminate Live-in Program as of July 1 2017 - move consumers to Hourly program. APD	(20,061,806)	(300,000)	(38,565,539)	(58,927,345)	0	0.00
Equity Model Reduction APD Delivery	(9,680,044)	0	(6,581,512)	(16,261,556)	0	0.00
State Staffing Workload Reduction APD Delivery	0	0	0	0	0	0.00
Screening Positions CW Delivery	(6,846,675)	0	(1,706,686)	(8,553,361)	0	(45.50)
One time use of Fairview Housing Trust Fund of $6.0 million. I/DD	(6,000,000)	0	0	(6,000,000)	0	0.00
Remove General Assistance from financial services (HB4042). Shared	0	(125,194)	0	(125,194)	0	(0.87)
Remove General Assistance from financial services (HB4042). SAEC	(62,597)	0	0	(62,597)	0	0.00
Remove General Assistance (HB4042). APD Delivery	(225,590)	0	0	(225,590)	(2)	(2.00)
Remove General Assistance (HB4042). APD	(1,597,705)	(1,869,511)	0	(3,467,216)	0	0.00
Eliminate OPI for people with disabilities. APD	(6,000,000)	0	0	(6,000,000)	0	0.00
Reduce OPI by $10M. APD	(10,000,000)	0	0	(10,000,000)	0	0.00
Reduce OPI by another $6M. APD	(6,000,000)	0	0	(6,000,000)	0	0.00
Reduce the Family to Family Network Program I/DD	(642,940)	0	0	(642,940)	0	0.00
Eliminate the Family to Family Network Program I/DD	(642,940)	0	0	(642,940)	0	0.00
Eliminate Regional Staff I/DD	(4,788,406)	0	(3,315,737)	(8,104,143)	0	0.00
Hold nursing facility rates flat at the rate being reimbursed at 6/30/17. (281.08) APD	(18,345,151)	(3,706,229)	(39,719,103)	(61,770,483)	0	0.00
Reduce Brokerage and CDDP Equity by 2% (93% equity) I/DD	(1,748,708)	0	(1,938,550)	(3,687,258)	0	0.00
Reduce Brokerage and CDDP Equity by additional 2% (91% equity) I/DD	(1,748,708)	0	(1,938,550)	(3,687,258)	0	0.00
Statewide AG Reduction	(869,839)	(65,418)	(1,125,620)	(2,060,877)	0	0.00
TANF Contingency Reduction	(10,000,000)	0	10,000,000	0	0	0.00

Descriptions of each Policy Option Package (POP) and many reductions are included in the appropriate programs' budget narrative in the following sections of the DHS ARB document.

Conclusion

For the 17-19 biennium, the Governor's Budget is proposing a package of services that promote safety, wellness and the economy for some of Oregon's most vulnerable Oregonians. These investments will help DHS meet the needs of Oregonians in this period of change and growth.

Oregon Department of Human Services
Central and Shared Services,
State Assessments and Enterprise-wide Costs,
Program Design Services

Overview

DHS Central, Program Design Services (PDS), Shared Services, and State Assessments and Enterprise-wide Costs (SAEC) provide critical leadership and business supports necessary to achieve the mission of the agency: helping Oregonians achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity.

DHS Central, Program Design Services (PDS), Shared Services and SAEC budgets include:

- Payments to DAS and third parties for goods and services that serve the whole agency, such as facility rents, state data center charges, the DAS risk assessment, DAS government service charges, computer replacement, and debt service.

- Payments for DHS share of the cost of services shared with OHA. When the agency split, DHS and OHA agreed to share information technology, financial, investigations, and other services to avoid cost increases and permit a greater focus on improving performance and efficiency.

- The cost of the DHS/OHA shared services provided by DHS. These costs are entirely Other Funds, paid for by the payments described in above and similar payments in the OHA budget. From a Total Fund perspective, these costs are double-counted in the DHS and OHA budgets.

- The cost of DHS central budgets, including the Director, Governor's Ombudsmen, Legislative and communication support, budget, diversity, and human resources.

- Program Design Services employ professionals who specialize in tasks that help the five DHS programs design and implement programs to achieve the agency's outcomes These supporting tasks include:

- Measuring whether the programs are being implemented the way they are designed
- Measuring how well the outcomes are being achieved
- Conducting research on better ways to achieve the outcomes
- Reporting to our federal and other partners
- Working with IT developers to design better IT systems to support program implementation.
- Improving business processes in delivering services.

The DHS Central, Program Design Service and Shared Services budgets are structured and administered according to the following principles:

Control over major costs. DHS centrally manages many major costs. Some of these costs, like many DAS charges, are essentially fixed to the agency. Others, like facility rents, are managed centrally to control the costs. DHS also strongly supports and actively participates in statewide efforts to locate work across the enterprise and install performance management systems to perform administrative functions more efficiently and effectively.

Customer-driven shared services. When the agency split, DHS and OHA agreed to maintain many administrative functions as shared services to prevent cost increases, maintain centers of excellence, and preserve standards that help the agencies work together.

DHS and OHA govern their shared services through a joint committee composed of operational leaders of the two agencies. This approach ensures that shared services are prioritized and managed to support program needs. The board and its subgroups have established service level agreements and performance measures for each service, moved staff in and out of shared services to rationalize service delivery, and begun implementing more integrated systems to support the performance of all our employees.

Performance management system. DHS has implemented a performance management system containing the following key elements:

- A clear statement of the outcomes DHS must achieve.
- Descriptions of the processes DHS uses to achieve its outcomes.
- Measures of success for each outcome and process.
- Owners for each measure.
- A quarterly all-leadership review of progress on each measure and strategy.

DHS is now implementing the same system within each program and support service category and revisiting the management system to better align with the agency mission and goals. The system is contained in the Director's Office and is managed by the executive team.

Centralized infrastructure. Based on the process maps developed in the performance management system, DHS restructured into five programs - Child Welfare, Self Sufficiency, Developmental Disabilities, Aging and People with Disabilities, and Vocational Rehabilitation. The five programs were given the essential functions to design and implement their programs within the performance management system. DHS then centralized many support services that previously had been performed separately by each program. This was intended to create efficiencies, assigns clear accountability for the performance of support services, and allow targeted investments to improve performance. Better support services ultimately improve performance of all DHS employees and our providers. These centralized programs include Program Integrity, Business Intelligence, Licensing and Regulatory Oversight (OLRO), Continuous Improvement, and Information Technology Business Support Unit (ITBSU) offices. DHS is currently reviewing whether centralization of these services had the intended outcomes. Over the next few months some of these functions (like OLRO and ITBSU) will be returned to the programs if the intended outcomes were not achieved.

Best practices in installing performance management require specific skills - especially in project management, LEAN tools, data analysis, and professional development of managers. DHS has reallocated resources and used savings to make some of these investments, but it must increase these skills as much more needs to be done.

Oregon Department of Human Services
Central and Shared Services,
State Assessments and Enterprise-wide Costs,
Program Design Services

The Governor's Budget recommends the following funding for all of Central Services, Program Design (PDS), State Assessments and Enterprise-wide Costs (SAEC) and Shared services:

Central, PDS, Shared, SAEC	GF	OF	FF	TF	POS	FTE
LAB 17-19	$ 257,319,360	$ 175,484,159	$ 266,708,925	$ 699,512,444	1,025	986.07
GB 17-19	$ 278,071,892	$ 189,302,101	$ 326,503,642	$ 793,877,635	924	875.60
Difference	$ 20,752,532	$ 13,817,942	$ 59,794,717	$ 94,365,191	-101	-110.47
Percent change	8.1%	7.9%	22.4%	13.5%	-9.9%	-11.2%

Program Area	GF	OF	FF	TF	POS	FTE
Central	$ 19,339,624	$ 736,854	$ 17,945,143	$ 38,021,621	96	95.42
PDS	$ 31,200,622	$ 18,547,526	$ 111,882,768	$ 161,630,916	150	139.87
Shared	$ -	$ 132,344,051	$ -	$ 132,344,051	678	640.31
SAEC	$ 227,531,646	$ 37,673,670	$ 196,675,731	$ 461,881,047	0	0.00
TOTAL ARB	$ 278,071,892	$ 189,302,101	$ 326,503,642	$ 793,877,635	924	875.60

DHS Central Services

DHS Central Services consist of the Office of the Director and Policy, the Office of Equity and Multicultural Services (OEMS), the Office of Human Resources, the DHS Office of the Chief Financial Officer and the Office of Communications. These offices provide essential business supports to programs in achieving the department and programs mission, vision and outcomes.

The DHS GB request for Central Services is $19.3 million General Fund and $38.0 million Total Funds:

CENTRAL SERVICES	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 18,154,354	$ 715,144	$ 17,416,183	$ 36,285,681	96	95.42
GB 17-19	$ 19,339,624	$ 736,854	$ 17,945,143	$ 38,021,621	96	95.42
Difference	$ 1,185,270	$ 21,710	$ 528,960	$ 1,735,940	0	0.00
Percent change	6.5%	3.0%	3.0%	4.8%	0.0%	0.0%

Major changes from LAB to Governor's Budget include:

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**(890,763)**	**(28,304)**	**(534,916)**	**(1,453,983)**	**0**	**0.00**
1% Additional Vacancy Savings	(217,693)	(2,928)	(109,226)	(329,847)	0	0.00
Remove inflation from S&S	(97,830)	(15,858)	(248,035)	(361,723)	0	0.00
Disallowed Backfill for Federal Grants	(418,960)	0	0	(418,960)	0	0.00
Statewide Reduction to S&S	(107,555)	(7,558)	(122,230)	(237,343)	0	0.00
Statewide AG Reduction	(48,725)	(1,960)	(55,425)	(106,110)	0	0.00

Below is an overview of the offices within the Central Budget.

Office of the Director and Policy is responsible for overall leadership, policy development and administrative oversight for all programs, staff and offices in DHS. These functions are coordinated by the Chief of Staff with the Governor's Office, the Legislature, other state and federal agencies, partners and stakeholders, communities of color, local governments, advocacy and client groups, and the private sector.

The Chief of Staff also oversees the Governor's Advocacy Office (GAO) - This office handles client complaints related to DHS services. This office operates independently in the investigations performed and reports directly to the Governor by providing a quarterly report on the status of the complaints. The team in this office works closely with field and central office staff, program staff; the Governor's Office; key stakeholders; and the DHS Director's Office to successfully, equitably and respectfully reach a conclusion.

The DHS Director's Office is also home to Tribal Affairs. We are committed to a positive working relationship with the nine tribes in Oregon. Staff regularly holds meetings with tribal governments through tribal liaisons and continually strives to ensure these communities receive sufficient and appropriate human services.

The Office of Human Resources (HR) serves as a strategic partner to its customers in, providing proactive and comprehensive human resources services, in alignment with agency and program mission and goals. HR works closely with internal customers on Workforce Strategies that support agency and program needs and strategies, and building a healthy workplace culture of ongoing development and

feedback to ensure the agency has a diverse workforce with the right people with the right skills, training, and support to do their work, now and in the future. This office provides essential HR administrative functions and services for DHS and OHA, and supports organizational development and an improved common culture of leadership and engagement across both agencies, through background checks and fitness determinations; personnel records management; leave administration; centralized position administration; safety and risk response and management; staff and management training.

The DHS Public Affairs Office is made up of three work units: Communications, Legislative, and Legal. The office provides DHS with unified support and coordination in outreach and communication, legislative action and strategy:

- Communications Unit - This office supports the mission by providing accurate information to a diversity of 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. Effective communication is the primary vehicle to demonstrate public transparency, accountability, and trust. The office also provides support to the department's priority projects as defined by the DHS Director and executive team.

- Legislative Unit - This unit handles all legislative matters for DHS. This team coordinates all DHS legislative matters with legislative offices, key stakeholders and the Governor's Office. This team supports both field and central office staff providing consultation and support in legislative matters, primarily working with central office staff on policy development for program services. During a legislative session, this unit tracks and assigns all bills related to DHS program and operations. Staff in this unit support the director of DHS, the directors of all program and operations in DHS and the district managers in field offices regarding legislative matters.

- Legal Unit - This Unit manages all lawsuits, tort claims and subpoenas related to DHS program and operations. Staff in this unit provide expert consultation to DHS field and central office staff, Department of Justice (DOJ) and Department of Administrative Services (DAS) Risk Management in policy related to legal matters. This team ensures timely completion of the required judicial documents to move smoothly through a complicated legal matter.

  Hearing and Rules Unit supports all DHS field office and central office programs by managing administrative rules and administrative hearings. This unit provides expert technical support to hearing representatives in DHS field services and liaison to the Office of Administrative Hearings and DOJ regarding DHS notices, hearing requests, and contested case hearings. This unit provides expert technical support to program staff writing rules and rule-related documents and handles rule filing and the public comment process for DHS programs. The Rules Coordinator advises, consults, leads, coordinates and trains staff in drafting, interpreting, defining and developing the intent and scope of administrative rules. In addition, the rules coordinator monitors and reviews contested case orders, trains hearing representatives, assists with legal issues and acts as liaison with the Office of Administrative Hearings to discuss performance measures.

Office of the Deputy Director – Agency Operations - is responsible for Shared Services such as Internal Audits, Business Intelligence, Licensing and Regulatory Oversight, Continuous Improvement, Information Technology (IT) Business Supports, Adult Abuse Prevention and Investigations, Program Integrity, Office of Payment Accuracy and Recovery, and the Chief Financial Officer.

Office of the Chief Financial Officer (OCFO) provides optimal business services to ensure accountability, data driven decisions, and stewardship of resources in support of the mission of DHS. This is done by working closely with DHS and OHA programs and the OHA Chief Financial Officer, to ensure accurate, timely and efficient recording and management of financial resources; culturally

competent and equitable services; authorizing the redistribution of available resources to meet changing needs; and establishing administrative controls.

The Office of Equity and Multicultural Services (OEMS) supports the mission of DHS by providing leadership and direction in supporting equity, diversity and inclusion initiatives throughout the agency. OEMS guides systemic changes to both internal workforce developments as well as improve service delivery to all Oregonians. The office also investigates all claims of discrimination and harassment by staff. The goals of the office include reducing service disparities; ensuring a diverse and culturally competent workforce; removing barriers to a welcoming work environment; and improving life outcomes for all DHS clients. OEMS also provides support to the department's priority projects as defined by the DHS director and Cabinet.

Program Design Services (PDS)

The PDS budget for 2017-19 GB is $31.2 million General Fund and $161.6 million Total Funds.

Program Design Services	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 31,368,970	$ 8,007,985	$ 77,765,397	$ 117,142,352	270	250.70
GB 17-19	$ 31,200,622	$ 18,547,526	$ 111,882,768	$ 161,630,916	150	139.87
Difference	$ (168,348)	$ 10,539,541	$ 34,117,371	$ 44,488,564	(120)	(110.83)
Percent change	-0.5%	131.6%	43.9%	38.0%	-44.4%	(0.44)

Major changes between LAB and CSL include:

GB Build - POPS	GF	OF	FF	TF	POS	FTE
TOTAL	7,678,161	18,275,000	101,862,673	127,815,834	39	28.87
102 - Centralized Abuse	68,192	0	67,966	136,158	1	0.58
201 - Integrated Eligibilty	7,609,969	18,275,000	101,794,707	127,679,676	38	28.29

102 Centralized Abuse Management System

House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents

of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations.

This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability to achieve the capabilities and efficiencies of the proposed integrated solution. The Other Funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one-time request for limitation. The General Fund is the best current estimate of costs of the ongoing operations and maintenance of the new system.

201 Integrated Eligibility Project
DHS is seeking continued legislative approval for a project that would transfer human service eligibility determination functionality from Kentucky to add to the new integrated OregONEligibility system. This will impact eligibility for Non-MAGI Medicaid, ERDC, SNAP and TANF programs.

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	(734,535)	(6,602)	(523,747)	(1,264,884)	0	0.00
1% Additional Vacancy Savings	(307,507)	(2,125)	(220,097)	(529,729)	0	0.00
Remove inflation from S&S	(204,606)	(3,189)	(211,002)	(418,797)	0	0.00
Disallowed Backfill for Federal Grants	(128,597)	0	0	(128,597)	0	0.00
Statewide Reduction to S&S	(93,825)	(1,288)	(92,648)	(187,761)	0	0.00

Overview of Program Design Services

Office of Program Integrity (OPI) conducts analysis and tests to determine whether DHS is implementing programs in the way they were designed and trains

caseworkers based on their findings to improve program integrity. The Quality Control Unit conducts operational and case reviews, many mandated by state and federal law, to determine how accurately each program is making eligibility and other determinations. The Quality Assurance Unit and CMS Waiver Group conducts field reviews to assess program quality.

The *Office of Business Intelligence (OBI)* compiles reports and conducts research to determine whether DHS programs are achieving their goals and desired outcomes. OBI specializes in managing data to ensure it is accurate, consistent, and useful to programs in assessing their success and making decisions to alter their program design. One important part of this role is managing the agency scorecard of outcome and process measures. OBI also conducts professional research requested by programs to give them a more rigorous foundation for their program design.

IT Business Supports (ITBSU) is a bridge between IT technical staff and program staff. Its mission is to help IT technical staff understand program needs so they can construct applications that better support the program, to improve program business processes to maximize the benefits of technology, and to integrate system implications into consideration of program policy changes. This mission requires staff who understand IT systems and language as well as program business processes. ITBSU also directly supports users of DHS systems (many of whom are county and other non-DHS staff) with issues particular to DHS program.

ITBSU's major project is the DHS Integrated Eligibility project – an agency strategy to improve program processes and IT systems to give the agency the ability to: (1) engage with clients in the way that maximizes our ability to help them achieve safety, health and self-sufficiency; (2) support caseworkers with information and tools that allow them determine how to best assist the client and that minimizes their need to perform administrative tasks; and (3) improve the efficiency of DHS operations.

ITBSU is also under review as a centralized service. Based on recent structural reviews of DHS ITBSU will be partially moved back to the programs each unit

supports leaving just enterprise project staff in ITBSU. This will allow greater accountability to the programs for program related work.

The *Office of Continuous Improvement (OCI)* helps DHS units implement the Lean Daily Management System and conduct business process improvement events. OCI employs project managers and people skilled in Lean tools that assist units in making high-priority process improvements and building their own Lean capacity.

The *Office of Licensing and Regulatory Oversight (OLRO)* licenses many providers of residential care to children, the aging and physically disabled, and people with developmental disabilities. These providers range across the continuum of care and serve clients of multiple DHS programs and other agencies as well as private persons. Through diligent oversight, investigation of complaints and reports of potential abuse, and corrective action, OLRO reduces future instances of unsafe conditions and improves the quality of care. These services are most effective when they are provided in a quality and prevention model aimed at preventing harm in the first place to protect the safety and health of vulnerable Oregonians. In the GB functions of OLRO are being placed back into program where the accountability for the function lies. In this budget only the Child Welfare related staff are left in OLRO. However, those positions will at some point be moved into Child Welfare likely after the review of that system has been completed.

The providers licensed by OLRO, and now program staff, include adult foster homes, assisted living facilities, residential care facilities, nursing homes, supported living and employment programs for people with developmental disabilities, and private child care agency licensing.

DHS Shared Services

DHS Shared Services supports both DHS and OHA by providing optimal business services to ensure accountability, data driven decisions, and stewardship of resources. Shared Services are completely Other Funded and provide services to both DHS and OHA. Funding for Shared Services is included in the Shared

Services Funding portion of the State Assessments and Enterprise-wide Costs (SAEC) budget.

SHARED SERVICES	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ -	$ 127,867,811	$ -	$ 127,867,811	659	639.95
GB 17-19	$ -	$ 132,344,051	$ -	$ 132,344,051	678	640.31
Difference	$ -	$ 4,476,240	$ -	$ 4,476,240	19	0.36
Percent change	0.0%	3.5%	0.0%	3.5%	2.9%	0.1%

Major changes between LAB and CSL include:

GB Build - POPS	GF	OF	FF	TF	POS	FTE
102 - Centralized Abuse Management System	-	157,072	-	157,072	1	0.75
205 - Background Check Unit Workload	-	7,251,800	-	7,251,800	22	11.00

In some cases the shared service investment is only part of the larger POP with the remainder in other program areas.

102 Centralized Abuse Management System
House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations. This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability to achieve the capabilities and efficiencies of the proposed integrated solution. The Other Funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one time request for

limitation. The General Fund is the best current estimate of costs of the ongoing operations and maintenance of the new system.

205 Background Check Unit Workload

Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines for background checks. Groups for whom BCU completes checks include but are not limited to home care workers, personal support workers, subsidized child care providers, child caring agencies, System of Care and SPRF providers, and staff and volunteers from residential care, nursing, and adult foster home facilities. The staff requested in this policy option package would meet currently required needs to maintain timely background checks for all regulated groups handled by BCU, and meet projected needs due to program growth and new federal and state statutes implementing during the 2017-2019 biennium. The result would be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for vulnerable Oregonians through quality background checks. In addition, Department of Human Services (DHS) has identified a variety of expansion options to current background check criteria for DHS and OHA providers whose fitness determination is completed by the Background Check Unit (BCU). These options would provide more intensive background checks by accessing a variety of DHS, state and federal information regarding health, safety, abuse and fraud not currently utilized. The result would be increased health, safety and financial wellness for vulnerable Oregonians. The BCU has authority to charge fees but does not currently do so. A fee for service model is an option to cover some or all costs of the BCU. There is a corresponding POP in the OHA budget for this investment.

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**0**	**(4,123,540)**	**0**	**(4,123,540)**	**0**	**-10.44**
1% Additional Vacancy Savings	0	(1,180,774)	0	(1,180,774)	0	0.00
Remove inflation from S&S	0	(327,680)	0	(327,680)	0	0.00
Statewide Reduction to S&S	0	(173,947)	0	(173,947)	0	0.00
Remove General Assistance from financial	0	(125,194)	0	(125,194)	0	-0.87
Statewide AG Reduction	0	(62,607)	0	(62,607)	0	0.00
Eliminate Oregon Enterprise Data Analitics unit	0	(2,253,338)	0	(2,253,338)	0	-9.57

Overview of Shared Services

DHS Shared Services contains the following key offices and programs:

Shared Services Administration provides leadership and direction for shared services offices as well as managing the business continuity planning efforts for both DHS and OHA.

The Budget Center provides program and administrative budget planning, financial analysis and technical budget support for DHS and OHA. These services are provided for department leadership, program, policy and field managers, staff and external policymakers.

The Office of Forecasting, Research and Analysis provides an independent, externally reviewed, forecast of the usage of DHS and OHA programs used for budget forecasts and legislative decision-making. OFRA also creates an integrated client dataset across programs to facilitate research on the combined effects of DHS and OHA programs. Additionally, OFRA houses the Office of Enterprise Data Analytics (OEDA) which conducts inter-agency research and advanced statistical modeling to answer cross agency operational questions.

The Office of Financial Services provides accounting services, administers employee benefits and payroll, prepares financial reports, and collects funds owed to DHS and OHA. This office provides accurate, accountable and responsive financial management and business services to DHS and OHA clients, providers, vendors, stakeholders and employees in support of both agencies' missions and in compliance with state laws and federal policies, rules and regulations.

The Office of Human Resources provides essential HR administrative functions and services for DHS and OHA, and supports organizational development and an improved common culture of leadership and engagement across both agencies, through background checks and fitness determinations; personnel records management; leave administration; centralized position administration; safety and risk response and management; staff and management training; facilitation services and LDMS coaching; HR data analysis and reporting; HR policy administration; and internal communication strategies and resources for managers and staff.

The Office of Facilities Management manages 2.7 million square feet of leased property for OHA and DHS statewide, including managing maintenance, remodeling, furniture acquisition and reconfiguration, staff relocations, coordination with DAS and state brokers on lease negotiations, and analysis of the costs and benefits of space utilization, ADA compliance, and energy conservation. OFM also oversees 1300 vehicles used by OHA and DHS staff around the state.

The Office of Imaging and Records Management provides document and records management services for DHS and OHA through imaging, electronic workflow, data entry, archiving and retention services.

The Office of Contracts and Procurement provides contract and procurement services for DHS and OHA by making purchases, conducting solicitations, and preparing and processing contracts with other government agencies, businesses and service providers.

The Office of Adult Abuse Prevention and Investigation conducts and oversees statewide protective services investigations of abuse and neglect, provides technical assistance to community-based mental health and developmental disability programs, and delivers training on investigations and abuse prevention services for DHS and OHA.

The Internal Audit and Consulting conducts independent audits on OHA and DHS programs identified in the agencies' risk assessment and audit plan and coordinates the agencies' engagement in and responses to external audits. The Secretary of State

and federal agencies conduct 30-50 external audits and reviews of DHS/OHA programs each year.

The Office of Payment Accuracy and Recovery provides recovery services for DHS and OHA by identifying and recovering moneys paid in error to clients or providers; investigates allegations of fraudulent activities; investigates and recovers state funds expended for services when a third party should have covered the service and the recovery of claims made by a client; and recovers funds from the estates of Medicaid recipients for the cost of cash and medical benefits provided.

State Assessments and Enterprise-wide Costs (SAEC)

This budget includes the DAS, ETS, Risk Management and other assessments, debt service, and the DHS rent, computer replacement and shared services funding budgets. The GB for SAEC is $227.5 million General Fund and $461.9 million Total Funds.

SAEC	GF	OF	FF	TF
LAB 15-17	$ 207,796,036	$ 38,893,219	$ 171,527,345	$ 418,216,600
GB 17-19	$ 227,531,646	$ 37,673,670	$ 196,675,731	$ 461,881,047
Difference	$ 19,735,610	$ (1,219,549)	$ 25,148,386	$ 43,664,447
Percent change	9.5%	-3.1%	14.7%	10.4%

Note: There are no positions or FTE in the SAEC budget.

Major changes between LAB and CSL include:

GB - POPS	GF	OF	FF	TF	POS	FTE
TOTAL	**10,625,157**	**0**	**1,221,826**	**11,846,983**	**0**	**0.00**
102 - Centralized Abuse Management System	157,072	0	0	157,072	0	0.00
201 - Integrated Eligibilty	4,349,819	0	0	4,349,819	0	0.00
205 - Background Check Unit Workload	6,118,266	0	1,221,826	7,340,092	0	0.00

In general these POPs are in other program areas and the costs included above are for the rent and other assessment costs attached to employee costs in the program area. For the 200 series POPS this includes the funding for the shared services POPs described above.

This budget does not fund the backfill of Federal Funds with General Funds for performance audits performed by the Secretary of State. The federal government will not pay for performance (as opposed to compliance) audits. The Secretary of State has stated that 49% of their audits are performance audits. At the time of this document they are still in discussion with the federal government to determine what percentage of their work is considered performance audits. This means these audits can only be paid for by General Fund and we can no longer bill performance audits to the federal government. This means the Governor's budget for DHS does not include funding for performance audits done by the Secretary of State. One option is for SOS to no longer do performance audits on DHS and lower their price list of costs to DHS. Another option is to fund the Secretary of State directly for performance audits. The final option is to backfill the GF DHS will need to comply with the federal policy on performance audits. Because the percentage of performance audits is still in question the amount necessary to fund SOS performance audits of DHS may need to change once the federal government agrees with the SOS proposed allocation of costs to performance audits.

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**(8,395,452)**	**(76,758)**	**(4,595,006)**	**(13,067,216)**	**0**	**0.00**
1% Additional Vacancy Savings	(426,365)	0	0	(426,365)	0	0.00
Remove inflation from S&S	(613,066)	(11,110)	(592,709)	(1,216,885)	0	0.00
Disallowed Backfill for Federal Grants	(2,770,443)	0	0	(2,770,443)	0	0.00
Statewide Reduction to S&S	(3,555,686)	(35,935)	(3,260,888)	(6,852,509)	0	0.00
Remove General Assistance from financial services (HB4042).	(62,597)	0	0	(62,597)	0	0.00
Statewide AG Reduction	(4,993)	(94)	(4,385)	(9,472)	0	0.00
Eliminate Oregon Enterprise Data Analitics unit	(962,302)	(29,619)	(737,024)	(1,728,945)	0	0.00

Oregon Department of Human Services
Self Sufficiency Programs

Overview

Oregonians access self-sufficiency services when they are in need and have no other alternatives. From all corners of the state, we served over one million Oregonians last year through our Supplemental Nutrition Assistance Program (SNAP). Most Oregonians seeking assistance need help meeting a variety of needs such as nutritious food – over 700,000 just this month – or basic needs such as shelter and utilities costs in addition to basic household supplies such as toothpaste, bedding, and other basic hygiene needs through cash assistance for families with children living in extreme poverty, or assistance with quality child care so parents can remain employed and maintain a path of financial stability. Programs also help low-income families impacted by domestic violence or refugees seeking a safe area to live. Some programs require participation in employment services or job training to help them move to supporting themselves and their families. Families can also receive help to apply for other federal programs (SSI) if employment is not a viable option due to a severe disability.

Challenges

When adequately resourced, staff delivering these programs help break the cycle of poverty and help Oregonians transition to jobs. This keeps families safe and stable, supporting the healthy development of young children. Unfortunately, with program reductions, an economic recession that triggered a dramatic increase in demand for services from Oregonians, and a slow economic recovery, these programs have been significantly challenged to achieve results. Additionally, caseloads remain high especially in SNAP.

Staff at the state and local levels continue to collaborate and build upon existing agency and community partnerships in order to help families find the resources and services they need. There is also a need, and an opportunity, to connect with the multiple redesigns of state systems (Workforce, Early Learning and Health) that touch or should touch families served by the DHS self-sufficiency programs. In particular, the economy is recovering slowly and unevenly creating challenges for people throughout the state to have access to jobs that build a path to self-sufficiency.

Seeking Self-Sufficiency

These programs are designed to help break the cycle of poverty, help Oregonians transition to jobs, support the healthy development of young children and help

keep families stable, preventing children from being abused or neglected and from requiring out-of-home placement in more expensive foster care.

In 2015 the Legislature passed HB 3535 and DHS' budget, which, taken together, authorized the Temporary Assistance for Needy Families (TANF) Reinvestment. These two legislative actions—House Bill 3535 and DHS' approved budget—produced a combination of policy and practice changes toward improved outcomes for children and families.

The TANF program has reinvested funds into efforts that maximize the dollars for benefits that are targeted at building participant progression in work related activities, identifying and building on skills and leveraging community collaborations to provide solid foundations that lead not only to employment placement but retention and advancement. The TANF reinvestment work focused in the following four key areas:

- Benefits Cliff – reduce number of participants affected by immediate loss of benefits when they become employed by raising TANF exit income limits, allowing for a three month reduced subsidized child care copay, and providing three months of transitional cash benefits.
- Time Limits – align the state TANF time clock with the federal TANF time clock and review extensions, which allow families who have reached the 60-month limit to remain on TANF.
- Re-Engagement – focus on opportunities for flexibility in the re-engagement processes including good cause, sanction levels, training, and statewide consistency.
- Community Collaborative Impact - develop pilot contracts, which allow community resources not currently provided within the TANF program to be utilized, focusing on the ability to provide ongoing family stability, job retention and prevention of TANF re-entry.

For the 17-19 biennium we plan to continue all the program improvements except for the pilot contracts; the pilot contracts will be evaluated based on effective outcomes in order to inform future service planning.

Oregon Department of Human Services
Self Sufficiency Programs

The proposed Self Sufficiency Governor's Budget is $441.2 million General Fund and $3.18 billion Total Funds primarily driven by SNAP benefits which are 100% Federal Funds.

SELF SUFFICIENCY	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 375,351,073	$ 99,873,152	$ 2,958,702,139	$ 3,433,926,364	2044	2035.49
GB 17-19	$ 441,153,001	$ 91,060,426	$ 2,646,145,265	$ 3,178,358,692	2046	2045.63
Difference	$ 65,801,928	$ (8,812,726)	$ (312,556,874)	$ (255,567,672)	2	10.14
Percent change	17.5%	-8.8%	-10.6%	-7.4%	0.10%	0.50%

Major changes from LAB to GB are driven mainly by:

- Backfilling $34 million in one-time revenues from 2015-17
- Phase in of investments from 2015-17
- Reduction of forecasted SNAP expenditures which are 100% Federal Funds

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**(12,179,236)**	**(11,914)**	**6,935,639**	**(5,255,511)**	0	0.00
1% Additional Vacancy Savings	(1,015,971)	(7,294)	(1,297,633)	(2,320,898)	0	0.00
Remove inflation from S&S	(778,849)	0	(1,203,803)	(1,982,652)	0	0.00
Statewide Reduction to S&S	(372,894)	(4,620)	(562,925)	(940,439)	0	0.00
Statewide AG Reduction	(11,522)	0	0	(11,522)	0	0.00
Assume TANF Contingency Funds Available	(10,000,000)	0	10,000,000	0	0	0.00

While the Self Sufficiency budget does not recommend any further investments outside of CSL, the program continues to work to:

- Continue to build case management capacity to assist families on their path to out of poverty;
- Create a glide path off of TANF to decrease the number of families who return to the program repeatedly and to incentivize employment;
- Improved access to services in local communities; and
- Increase access to quality child care.

Unfortunately the Employment Related Day Care (ERDC) program is anticipated to be reduced from CSL by $9.3 million dollars or an average of 493 cases per month due to a reduction in Federal Funds that come to DHS as Other Funds via the Department of Education Early Learning Division. This reduction is due to needs within the Early Learning Division and partially offsets the CSL investment in child care subsidies in 2017-19 that begun in 2015-17. The state investment has not changed in the GB.

Conclusion

These upfront and local investments from 2015-17 that are continued in 2017-19 will, in the short-run, maximize results for clients and further reduce the TANF caseload by maximizing employment outcomes. Improving participation and employment outcomes will also help avoid penalties to the federal government, keeping our limited state dollars in Oregon.

In the long-run, these investments will improve service quality and equity, ensure that DHS clients benefit from coordination with other child and family serving systems (including health, education, and workforce systems), and allow the Department to maximize results for families.

Oregon Department of Human Services
Child Welfare Programs

Overview

We provide prevention, protection and regulatory programs for Oregon's most vulnerable children – keeping them safe and improving their quality of life. Prolonged economic stress is increasingly putting Oregon children in situations that are unsafe. These issues are disproportionately affecting communities of color contributing to their over-representation in both the child welfare and corrections systems. We know that the demand for state-funded services in the future is directly related to our ability to prevent and mitigate these traumas today.

Engaging Families

Our strategies depend on creating an environment that is safe for citizens who are most vulnerable based on family, social and economic issues. We focused our initiatives toward minimizing risk by transforming our interventions to better meet the challenges families are facing. This will enhance our ability to engage individuals who are less able to care for themselves, their families and communities. This creates a stronger continuum of efforts to prevent abuse and neglect, and efforts to hold perpetrators of that abuse and neglect accountable.

Our budget proposal seeks to ensure that Oregonians are safer in the future than they are today by focusing on strategies that have proven to result in the greatest reduction in overall risk. We aim to achieve the following outcomes:

- A clear focus on safety strategies for the most vulnerable citizens in care in Oregon.
- A better array of evidence based interventions with community-based supports for families before, during and after involvement with the Child Welfare system, including strategies to safely and equitably reduce the number of children who experience foster care. This includes available services and supports so children are not at risk for re-entry into foster care and families can be stabilized.

Improved services for children and families disproportionally represented in the child welfare population, targeting culturally appropriate strategies to provide intervention and services, and using decision point analysis to address disparities.

Funding Request – Strategic Initiatives

The Governor's Budget is proposed to be $541.6 million General Fund and $1.05 billion Total Funds for the 17-19 biennium.

CHILD WELFARE	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 481,251,155	$ 23,165,610	$ 459,015,944	$ 963,432,709	2,597	2,550.05
GB 17-19	$ 541,608,088	$ 24,443,723	$ 484,724,512	$ 1,050,776,323	2,718	2,620.15
Difference	$ 60,356,933	$ 1,278,113	$ 25,708,568	$ 87,343,614	121	70.10
Percent change	12.5%	5.5%	5.6%	9.1%	4.7%	2.7%

Major changes from LAB to GB are driven mainly by:

- Forecasted increases in Caseload and Cost Per Case
- Increase in level of staffing for Child Welfare Services
- Increases in rates for foster parents and BRS providers
- Increased funding for legal representation in Child Welfare

Strategic Funding Investments

Children and Families: Child Welfare services represent a continuum of supports with the ultimate goal of keeping children safe. Historically in Oregon that has equated with removal and placement into foster care. Based on research and feedback from children, youth and families who experience our system, our strategic efforts are refocusing the service continuum to ensure safety while also focusing on child well-being, family stability and, when possible, avoid removal and placement in foster care by supporting families safely parenting their children at home. Post adoption and guardianship support helps sustain permanency for children, again preventing them from returning to foster care.

These strategies include:

1. An increased focus and culture of Safety in Child Welfare;
2. Differential Response - Changing our upfront intervention to more fully engage families building on their strengths and engage them in outcomes that remediate the issues that are challenging the family;
3. Programs that are designed to strengthen, preserve and reunify families involved in the child welfare system, preventing entry into the foster care system and shortening the length of stay for children that do enter;
4. Focusing on addressing disproportionality of children entering and remaining in the foster care system; and
5. Assisting more families in extreme poverty at risk of involvement with Child Welfare;
6. Program funding investments are intertwined in the Child Safety, Child Welfare Design and Delivery, and Permanency Programs

GB POPS	GF	OF	FF	TF	POS	FTE
TOTAL	**16,958,778**	**0**	**21,639,352**	**38,598,130**	**0**	**0.00**
108 - Family Foster Care Rate Reimbursement	7,926,190	0	4,857,987	12,784,177	0	0.00
109 - BRS Rates	2,116,547	0	3,823,804	5,940,351	0	0.00
110 - Legal Representation in Child Welfare	6,916,041	0	12,957,561	19,873,602	0	0.00

108 Family Foster Care Rate Reimbursement

Reimbursement rates for Family Foster Care have not been adjusted to the cost of living for a decade. In 2009 rates were adjusted to 90% of the cost of care based on a 2007 rate methodology. In 2011, these rates were reduced by an additional 10% due to department budget cuts. Families coming forward to provide foster care has continued to diminish over the last 5 years in part due to the low reimbursement rates. The current daily rate is $18.90 per day for a child under age 5 years old or $24.36 per day for a teenager. This is intended to cover the costs of food, shelter, clothing, school supplies, extracurricular activities, etc. Based on the methodology created in 2009 Oregon is currently providing only 40-46% of the actual cost of care. Other states have been sued due to the low rate of family foster care payments and Oregon continues to increase the risk of a class action lawsuit. This investment increases the base rate and is estimated to cover 60% of actual costs.

109 BRS rates

Update the rate model for Behavioral Rehabilitation Services (BRS) program to pay contracted providers for cost increases above inflation. Rates directly impact state agencies access to these programs. The BRS rate model has not been kept current since first established in 1998. Simply adding inflation to the previous biennium rate has not kept pace with significantly increasing costs. Some of the most heavily used programs have closed over the past two biennia. More programs have signaled if they don't receive more financial support from the state they will have to close soon. This package is most importantly about child and youth safety as well as maintaining access to this essential part of the system serving Oregon's most needy children. Without increases to the rate state agencies will continue to have pressure on the BRS system as provider costs increase and the rate remains inadequate.

110 Legal Representation in Child Welfare

Historically, DOJ's billable hour model has been considered cost-prohibitive in juvenile dependency cases and has been a deterrent to DHS accessing and utilizing

DOJ for full representation—including attendance at all hearings, regular case consultation, impromptu legal advice, and regular participation in case worker training, meetings, and staffing. A block grant model will allow DOJ to manage cases according to a workload method of case assignment with each DOJ attorney carrying a consistent number of weighted cases. In this model, each dependency case is assigned to an attorney who handles it from petition to permanency. This case assignment method will provide DHS caseworkers with continuous representation which, in turn, will promote attorney-caseworker collaboration, improve caseworker job satisfaction and retention, avoid the risk for unlawful practice of law by case workers, and improve the overall efficiency and cost-effectiveness of the system. This POP assumes a Total Fund funding model of just under $45 million for full representation and assumes the exception to DHS representation in these cases is lifted. If the representation exception is continued and no investment made DHS is still short $4.5 million GF in order to meet projected CW AG costs in 2017-19.

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**(22,299,200)**	**(46,809)**	**(6,961,040)**	**(29,307,049)**	**0**	**-54.50**
1% Additional Vacancy Savings	(2,761,009)	(15,040)	(1,982,802)	(4,758,851)	0	0.00
Remove inflation from S&S	(447,295)	(18,360)	(761,391)	(1,227,046)	0	0.00
Disallowed Backfill for Federal Grants	(9,910,089)	0	0	(9,910,089)	0	0.00
Statewide Reduction to S&S	(640,747)	(13,295)	(544,611)	(1,198,653)	0	0.00
Staffing Workload Reduction	(920,440)	0	(917,676)	(1,838,116)	0	-9.00
Screening Positions	(6,846,675)	0	(1,706,686)	(8,553,361)	0	-45.50
Statewide AG Reduction	(772,945)	(114)	(1,047,874)	(1,820,933)	0	0.00

Conclusion

We want to break the cycle that causes harm to individuals and drives Oregonians into expensive state-sponsored programs. Our strategies focus on helping ensure that Oregonians are safer in the future than they are today by increasing resources proven to result in the greatest reduction in overall risk. Though those strategies require some upfront, taxpayer investment, we are committed to being accountable for needed service delivery and performance metrics focused on improvements in the lives of those we serve and long-term reductions in the demand for state services. We know that abuse and neglect will never totally be eliminated, but we believe that Oregon should be a place where our children are safe, and we believe our budget proposal will improve the state's ability to work with individuals and communities to achieve that goal, while reducing the demand for costly state services in the future.

Oregon Department of Human Services
Vocational Rehabilitation Programs

Overview

We help Oregonians with disabilities become employed through specialized training and new skills. This includes helping youth with disabilities transition to jobs as they become adults, helping employers overcome barriers to employing people with disabilities, and partnering with other state and local organizations that coordinate employment and workforce programs. A total of 383,381 work age Oregonians experience a disability but only 36 percent are employed. Employment helps people with disabilities become more self-sufficient, involved in their communities and live more engaged, satisfying lives. Investments through this program provide outcomes for individuals, improving their lives, helping them become productive members of our society, contributing to local economies and reducing a reliance on expensive state and federal programs.

The Workforce Innovation and Opportunity Act (WIOA) which passed in July of 2014 reauthorized Title I the State Vocational Rehabilitation Services program and Title VI the Supported Employment program. WIOA makes significant changes to Title I strengthening alignment with core components of the workforce development system, redefining employment outcome to be competitive integrated employment, defining students with disabilities and youth with disabilities as specific populations requiring defined services. Title VI now requires that supported employment be in a competitive integrated setting and places a focus on youth with the most significant disabilities. The act further set aside portions of the federal funds to be dedicated to specific populations as well requiring specific services be delivered to those populations. There is a significant increase in reporting requirements and an emphasis on job retention and credential attainment.

Current funding levels

The proposed Governor's Budget to operate the Vocational Rehabilitation (VR) program is $27.0 million General Fund and $114 million Total Funds for the 17-19 biennium.

OVRS	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 24,308,416	$ 2,327,882	$ 84,146,036	$ 110,782,334	261	259.17
GB 17-19	$ 26,996,950	$ 2,340,616	$ 84,634,350	$ 113,971,916	261	260.25
Difference	$ 2,688,534	$ 12,734	$ 488,314	$ 3,189,582	0	1.08
Percent change	11.1%	0.5%	0.6%	2.9%	0.0%	0.4%

Major changes from LAB to GB are driven mainly by:

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**(7,567,909)**	**(4,138)**	**6,935,095**	**(636,952)**	**0**	**0.00**
Use one time ReAllotment	(7,400,000)	0	7,400,000	0	0	0.00
1% Additional Vacancy Savings	(101,870)	(4,138)	(365,445)	(471,453)	0	0.00
Remove inflation from S&S	(41,790)	0	0	(41,790)	0	0.00
Statewide Reduction to S&S	(21,329)	0	(95,667)	(116,996)	0	0.00
Statewide AG Reduction	(2,920)	0	(3,793)	(6,713)	0	0.00

The Governor's Budget continues funding for Vocational Rehabilitation services. One time funding of $7.4 million in "reallotment" dollars were used to backfill some of the General Fund dollars added at CSL. Currently OVRS is estimated to be able to meet Maintenance of Effort requirements and draw down all available funds. There is also a possibility of future "reallotment" funding that Oregon would be eligible for under the Governor's Budget.

However, there is a significant risk that OVRS will need to enter an Order of Selection by the end of the 2017-19 biennium depending on the number of clients that access OVRS services.

Conclusion

As the economy continues to recover, the focus on workforce development, employment and opportunity for *all* Oregonians has increased. The Vocational Rehabilitation program welcomes the opportunity to help the growing number of Oregonians with disabilities meet their employment goals. Over the last two years, employment outcomes for VR clients have increased by 27.4 percent even while caseload is increasing.

Vocational Rehabilitation is committed to achieving the outcomes identified in the Governor's Executive Order for Employment for People with I/DD and the Lave v. Brown settlement. VR will also continue to identify new ways to enhance its work with the Oregon Workforce Investment Board, Local Workforce Investment Boards, and the Workforce Policy cabinet in the implementation of the OWIB strategic plan and local board's efforts to better align economic and workforce development activities.

Oregon Department of Human Services
Aging and People with Disabilities Programs

Overview

The Department of Human Services Aging and People with Disabilities (APD) program's mission is to assist Oregon's diverse population of older adults and people with disabilities achieve well-being through opportunities for community living, employment, family support, and services that promote independence, choice, and dignity.

The state of Oregon is a leader in long-term care systems and was ranked number three nationally in AARP's latest ranking. In 1981, Oregon received the first waiver nationwide for long-term care services which allowed Oregonians receiving Medicaid to choose services in their own home or in their communities rather than an institutional facility such as a nursing home. In 2013, Oregon transitioned most of its services into the 1915(K) State Plan Option. The K Option provides significant benefits to the state in cost savings while allowing Oregonians to make individual choices to best meet their needs. Oregonians value receiving long-term care services in a non-institutional setting with nearly 88 percent choosing alternatives that allow them to remain independent and safe.

Long Term Care Setting (as of April 2016)	**# of Recipients**	**% of LTC Caseload**
Nursing Facility	4,221	12.5%
In Home	17,779	52.6%
Community Based Setting	11,815	34.9%
Total	**33,815**	**100%**

Oregon's population is aging

The 65+ population is projected to grow from 502,000 to 950,000 by 2030. While the state prepares for this growth, it must do more than create cost effectiveness in the choices of long-term care. The state must also look at measures Oregonians can implement now to prevent the need for publicly funded long-term care services.

The Department has prepared a strategic budget to focus on continuing modernization and improvements to help Oregonians sustain long-term care services and become more independent and safe.

Funding

The cost to operate the Aging and People with Disabilities (APD) Governor's Budget (GB) is $992 million General Fund and $3.4 billion Total Funds for the 2017-19 biennium.

AGING AND PEOPLE WITH PHYSICAL DISABILITIES	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 897,033,751	$ 206,960,674	$ 2,001,265,680	$ 3,105,260,105	1,246	1,235.28
GB 17-19	$ 991,999,727	$ 218,311,152	$ 2,204,521,559	$ 3,414,832,438	1,451	1,381.93
Difference	$ 94,965,976	$ 11,350,478	$ 203,255,879	$ 309,572,333	205	146.65
Percent change	10.6%	5.5%	10.2%	10.0%	16.5%	11.9%

Major changes from LAB to GB are driven mainly by:

- Forecasted Cost per Case and Caseload changes including AAA staff funding
- Changes in Federal Fund Match Rates

GB - POPS	GF	OF	FF	TF	POS	FTE
TOTAL	**1,694,922**	**2,050,000**	**147,945**	**3,892,867**	**2**	**1.50**
102 - Centralized Abuse Management	1,694,922	2,050,000	147,945	3,892,867	2	1.50

102 Centralized Abuse Management System

House Bill 4151 requires the state of Oregon and DHS as its agent to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing, and investigating incidents of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations and inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations. This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability to achieve the capabilities and

efficiencies of the proposed integrated solution. The Other Funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one time request for limitation. The General Fund is the best current estimate of costs of the ongoing operations and maintenance of the new system.

Reductions

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**(86,422,421)**	**(8,301,136)**	**(111,262,781)**	**(205,986,338)**	**(2)**	**-60.00**
1% Additional Vacancy Savings	(1,015,971)	(7,294)	(1,297,633)	(2,320,898)	0	0.00
Remove inflation from S&S	(506,588)	(753,347)	(308,704)	(1,568,639)	0	0.00
Disallowed Backfill for Federal Grants	(546,791)	0	0	(546,791)	0	0.00
Statewide Reduction to S&S	(351,488)	(325,064)	(336,892)	(1,013,444)	0	0.00
Staffing Workload Reduction APD Delivery	(5,480,377)	0	(3,475,794)	(8,956,171)		-58.00
Reduce the complex medical add-on for nursing facilities by 50%. APD	(6,590,582)	(1,339,048)	(20,969,352)	(28,898,982)	0	0.00
Eliminate Live-in Program as of July 1 2017 - move consumers to Hourly program. APD	(20,061,806)	(300,000)	(38,565,539)	(58,927,345)	0	0.00
Equity Model Reduction APD Delivery	(9,680,044)	0	(6,581,512)	(16,261,556)	0	0.00
Remove General Assistance (HB4042). APD	(225,590)	0	0	(225,590)	(2)	-2.00
Remove General Assistance (HB4042). APD	(1,597,705)	(1,869,511)	0	(3,467,216)	0	0.00
Eliminate OPI for people with disabilities.	(6,000,000)	0	0	(6,000,000)	0	0.00
Reduce OPI by $10M. APD	(10,000,000)	0	0	(10,000,000)	0	0.00
Reduce OPI by another $6M. APD	(6,000,000)	0	0	(6,000,000)	0	0.00
Hold nursing facility rates flat at the rate being reimbursed at 6/30/17. (281.08) APD	(18,345,151)	(3,706,229)	(39,719,103)	(61,770,483)	0	0.00
Statewide AG Reduction	(20,328)	(643)	(8,252)	(29,223)	0	0.00

There are several reductions or flat funding of rates within the APD GB that require further clarification:

- Eliminates the General Assistance program, passed in 2016 as HB 4042. House Bill 4042 required the Department of Human Services (DHS) to establish a General Assistance (GA) project, beginning July 1, 2016, to serve a maximum of 200 people per month who are enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. DHS was also directed to convene an advisory group that includes representatives from nonprofit agencies advocating for and providing services to low-income individuals. - $1.9 million GF.

- Eliminates the Live-In Program in Aging and People with Disabilities as of 7/1/2017 - $20.8 million GF. The program will convert most clients to the in-home hourly program. This management action has already started in 2015-17 to address the sustainability of APD programs.
- Eliminates Oregon Project Independence for people with disabilities; in addition, it reduces the remainder of the program expenditures by 75 percent - $22 million GF total. Oregon Project Independence is funded at $5.0 million GF which is the Maintenance of Effort criteria for the Older American's Act.
- Holds nursing facility rates at the 6/30/2017 level. Statutorily, rates would increase significantly based on cost reports of the industry. The rate for nursing facilities in the DHS CSL budget for 2017-19 was projected based on a blend of the DRI inflation and the traditional method using cost trending; and was intended to reflect the statutory rate setting methodology. That estimate put the rates at $294.35 July 2017 and $307.64 on July 2018. The Governor's budget holds the rate paid on June 30, 2016 at $281.08 for the entire 2017-19 biennium - $18.3 million GF.
- Implements a partial reduction (50 percent) in the complex medical add-on for nursing facilities. Currently the complex medical add on is 40 percent of the base rate. This reduction proposes to reduce the complex medical add on to 20 percent of the daily rate - $6.6 million GF.
- Cuts in half the FTE earned in CSL by state and AAAs due to forecasted caseload growth.

Conclusion

The Governor's Recommended Budget makes difficult choices due to the current budget environment. In addition to the issues stated above, the budget continues investments in APD including but not limited to continuing funding for Service Priority Levels 1-13, protecting current caseload and eligibility criteria, and supports a staffing level of a net 90.4 percent of the workload model by the end of the biennium (based on the fall 2016 caseload forecast). The proposed budget includes services that promote sustainability, safety, and wellness for Oregon's older adults and people with disabilities. These investments will help DHS meet the needs of Oregonians in this period of change and growth.

Oregon Department of Human Services
Intellectual and Developmental Disabilities Program

Overview

The Office of Developmental Disabilities Services (ODDS) provides services to cover a lifetime of support to Oregonians with intellectual/developmental disabilities. People with disabilities of all ages want the same opportunities every Oregonian wants: not just to survive but to thrive. They want to live in their own homes and make decisions about daily activities, so they can attend school, work, and religious activities, enjoy recreational activities, and participate fully in their communities. ODDS assists more than 25,000 children, adults, and their families experience the best quality of life possible at all stages of their lifespan. Most individuals with developmental disabilities are eligible for a Medicaid waiver or state plan which allows them to remain in their family home or community instead of an institution. Our mission is to help them be fully engaged in life and at the same time address their critical health and safety needs.

History and Future State

The state of Oregon is recognized nationally as an innovative leader in developing community-based services for individuals with intellectual/developmental disabilities. Oregon is one of only three states that have no state or privately operated institutional level services specifically for people with developmental disabilities. In fact, the majority of individuals with intellectual/developmental disabilities in Oregon are served in their own home or their family's home.

That is the result of two decades of work to aggressively re-balance the intellectual/developmental disabilities system — moving from an institutional model with expensive one-size-fits-all approach — to a self-directed, family involved, individually focused, and less expensive approach to service. Today, consumers and families report a high level of satisfaction through the increased control over services, the ability to more fully integrate in home communities, as well as the benefits of home community life.

Oregon home- and community-based services for people with intellectual and developmental disabilities are provided under several Medicaid authorities, including Community First Choice Option (also known as K-Plan) and five 1915(c) waiver programs. Supports provided under K-Plan include attendant services that support individuals in accomplishing Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL), relief care, behavioral

support services, transportation, environmental modifications, and assistive technology and devices. By moving most services to the K-Plan, most of the caps on services and limits on eligibility for services to those with I/DD were removed based on federal requirements to gain a 6 percent increased federal participation in those programs.

In addition, the Lane v. Brown Settlement has added additional requirements to I/DD programs around placement of those with I/DD into integrated settings and moving away from sheltered workshops which the federal government will no longer support as of April 1, 2019.

To serve the increasing number of people with intellectual and developmental disabilities, maintain those high levels of satisfaction, and to further advance the inclusion of people with intellectual/developmental disabilities in their communities, the system has an urgent need to continue its evolution in a fiscally sustainable manner.

To that end, the Governor's Budget is designed to further improve the customer experience and advance efficiencies to maximize resources. Specifically, it seeks to achieve the following outcomes and goals:

- Ensure the health and safety of individuals served
- Increase provider rates to create a more stable and competent workforce for I/DD services
- Be responsive to emerging consumer demands for individualized, self-directed services and sufficient service choices
- Promote maximum consumer independence and engagement in homes and communities
- Leverage use of available federal funding options
- Address improvements in business practices such as payment and information systems to achieve overall operational efficiencies

Funding

The proposed Governor's Budget to operate the Intellectual & Developmental Disability (I/DD) program for the 2017-19 biennium is $893.9 million in General Fund and $2.7 billion Total Funds.

INTELLECTUAL & DEVELOPMENTAL DISABILITIES	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ 743,386,397	$ 31,386,168	$ 1,548,261,903	$ 2,323,034,468	887	841.73
GB 17-19	$ 893,907,067	$ 28,984,810	$ 1,789,806,816	$ 2,712,698,693	894	893.00
Difference (LAB to GB)	$ 150,520,670	$ (2,401,358)	$ 241,544,913	$ 389,664,225	7	51.27
Percent change (LAB to GB)	20.2%	-7.7%	15.6%	16.8%	0.8%	6.1%

Major changes from LAB to GB are driven mainly by:

- Forecasted cost per case and caseload changes including CDDP and Brokerage funding
- Changes in Federal Fund match rates

GB - POPS	GF	OF	FF	TF	POS	FTE
TOTAL	**22,281,720**	**0**	**49,045,426**	**71,327,146**	**1**	**1.00**
105 - Stable and Competent Workforce for I/DD	22,281,720	0	49,045,426	71,327,146	1	1.00

105 Stable and competent workforce for I/DD

Perpetually low wages from an outdated rate model for the I/DD provider workforce has created a record level of turnover and a critical shortage of direct support professionals (DSPs). DSPs provide support for people with I/DD to live and work in a safe and healthy manner as members of their communities. DHS and stakeholders created the existing rate structure based on 2007 fiscal data. This model needs to be updated to align with current economic realities, new minimum wage requirements, new DOL overtime rules, and expectations around service quality, safety, and competency/training requirements. A stable and well trained workforce is critical to the ability of I/DD provider network to providing high quality of services to individuals and ensuring their health and safety. Provider rate structure needs to reflect these requirements and provide adequate compensation to assure that individuals with I/DD are served by competent workers.

This POP will:

- Ensure adequate DSP wages that are above minimum wage to reflect DHS' longstanding policy that DSP work is not minimum wage work
- Address compression effect of minimum wage increases on wages of house managers and supervisors
- Address cost impact of new DOL requirements around overtime pay for workers earning less than $913 a week ($47,476 a year)
- Provide financial incentives for providers to ensure their staff achieves highest level of training and competency and by making available College of Direct Support training to Oregon DSPs
- Provide one FTE for ODDS to coordinate provider training requirements and programs

Reductions	GF	OF	FF	TF	POS	FTE
TOTAL	**(16,701,410)**	**(124,469)**	**(8,829,341)**	**(25,655,220)**	**0**	**0.00**
1% Additional Vacancy Savings	(594,289)	(14,295)	(881,423)	(1,490,007)	0	0.00
Remove inflation from S&S	(355,898)	(68,525)	(516,632)	(941,055)	0	0.00
Statewide Reduction to S&S	(171,115)	(41,649)	(232,558)	(445,322)	0	0.00
One time use of Fairview Housing Trust Fund of $6.0 million. I/DD	(6,000,000)	0	0	(6,000,000)	0	0.00
Reduce the Family to Family Network Program	(642,940)	0	0	(642,940)	0	0.00
Eliminate the Family to Family Network Program	(642,940)	0	0	(642,940)	0	0.00
Eliminate Regional Staff I/DD	(4,788,406)	0	(3,315,737)	(8,104,143)	0	0.00
Reduce Brokerage and CDDP Equity by 2% (93% equity) I/DD	(1,748,708)	0	(1,938,550)	(3,687,258)	0	0.00
Reduce Brokerage and CDDP Equity by additional 2% (91% equity) I/DD	(1,748,708)	0	(1,938,550)	(3,687,258)	0	0.00
Statewide AG Reduction	(8,406)	0	(5,891)	(14,297)	0	0.00

There are several reductions that require further clarification.

- Eliminates the Family to Family Network for I/DD effective 7/1/17. After significant reductions in the Family Support Program were made in 2011, the Family to Family Network program was created. The work accomplished by these networks includes family training, identification of local resources, and general support from one family to another. The networks leverage

parent time and local resources in an effort to provide support at no cost to DHS/DD - $1.3 million GF
- Eliminates funding for Regional Programs for I/DD - $4.8 million GF
- Expends $6 million in funding from the Fairview Housing Trust and makes a one-time investment in the DHS I/DD program's K-Plan services, leaving approximately $100k in the trust
- Reduces Brokerage and Community Developmental Disabilities Programs (CDDP) equity funding from 95 percent to 91 percent - $3.5 million GF

Conclusion

This proposal represents planning that will allow the I/DD system to improve the quality of service it offers to Oregonians with intellectual/developmental disabilities and their families that support them. The primary focus is on sustainable, quality service programming that accounts for the short- and long-term budget realities that shape our implementation planning. Out-of-home placements for people with disabilities can range from $24,000 to $156,000 a year. Focusing efforts on helping people with disabilities remain at home or in their community provides not only financial benefits, but better quality throughout their lifespan. ODDS is confident that this plan will maximize resources and strengthen the service system, enhancing its ability to produce results for those we serve.

Department of Human Services
Central and Shared Services,
State Assessments and Enterprise-wide Costs,
Program Design Services

Mission

To help Oregonians in their own communities achieve safety, wellbeing and independence through opportunities that protect, empower, respect choice and preserve dignity.

Goals

- Every Oregon child and youth in our care deserves to grow up safely -- with support for success in school.
- Every Oregon adult deserves to live in safety – free from abuse, neglect and financial exploitation.
- Every Oregonian has the right to live as independently as possible -- with dignity, choice and self-determination.
- Every Oregonian can work to the best of their abilities to contribute to their family and their community.
- All Oregonians deserve efficient and effective services from DHS.

DHS Central Services

DHS Central Services consist of the Office of the Director; Chief of Staff; Human Resources; Public Affairs; Tribal Affairs, and Equity and Multicultural Services. These offices provide essential supports to programs in achieving the department and programs mission, vision and outcomes.

Office of the Director

The DHS Director's Office is responsible for overall leadership, policy development and administrative oversight for all programs, staff and offices in DHS. These functions are coordinated by the Chief of Staff with the Governor's Office, the Legislature, other state and federal agencies, partners and stakeholders, communities of color, local governments, advocacy and client groups, and the private sector.

The Chief of Staff also oversees the Governor's Advocacy Office (GAO) - This office handles client complaints related to DHS services. This office operates

independently in the investigations performed and reports directly to the Governor by providing a quarterly report on the status of the complaints. The team in this office works closely with field and central office staff; program staff; the Governor's Office; key stakeholders; and the DHS Director's Office to successfully, equitably and respectfully reach a conclusion.

The DHS Director's Office is also home to Tribal Affairs. We are committed to a positive working relationship with the nine tribes in Oregon. Staff regularly holds meetings with tribal governments through tribal liaisons and continually strives to ensure these communities receive sufficient and appropriate human services.

The Office of Human Resources serves as a strategic partner to its customers in, providing proactive and comprehensive human resources services, in alignment with agency and program mission and goals. HR works closely with internal customers on Workforce Strategies that support agency and program needs and strategies, and building a healthy workplace culture of ongoing development and feedback to ensure the agency has a diverse workforce with the right people with the right skills, training, and support to do their work, now and in the future.

The DHS Public Affairs Office is made up of three work units: Communications, Legislative, and Legal. The office provides DHS with unified support and coordination in outreach and communication, legislative action and strategy:

- Communications Unit - This office supports the mission by providing accurate information to a diversity of 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. Effective communication is the primary vehicle to demonstrate public transparency, accountability, and trust. The office also provides support to the department's priority projects as defined by the DHS Director and executive team.
- Legislative Unit - This unit handles all legislative matters for DHS. This team coordinates all DHS legislative matters with legislative offices, key stakeholders and the Governor's Office. This team supports both field and central office staff providing consultation and support in legislative matters, primarily working with central office staff on policy development for program services. During a legislative session, this unit tracks and assigns all bills related to DHS program and operations. Staff in this unit support

the director of DHS, the directors of all program and operations in DHS and the district managers in field offices regarding legislative matters.

- Legal Unit - This Unit manages all lawsuits, tort claims and subpoenas related to DHS program and operations. Staff in this unit provide expert consultation to DHS field and central office staff, Department of Justice (DOJ) and Department of Administrative Services (DAS) Risk Management in policy related to legal matters. This team ensures timely completion of the required judicial documents to move smoothly through a complicated legal matter.

  Hearing and Rules Unit supports all DHS field office and central office programs by managing administrative rules and administrative hearings. This unit provides expert technical support to hearing representatives in DHS field services and liaison to the Office of Administrative Hearings and DOJ regarding DHS notices, hearing requests, and contested case hearings. This unit provides expert technical support to program staff writing rules and rule-related documents and handles rule filing and the public comment process for DHS programs. The Rules Coordinator advises, consults, leads, coordinates and trains staff in drafting, interpreting, defining and developing the intent and scope of administrative rules. In addition, the rules coordinator monitors and reviews contested case orders, trains hearing representatives, assists with legal issues and acts as liaison with the Office of Administrative Hearings to discuss performance measures.

Office of Equity and Multicultural Services (OEMS) provides leadership and direction in supporting equity, diversity and inclusion initiatives throughout the agency. OEMS guides systemic changes to both internal workforce developments as well as improve service delivery to all Oregonians. The office also investigates all claims of discrimination and harassment. The goals of the office include reducing service disparities in all program areas; ensuring a diverse and culturally competent workforce; removing barriers to a welcoming work environment; and improving life outcomes for all DHS clients.

Office of the Deputy Director – Agency Operations

The DHS Deputy Director is responsible for Shared Services such as Internal Audits, Business Intelligence, Licensing and Regulatory Oversight, Continuous Improvement, Information Technology (IT) Business Supports, Adult Abuse Prevention and Investigations, Program Integrity, Office of Payment Accuracy and Recovery, and the Chief Financial Officer.

Office of the Chief Financial Officer (OCFO) provides optimal business services to ensure accountability, data driven decisions, and stewardship of resources in support of the mission of DHS. This is done by working closely with DHS and OHA programs and the OHA Chief Financial Officer, to ensure accurate, timely and efficient recording and management of financial resources; culturally competent and equitable services; authorizing the redistribution of available resources to meet changing needs; and establishing administrative controls.

Shared Services

DHS Shared Services supports both DHS and OHA by providing optimal business services to ensure accountability, data-driven decisions, and stewardship of resources. DHS Shared Services contains the following key offices and programs that serve both DHS and OHA.

Shared Services Administration

This office provides leadership and direction for shared services offices which support both DHS and OHA.

Budget Center

This area provides program and administrative budget planning, financial analysis and technical budget support for DHS and OHA. These services are provided for department leadership, program, policy and field managers, staff and external policymakers.

Office of Forecasting and Research Analysis (OFRA)

OFRA supports DHS and OHA by providing accurate, timely, unbiased caseload forecasts, and related research and analysis to support budgeting, policy development, and operational planning. Additionally, OFRA houses the Office of Enterprise Data Analytics (OEDA) which conducts inter-agency research and advanced statistical modeling to answer cross agency operational questions.

Office of Financial Services (OFS)

This area provides accounting services, administers employee benefits and payroll, prepares financial reports, and collects funds for DHS and OHA. This area provides accurate, accountable and responsive financial management and business services to clients, providers, vendors, stakeholders and employees to ensure compliance with state laws and federal policies, rules and regulations.

Human Resources Center

This office provides essential HR administrative functions and services for DHS and OHA, and supports organizational development and an improved common culture of leadership and engagement across both agencies, through background checks and fitness determinations; personnel records management; leave administration; centralized position administration; safety and risk response and management; staff and management training; facilitation services and Lean Daily Management System (LDMS) coaching; HR data analysis and reporting; HR policy administration; and internal communication strategies and resources for managers and staff.

Office of Facilities Management

This office provides coordination of facility matters for branch offices and other facilities statewide for both DHS and OHA. Facilities staff supports the mission by maintaining and enhancing buildings, vehicles, telecommunications, and the physical infrastructure in a cost-effective and environmentally responsible manner.

Office of Imaging and Records Management (IRMS)

IRMS provides services tailored to the business and program operational needs related to: agencies delegated authority regarding imaging, electronic and physical document and records management; data entry of documents to send data to mainframe applications to generate payment to medical and childcare providers; image and data capture of source documents into a central repository; image and data capture of documents into electronic workflow eliminating the need for the customer(s) to process physical documents; archive storage of physical records; tracking of archived records; shipping of archived records at customer request; and destruction of physical documents/records per customer agreement and Secretary of State's Office retention schedule.

Office of Contracts and Procurement (OC&P)

The Office of Contacts and Procurement supports all offices of the Department of Human Services, the Oregon Health Authority, and the Home Care Commission by procuring supplies and services in the most cost effective manner through innovative and responsible solutions.

Office of Adult Abuse Prevention and Investigations (OAAPI)

OAAPI is responsible for conducting and coordinating abuse investigations and providing protective services statewide in response to reports of abuse and neglect to people they serve, including:

- Adults over the age of 65
- Adults with physical disabilities
- Adults with intellectual or developmental disabilities
- Adults with mental illness, and
- Children receiving residential treatment services

Internal Audit and Consulting (IAC)

The Internal Audit and Consulting (IAC) Unit provides independent and objective information and consulting services for DHS/OHA. The internal audit team reviews all areas of DHS/OHA including centralized operations and programs, field offices, and institutions. The unit provides other services such as consultation on internal controls and process improvement efforts, facilitation of risk assessment activities, coordination of external audits, and tracking and follow-up on both internal and external audit findings.

Office of Payment Accuracy and Recovery (OPAR)

OPAR provides recovery services by identifying and recovering moneys paid in error to clients or providers; investigates allegations of fraudulent activities; investigates and recovers state funds expended for services when a third party should have covered the service and the recovery of claims made by a client; and recovers funds from the estates of Medicaid recipients for the cost of cash and medical benefits provided.

Publications and Design (P&D)

P&D manages the writing, design, development, printing and distribution of DHS and OHA publications for internal and external audiences, which includes alternate formats and alternate languages. P&D provides consulting to plan professional quality publications that reflect DHS and OHA style guidelines; edit and proof materials created by staff experts and partners in their individual fields; provide graphic design, layout, original and digital illustration, forms creation, graphic artwork and Web and electronic materials.

State Assessments and Enterprise-wide Costs

DHS also has statewide assessments that include DAS charges such as the State Government Service Charge, Risk Assessment and State Data Center Charges. Rent for all of DHS is in the Facilities budget, IT Direct is for all computer replacement needs. The Shared Services funding is the revenue for the DHS portion of DHS and OHA shared services and Debt services is to pay off Certificates of Participation or Q-Bond loans taken for major DHS projects. Each service, both shared and assessed, are important for DHS to attain its programmatic outcomes. It is critical to continue to look for efficiencies in our systems, processes or staffing.

Program Design Services

To become outcome-driven, an agency must determine the outcomes it wants to achieve, measure the outcomes, design programs to achieve the outcomes, implement the design through business and IT processes and systematically review whether the processes are being implemented as designed and how well the outcomes are being achieved.

Office of Business Intelligence (OBI)

OBI compiles reports and conducts research to determine whether DHS programs are achieving their goals and desired outcomes. OBI specializes in managing data to ensure it is accurate, consistent, and useful to programs in assessing their success and making decisions to alter their program design. One important part of this role is managing the agency scorecard of outcome and process measures. OBI also conducts professional research requested by programs to give them a more rigorous foundation for their program design.

Office of Information Technology Business Supports (ITBS)

ITBS bridges the gaps between the Aging and People with Disabilities (APD) and Intellectual / Developmentally Disabled (I/DD) program needs and the technology used to deliver assistance. ITBS leads program area efforts to develop functional IT business requirements, document/perform IT solution testing, execute IT project delivery and operate IT systems supporting program client/provider needs across the spectrum of benefit delivery. ITBS fields technology support contacts for internal and external staff, partners, customers and clients seeking assistance with

daily eligibility, enrollment, payments and access/security. ITBS is embedded in DHS program design and is focused on the following areas of concern:

- Stable and reliable IT operations
- Accurate business analysis for solution enhancement, development and documentation
- Broad knowledge of key benefit programs, concerns and supporting systems
- Comprehensive Level of Effort (LoE) estimation for documented business requirements
- Consistent, documented testing of application patches and releases
- Expert IT project/solution delivery using a consistent, professional methodology.

Office of Continuous Improvement (OCI)

OCI helps DHS units implement the Lean Daily Management System and conduct business process improvement events. OCI employs project managers and staff skilled in Lean tools to assist units in making high-priority process improvements and building their own Lean capacity**.**

Office of Licensing & Regulatory Oversight (OLRO)

OLRO provides for the safety of children, aging and physically disabled, and people with intellectual and developmental disabilities through licensing, regulatory and corrective action functions within programs provided by DHS. This includes Intellectual and Developmentally Disabled (I/DD) programs, Aging and People with Disabilities (APD) programs, Child Welfare (CW) providers, adult foster homes, assisted living facilities, residential care facilities, nursing homes, supportive living and employment programs for people with intellectual and developmental disabilities, and private child care agencies. OLRO strives to ensure service equity and delivery of culturally and linguistically appropriate services are provided to Oregonians. In the GB functions of OLRO are being placed back into program where the accountability for the function lies. In this budget only the Child Welfare related staff are left in OLRO. However, those positions will at some point be moved into Child Welfare likely after the review of that system has been completed.

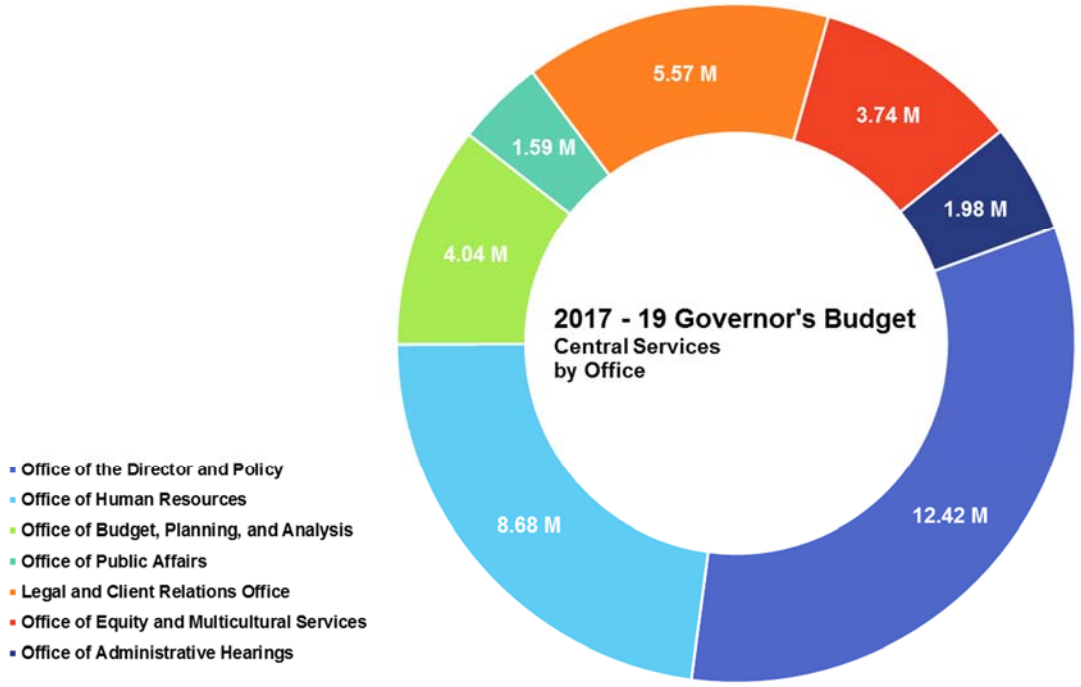
Office of Program Integrity (OPI)

OPI conducts analysis and tests to determine whether DHS is implementing programs in the way they were designed and trains caseworkers based on their

findings to improve program integrity. The Quality Control Unit conducts operational and case reviews, many mandated by state and federal law, to determine how accurately each program is making eligibility and other determinations. The Quality Assurance Unit and the Centers for Medicare and Medicaid Services Waiver Group conducts field reviews to assess program quality.

Department of Human Services: Central Services

Primary Long Term Focus Area: Excellence in State Government
Secondary Long Term Focus Area:
Program Contact: Eric Moore



Program Overview

DHS Central Services consist of the Office of the Director and Policy, the Office of Human Resources, the Central Budget Office, the Office of Communications, the Office of Legislative and Client Resources (LCRO) within the Public Affairs Office and the Office of Equity and Multicultural Services (OEMS). These offices provide essential business supports to programs in achieving the department and programs mission, vision and outcomes.

Program Funding Request

CENTRAL SERVICES	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
2015 - 17 LAB	18,154,354	715,144	17,416,183	36,285,681	96	95.42
2017 - 19 GB	19,339,624	736,854	17,945,143	38,021,621	96	95.42
Difference	1,185,270	21,710	528,960	1,735,940	0	0.00
Percent change	6.53	3.04	3.04	4.78	0.00	0.00

Program Description

Office of the Director and Policy

The DHS Director's Office is responsible for overall leadership, policy development and administrative oversight. These functions are coordinated 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 DHS Director's Office provides leadership in achieving the mission of the agency: helping Oregonians achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity. The office supports all DHS field office and central office programs by managing legislative and legal matters, client concerns, written rules, and contested hearings.

DHS Office of the Chief Financial Officer (OCFO)

OCFO provides optimal business services to ensure accountability, data driven decisions, and stewardship of resources in support of the mission of DHS. This is done by working closely with DHS programs and the OHA CFO and programs, to ensure accurate, timely and efficient recording and management of financial resources; culturally competent and equitable services; authorizing the redistribution of available resources to meet changing needs; and establishing administrative controls. The OCFO is responsible to provide leadership and direction to the DHS Budget Office and the fiscal offices located in DHS that serve both DHS and OHA, including the Budget Center, Office of Financial Services, and Office of Forecasting. These offices ensure that accounting, budget, and forecasting practices comply with all applicable laws, rules, and professional standards and ensure transparency and accountability in the financial practices of DHS and OHA.

Budget, Planning and Analysis (BPA)

This office functions as the central budget for DHS based programs working under the guidance of the OCFO. The OCFO is responsible to provide leadership and direction to the DHS Budget Office and the fiscal offices located in DHS that serve both DHS and OHA, including the Office of Financial Services, the Central Budget Unit, and Office of Forecasting. These offices ensure that accounting, budget, and forecasting practices comply with all applicable laws, rules, and professional standards and ensure transparency and accountability in the financial practices of DHS and OHA.

Office of Human Resources (Dedicated HR)

HR serves as a strategic partner to its customers in DHS, providing proactive, comprehensive human resources services, in alignment with agency and program mission and goals. HR works closely with internal customers on Workforce Strategies that support agency and program needs and strategies, and building a healthy workplace culture of ongoing development and feedback to ensure the agency has a diverse workforce with the right people with the right skills, training, and support to do their work, now and in the future.

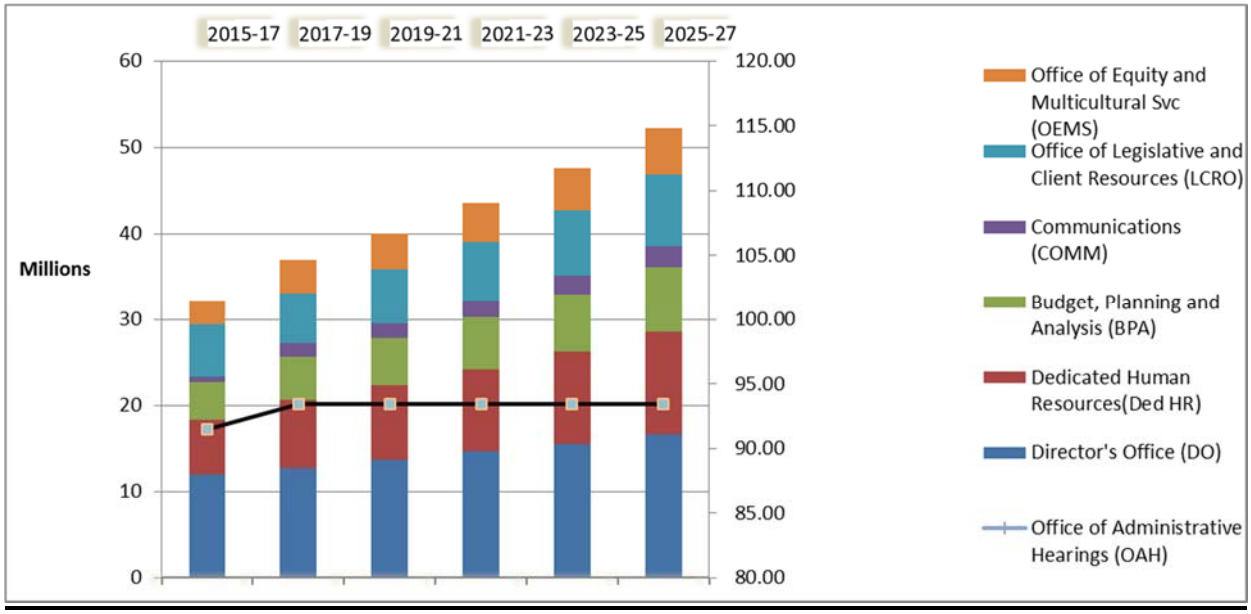
Office of Public Affairs

The DHS Public Affairs Office is made up of three work units: Communications, Legislative, and Legal. The office provides DHS with unified support and coordination in outreach and communication, legislative action and strategy:

- Communications Unit - This office supports the mission by providing accurate information to a diversity of 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. Effective communication is the primary vehicle to demonstrate public transparency, accountability, and trust. The office also provides support to the department's priority projects as defined by the DHS Director and executive team.
- Legislative Unit - This unit handles all legislative matters for DHS. This team coordinates all DHS legislative matters with legislative offices, key stakeholders and the Governor's Office. This team supports both field and central office staff providing consultation and support in legislative matters, primarily working with central office staff on policy development for program services. During a legislative session, this unit tracks and assigns all bills related to DHS program and operations. Staff in this unit support the director of DHS, the directors of all program and operations in DHS and the district managers in field offices regarding legislative matters.
- Legal Unit - This Unit manages all lawsuits, tort claims and subpoenas related to DHS program and operations. Staff in this unit provide expert consultation to DHS field and central office staff, Department of Justice (DOJ) and Department of Administrative Services (DAS) Risk Management in policy related to legal matters. This team ensures timely completion of the required judicial documents to move smoothly through a complicated legal matter.

Office of Equity and Multicultural Services (OEMS)
OEMS provides leadership and direction in supporting equity, diversity and inclusion initiatives throughout the agency. OEMS guides systemic changes to both internal workforce developments as well as improve service delivery to all Oregonians. The office also investigates all claims of discrimination and harassment. The goals of the office include reducing service disparities in all program areas; ensuring a diverse and culturally competent workforce; removing barriers to a welcoming work environment; and improving life outcomes for all DHS clients.

Program Justification and Link to Focus Areas



DHS Central Services provide critical leadership and business supports necessary to achieve the mission of the agency: helping Oregonians achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity.

DHS Central Services include the cost of DHS Budget, Planning and Analysis, the Director, Governor's Ombudsmen, Legislative and Communications & support, Diversity and Dedicated Human Resources.

The DHS Central Services budgets are structured and administered according to the following principles:

Control over major costs
DHS centrally manages many major costs. Some of these costs, like many DAS charges, are essentially fixed to the agency. Others, like facility rents, are managed centrally to control the costs. DHS also strongly supports and actively participates in statewide efforts to locate work across the enterprise and install performance management systems to perform administrative functions more efficiently and effectively.

Performance management system
DHS is has implemented a performance management system containing the following key elements:

- A clear statement of the outcomes DHS must achieve.
- Descriptions of the processes DHS uses to achieve its outcomes.
- Measures of success for each outcome and process.
- Owners for each measure.
- Written "breakthrough" strategies for each initiative that will significantly improve outcomes and processes.
- A quarterly all-day all-leadership review of progress on each measure and strategy.

DHS is now implementing the same system within each program and support service category. The system is contained in the Director's Office and is managed by the entire executive team.

Best practices in installing performance management require specific skills - especially in project management, Lean tools, data analysis, and professional development of managers. DHS has reallocated resources and used savings to make some of these investments, but it must increase these skills as much more needs to be done.

Enabling Legislation/Program Authorization

ORS 409.010

Funding Streams

- Allocated Costs – Costs benefiting more than one federal or state program are charged to a cost allocation pool. The allocating grant numbers accumulate costs until the monthly cost allocation process is run.

- Direct Charge – Costs benefiting a single federal or state program are charged directly to the grant number representing the program. There is no additional allocation for these costs.
- Monthly Process – The process runs each month based on actual accumulated costs. On a monthly basis, statistics are generated to complete the allocation process. The cost allocation pools are cleared each month by the operation of the cost allocation process to transfer the costs to the final grant and cost objective.
- Federal Financial Participation (FFP) Calculation – After costs are allocated to final cost objectives, DHS calculates and records the level of Federal Financial Participation for the specific grant.

Funding Justification and Significant Changes to 17-19 CSL

There are no POPs relevant to the Central Service Areas. This funding proposal maintains the program at Current Service Level, assuming only the minimal standard inflationary rates.

Department of Human Services: Shared Services

Primary Long Term Focus Area: Excellence in State Government
Secondary Long Term Focus Area:
Program Contact: Eric Moore

Shared Service Programs

DHS Shared Services	GF	OF	FF	TF	POS	FTE
Shared Services Administration		1,255,935		1,255,935	3	3.00
Budget Center		3,789,878		3,789,878	15	15.00
Office of Forecasting & Research Analysis		4,003,187		4,003,187	25	15.43
Office of Financial Services		27,966,990		27,966,990	160	154.96
Human Resource Center		23,966,446		23,966,446	97	84.00
Office of Facilities Management		5,218,639		5,218,639	28	28.00
Imaging & Records Management Svcs		12,247,265		12,247,265	76	74.29
Office of Contracts & Procurement		9,590,239		9,590,239	44	43.60
Office of Adult Abuse Prevention & Investigation		11,002,116		11,002,116	54	51.88
Internal Audits & Consulting		2,141,461		2,141,461	9	8.97
Office of Payment Accuracy & Recovery		28,446,215		28,446,215	153	147.18
Publication & Design		2,715,680		2,715,680	14	14.00
DHS Shared Services	**-**	**132,344,051**	**-**	**132,344,051**	**678**	**640.31**

Program Overview

DHS Shared Services supports DHS and OHA by providing optimal business services to ensure accountability, data driven decisions, and stewardship of resources.

Program Funding Request

SHARED SERVICES	GF	OF	FF	TF
LAB 15-17	$ -	$ 127,867,811	$ -	$ 127,867,811
GB 17-19	$ -	$ 132,344,051	$ -	$ 132,344,051
Difference	$ -	$ 4,476,240	$ -	$ 4,476,240
Percent change	0.0%	3.5%	0.0%	3.5%

Program Description

DHS Shared Services contains the following key offices and programs:

Shared Services Administration

This office provides leadership and direction for the shared services offices.

The goals of the Shared Services offices are to:

- Implement standardized business practices that are used throughout DHS/OHA;
- Increase the efficiency, effectiveness and coordination of administrative services through the consolidation of functions across DHS/OHA;
- Provide relevant information and recommendations regarding budget, forecasting and analysis of policy issues;
- Ensure effectiveness and efficiency in program management and measurement of results;
- Develop clear, concise information to support effective decision-making;
- Work effectively across DHS/OHA to ensure department policies are incorporated and appropriately reflected in both agencies' budgets; and
- Provide reliable caseload and cost-per-case forecasts for all major programs, incorporating impacts of policy changes, changing demographics and any other relevant information available.

Budget Center

This office provides program and administrative budget planning, financial analysis and technical budget support for DHS and OHA. These services are provided for department and program leadership, policy and field managers, staff and external policymakers.

- Budget Services Financial Support
- Budget Services Quality Assurance and Reporting
- Legislative Fiscal Coordination

Office of Forecasting, Research and Analysis

This office provides client caseload forecasting services for DHS and OHA. The Office of Forecasting, Research and Analysis provides critical forecasting and technical support to assist program managers to determine projected need for services and to develop the department budget to address these needs, anticipate changes in federal and other funding streams that may affect the ability to provide services, assure compliance with federal funding regulations and requirements, manage appropriation allotments and cash flow throughout the biennium, provide

analysis and estimates to respond to inquiries from internal and external parties, and provide information and assistance in managing the DHS/OHA budgets during the biennium.

- Client caseload forecasting:
- Producing semi-annual caseload forecasts for various DHS programs (divisions);
- Monitoring actual client counts compared to the forecast; and
- Tracking and researching local, state and national trends affecting client caseloads

Geographic Information Systems (GIS) – Location Data Services
The GIS Location Data Services group is a part of the Office of Forecasting, Research and Analysis. This group develops, codes and maintains spatial data sets related to program areas within the DHS and OHA. The team is responsible for,

- mapping existing data
- spatial coding of data
- data development
- overlay Analysis
- travel-time and least-cost path analysis

Oregon Enterprise Data Analytics
The 2015 Oregon State Legislature created Oregon Enterprise Data Analytics. This group produces evidence-based, actionable information though inter-agency research to improve the lives of Oregonians. They collaborate across state agencies such as OHA, Education, Housing, Oregon Youth Authority and others to create useful insights and supportive.

Office of Financial Services (OFS)
This office provides accounting services, administers employee benefits and payroll, prepares financial reports, and collects funds owed to DHS and OHA. This office provides accurate, accountable and responsive financial management and business services to DHS and OHA clients, providers, vendors, stakeholders and employees in support of both agencies' missions and in compliance with state laws and federal policies, rules and regulations. OFS is organized by functional area with the goal of maximizing operational efficiency. OFS works closely with the DAS State Controller's Division, other state agencies and the federal government.

- The **Accounts Receivable Unit** produces invoices, collects funds due back to DHS/OHA, and provides DHS/OHA Accounts Receivable collection data annually to the Legislative Fiscal Office (LFO). This unit also receives and processes garnishments levied on the department.

- The **Receipting Unit** deposits all negotiable instruments received by DHS/OHA; accurately records the revenue and reduction of expense transactions into SFMA for these receipts, as well as from credit card and ACH activity in DHS/OHA Treasury accounts.

- The **Disbursements and Travel Unit** processes invoices for goods and services including rent, utilities, supplies, interagency services, SPOTS VISA and travel claims for DHS/OHA employees and other authorized non-state individuals.

- The **Contract Payments Unit** processes contract payments for services with providers and local governments, ensures payments are within contract limitations, and processes contract settlements as needed.

- The **Payroll Unit** processes agency payroll data and ensures that each employee of DHS/OHA receives proper compensation in pay and benefits for work done.

- The **Strategic Systems Unit** takes financial data from the various DHS/OHA proprietary payment and receipting systems, converts the data and interfaces the data into SFMA. Interfaced transactions include payments, payment cancellations, accounts receivable and recoupments. This unit is also responsible for the SFMA structures and cash flow management,

- The **Management Reporting and Cost Allocation Unit** develops, maintains and implements the department-wide cost allocation plan to allocate indirect administrative expenditures to federal, state and other sources; and provides data management support to internal customers as well as division support in the monitoring of budget to actual reporting.

- The **Statewide Financial Reporting and Trust Accounting Unit** prepares annual financial report information for inclusion in the statewide Combined Annual Financial Report; manages trust accounts.

- The **Reconciliation Unit** completes all reconciliation reports, compares results in SFMA, the State Treasury and DHS/OHA proprietary systems.

- The **Federal and Grant Reporting Unit** maintains, analyzes reviews and reports on various grant types such as entitlement, block and categorical grants; and submits, receipts, and distributes federal draw requests for federal expenditure disbursements.
- The **Portland Accounting Unit** provides accounting services for Public Health Division (PHD) programs including accounts payable, monitoring sub-contractor expenditures, cash receipting, accounts receivable, audit coordination, and grant financial review and reporting.
- The **Internal Control and Policy Unit** monitors system security and control structure. Forgery Services Section handles and researches overpayments, forged, counterfeit and altered checks.

Office of Human Resources

This office provides essential HR administrative functions and services for DHS and OHA, and supports organizational development and an improved common culture of leadership and engagement across both agencies, through background checks and fitness determinations; personnel records management; leave administration; centralized position administration; safety and risk response and management; staff and management training; facilitation services and Lean Daily Management System (LDMS) coaching; HR data analysis and reporting; HR policy administration; and internal communication strategies and resources for managers and staff.

- Employee Records and Benefits Administration;
- Workforce Capacity Reports;
- Safety, Health and Wellness;
- Leave Law interpretation/ADA/Workers' Compensation
- Background Checks
- Organizational Advancement

Office of Facilities Management

The Facilities Center is a shared service office that provides Facilities functions for DHS/OHA. The office acquires and administers leases and contracts for

approximately 173 DHS/OHA facilities statewide; coordinates construction, remodeling and modifications of facilities to meet service delivery needs; plans and manages modular furniture installations; monitors energy use; oversees both agencies' motor vehicle fleet; manages mail and parcel delivery; plans, develops, installs, and repairs DHS/OHA telecommunications systems; audits the DHS/OHA telephone bills; and conducts detailed research and analysis of phone systems to determine the most appropriate systems for both agencies' operations.

Facilities Management works with community colleges, cities and county governments to deliver its services. It also helps DHS/OHA managers, staff and community partners develop and organize offices to meet the service delivery needs. Services include:

- Acquisition and administration of DHS/OHA leases and contracts for an estimated 173 leased facilities statewide;
- Oversight of the DHS/OHA motor vehicle fleets;
- Coordination of construction and remodeling of leased facilities, facilities project management; and
- Plans modifications of workspace to accommodate changes in program service delivery needs.

Central Services serves administrative offices located in five buildings in Salem and Portland. Services include:

- Coordination of building maintenance and management of energy use;
- Management of mail and parcel delivery at the Barbara Roberts Human Services Building and the Portland State Office Building;
- State vehicle management and scheduling at the Barbara Roberts Human Services Building and the Portland State Office Building;
- Lobby reception at the Barbara Roberts Human Services Building;
- Security and evacuation management at the Barbara Roberts Human Services Building; and
- Management of the furniture purchasing and centralized furniture warehouse in Salem, including inventory tracking.

Telecommunications administers the DHS/OHA telecommunications. Services include:

- Planning, development and installation of telecommunications systems in 173 buildings statewide;
- Upgrading and repairing current systems;
- Telephone billing audits; and
- Detailed research and analyses of phone systems to determine the most appropriate systems for the department's operations.

Office of Imaging and Records Management Services (IRMS)
This office provides document and records management services for DHS and OHA through imaging, electronic workflow, data entry, archiving and retention services.

- Data capture services for billing claims related to medical and dental services, hospitals, nursing homes, in-home services, home-delivered meals and child care
- Imaging services related to Oregon Health Plan applications, SNAP applications, Senior Prescription Drug applications, Human Resources documents, criminal history background documents, checks, hearing documents, intentional program violations, child care, medical claims, sterilization consent forms, Financial Services documents, and client case records.
- Electronic and physical records archival, retrieval and coordination of destruction services

This office electronically images more than 2,111,000 documents each month. These are related to the Oregon Health Plan, SNAP program, Direct Pay Unit/Child Care programs, Financial Services, Oregon Health Authority, Background Check Unit, and provider and client hearings. IRMS provides images of checks to Financial Services to allow for timely receipt and deposit of funds, and provides images to the Background Check Unit to assist in expediting retrieval of records to answer provider questions.

IRMS also receives an average of 125,620 paper claims and checks each month for data capture. Most are for medical and dental services, hospitals, nursing homes, in-home services, home-delivered meals, and child care. IRMS provides data and images, which allow SNAP programs, Oregon Health Plan and Oregon Health Authority staff to answer provider and client questions regarding eligibility and payment. The Electronic Document Management System (EDMS) electronically images documents and stores the images on a Storage Area Network (SAN), providing a single repository resulting in immediate accessibility to all authorized DHS/OHA staff throughout the state of Oregon.

Office of Contracts and Procurement (OC&P)
This office provides contract and procurement services for DHS and OHA by making purchases, conducting solicitations, and preparing and processing contracts with other government agencies, businesses and service providers.

There are approximately 500 DHS/OHA program personnel who work directly with OC&P to put contracts in place which support both agencies. Additionally, there are approximately 1,000 DHS/OHA administrative support personnel who require OC&P services related to purchases supporting DHS/OHA business operations.

Office of Adult Abuse Prevention and Investigations
This office conducts investigations and provides protective services in response to reported abuse and neglect of seniors and people with physical disabilities; adults with developmental disabilities or mental illness; and children receiving residential treatment services. The types of abuse we investigate may include physical, sexual, verbal and financial abuse; neglect, involuntary seclusion, and wrongful restraint. (See also individual Bid Form for more details)

Internal Audits and Consulting
This unit provides independent and objective information about DHS and OHA operations, programs and activities to help management make informed decisions and improve services.

The unit assists management through reviews of DHS/OHA programs and activities, ensuring effective and efficient use of resources to achieve the department's goals and outcomes. The unit performs independent audits and reviews, which include:

- Reliability and integrity of financial and operational information,
- Effectiveness and efficiency of operations,
- Safeguarding of assets,
- Evaluation of management controls (which may be related to investigations of alleged misconduct and illegal activities), and
- Compliance with laws and regulations, contracts, and grant awards.
- These services are important because they:
- Help decrease the amount of fraud, waste and abuse;
- Ensure the reliability and integrity of financial and operational information;
- Ensure effectiveness and efficiency of operations;
- Ensure adequacy of internal controls to prevent or minimize alleged misconduct and illegal activities; and
- Ensure compliance with laws and regulations, contracts and grant awards.

Office of Payment Accuracy and Recovery (OPAR)
This office provides recovery services for DHS and OHA by identifying and recovering moneys paid in error to clients or providers; investigates allegations of fraudulent activities; investigates and recovers state funds expended for services when a third party should have covered the service and the recovery of claims made by a client; and recovers funds from the estates of Medicaid recipients for the cost of cash and medical benefits provided.

OPAR strives to improve program integrity, payment accuracy and financial recovery on behalf of many DHS/OHA programs (SNAP, Medicaid, Temporary Assistance to Needy Families (TANF), Child Care, and others). Specific services provided include:

- Audits and investigations
- Establishment of overpayment debts and collection of those debts
- Facilitation of third-party recoveries

- Identification of third-party resources
- Assistance to DHS field staff with data integrity issues
- Recovery of Medicaid, Clawback and General Assistance funds from estates of deceased clients

Publication and Design Section
This section manages the writing, design, development, printing and distribution of DHS and OHA publications for internal and external audiences, which includes alternate formats and alternate languages. Provides consulting to plan professional quality publications that reflect DHS and OHA style guidelines; edit and proof materials created by staff experts and partners in their individual fields; provide graphic design, layout, original and digital illustration, forms creation, graphic artwork and Web and electronic materials.

Program Justification and Link to Focus Areas
DHS Shared Services provide critical business supports necessary to achieve the mission of the agency: helping Oregonians achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity.

DHS Shared Services include:

- Payments to DAS and third parties for goods and services that serve the whole agency, such as facility rents, state data center charges, the DAS risk assessment, DAS government service charges, computer replacement, and debt service.
- Payments for DHS's share of the cost of services shared with OHA. When the agency split, DHS and OHA agreed to share information technology, financial, investigations, and other services to avoid cost increases and permit a greater focus on improving performance and efficiency.
- The cost of the DHS/OHA shared services provided by DHS. These costs are entirely Other-funded, paid for by the payments described in the 2nd bullet above and there are similar payments in the OHA budget. From a total fund perspective, these costs are double-counted in the DHS and OHA budgets, but are needed in order for the offices to perform their daily operations.

The DHS Shared Services budget is structured and administered according to the following principles:

Control over major costs
DHS centrally manages many major costs. Some of these costs, like many DAS charges, are essentially fixed to the agency. Others, like facility rents, are managed centrally to control the costs. DHS also strongly supports and actively participates in statewide efforts to locate work across the enterprise and install performance management systems to perform administrative functions more efficiently and effectively.

Customer-driven shared services
When the agency split, DHS and OHA agreed to maintain many administrative functions as shared services to prevent cost increases, maintain centers of excellence, and preserve standards that help the agencies work together.

Shared Governance
DHS and OHA govern their shared services through committees composed of operational leaders of the two agencies. This approach ensures shared services are prioritized and managed to support program needs. The committee and its subgroups have established service level agreements and performance measures for each service, implemented recent budget cuts selectively, moved staff in and out of shared services to rationalize service delivery, and started implementing more integrated systems to support the performance of all our employees.

Best practices in installing performance management require specific skills - especially in project management, Lean tools, data analysis, and professional development of managers. DHS has reallocated resources and used savings to make some of these investments, but in order to increase these skills much more needs to be done.

Enabling Legislation/Program Authorization
ORS 409.010

Funding Streams
Funding streams are billed through an approved cost allocation plan. The model contains a billing allocation module and a grant allocation module.

The billing allocation module allocates Shared Service costs to the two agencies. The billing module allocates costs to customers within each agency. It does not allocate costs directly to Federal grants.

The grant allocation module allocates costs within DHS to State and Federal grants. These costs include those directly incurred by DHS, Shared Service costs allocated to DHS by the billing allocation module, and external costs allocated to DHS by other State agencies.

Both modules allocate aggregated costs on a monthly basis and use similar allocation methods.

Funding Justification and Significant Changes to CSL

This does not include statewide reductions. Below is a table of proposed investments in shared services. POP 102 is just the shared portion of the larger POP cost with only the shared services portion displayed below. POP 205 has a corresponding POP in the OHA budget. Funding for these POPs are included in the SAEC budget under the shared services funding line item.

	GF	OF	FF	TF	POS	FTE
GB Build - POPS	**-**	**7,408,872**	**-**	**7,408,872**	**23**	**11.75**
102 - Centralized Abuse Management System	-	157,072	-	157,072	1	0.75
205 - Background Check Unit Workload	-	7,251,800	-	7,251,800	22	11.00

102 Centralized Abuse Management System

House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations. This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability to achieve the capabilities and

efficiencies of the proposed integrated solution. The Other Funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one time request for limitation. The General Fund is the best current estimate of costs of the ongoing operations and maintenance of the new system.

205 Background Check Unit Workload

Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines for background checks. Groups for whom BCU completes checks include but are not limited to home care workers, personal support workers, subsidized child care providers, child caring agencies, System of Care and SPRF providers, and staff and volunteers from residential care, nursing, and adult foster home facilities. The staff requested in this policy option package would meet currently required needs to maintain timely background checks for all regulated groups handled by BCU, and meet projected needs due to program growth and new federal and state statutes implementing during the 2017-2019 biennium. The result would be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for vulnerable Oregonians through quality background checks. In addition, Department of Human Services (DHS) has identified a variety of expansion options to current background check criteria for DHS and OHA providers whose fitness determination is completed by the Background Check Unit (BCU). These options would provide more intensive background checks by accessing a variety of DHS, state and federal information regarding health, safety, abuse and fraud not currently utilized. The result would be increased health, safety and financial wellness for vulnerable Oregonians. The BCU has authority to charge fees but does not currently do so. A fee for service model is an option to cover some or all costs of the BCU.

Reductions:

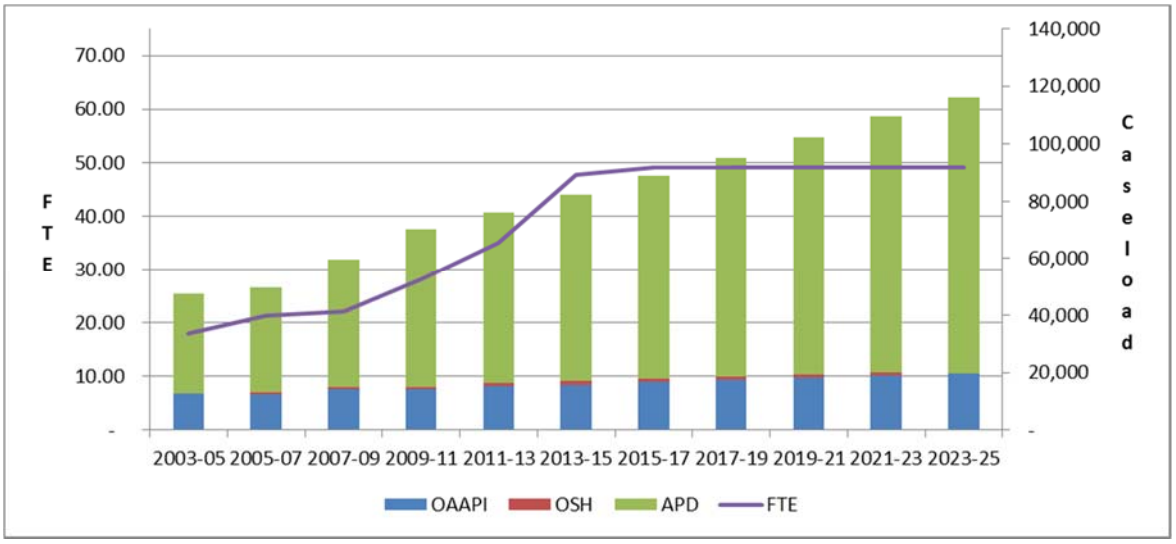
- Remove General Assistance from financial services (HB4042). - House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a

condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded. NOTE: This is the Shared Services protion of the reduction. Please also see APD Delivery for remaining portions. ($125,194 OF)

Department of Human Services: Office of Adult Abuse Prevention and Investigations

Primary Long Term Focus Area: Safety
Secondary Long Term Focus Area: Healthy People
Program Contact: Justin Hopkins, OAAPI Director

Caseloads by Area of Investigation and Staffing Levels



Note: This chart shows caseloads by area of investigation compared to staffing levels, with an almost 68% increase in caseload from FY 05-07 to FY 13-15.

Program Overview

The Office of Adult Abuse Prevention & Investigations (OAAPI) is a DHS/OHA Shared Service that provides abuse-related services to the Aging & People with Physical Disabilities (APD), Intellectual/Developmental Disabilities Services (I/DD) and Child Welfare (CW) programs at DHS, and the Health Systems Division and the Oregon State Hospital at OHA.

Together with its program partners, OAAPI serves some of Oregon's most vulnerable individuals, in their own homes or in licensed care facilities. The approximate numbers served include:

- 619,000 older adults and people with physical disabilities;
- 16,300 adults enrolled in Intellectual and Developmental Disabilities (I/DD) programs;
- 57,200 adults receiving Community Mental Health Services or residing in the Oregon State Hospital (OSH); and
- 3,600 children residing in licensed facilities that provide therapeutic treatment, or children enrolled in I/DD services.

OAAPI has a core staff providing specialized abuse-related services statewide. OAAPI's staff monitors and supports the work of over 250 abuse screeners, investigators, protective service workers and managers around the state who work for many different entities, including state offices, Area Agencies on Aging, and community mental health and developmental disability programs.

In 2015, nearly 43,000 reports of possible abuse or neglect of vulnerable Oregonians were received and screened statewide by OAAPI and its program partners. Of those, 19,041 allegations were assigned for investigation by OAAPI or program staff, to determine if abuse had occurred and to provide protective services to the alleged victim. About 29% of all allegations investigated (5497) were substantiated in 2015.

Program Funding Request

OAAPI	GF	OF	FF	TF	POS	FTE
LAB 15-17	$ -	$ 10,540,924	$ -	$ 10,540,924	56	52.76
GB 17-19	$ -	$ 11,002,116	$ -	$ 11,002,116	54	51.88
Difference	$ -	$ 461,192	$ -	$ 461,192	(2)	(0.88)
Percent change	0.0%	4.4%	0.0%	4.4%	-3.6%	-1.7%

Program Description

OAAPI exists to ensure a prompt, consistent and equitable response to all reports of abuse of vulnerable adults (and children in certain settings) across the state, to provide proactive prevention training and services to vulnerable populations and those who care for them and to help prevent abuse from happening in the first place.

OAAPI works toward these goals by the provision of the following specialized, abuse-related services to its DHS and OHA program partners:

- Data collection and analysis;
- Quality assurance and continuous improvement activities;
- Staff training and development;
- Research and prevention activities;
- Program coordination and technical assistance; and
- Specialized investigation services.

As a Shared Service with a broad view of adult abuse trends across varying populations and settings, OAAPI is uniquely positioned to provide trend data and outcomes to program and agency partners, who use that information to ensure and enhance the safety of their respective client populations.

For example, in 2014 OAAPI published its second financial exploitation study, providing updated and comprehensive statewide data about financial exploitation – currently the most frequently investigated form of abuse in Oregon. The study allowed OAAPI and its partners to better define and explain the cost of abuse, identify regional trends and enhance community engagement efforts, and has been recognized nationally as a pioneering study.

In 2016, OAAPI published its third Annual Report (Calendar Year 2015) which provided abuse data for all the populations served by OAAPI and its partners, as well as a unified view of the serious risks faced by all vulnerable Oregonians.

Reports such as these provide the important link between research and practice, allowing OAAPI and our partners to use actual data to focus our efforts and drive decision-making and program development.

In addition to supporting program staff in the field, OAAPI screens and responds to reports of abuse in state-operated facilities directly. These settings include Children's 24-Hour Residential Developmental Disability (DD) programs, the Oregon State Hospital, I/DD Stabilization and Crisis Units (SACU) and Secure Residential Treatment Facilities either operated or contracted by the state, as well as Residential Child Caring Programs. In 2015, approximately 3,000 reports of possible abuse were reported in these settings and over 700 were assigned for investigation by OAAPI staff investigators.

To fulfill its mission, OAAPI works closely with other state agencies and offices, such as the Long Term Care Ombudsman and the Background Check Unit, to respond to allegations of abuse as well as to share abuse-related information, as allowed, to further protect vulnerable Oregonians. When residents of licensed facilities are reported to have been abused, OAAPI works closely with the DHS offices that are responsible for licensing and taking corrective action in facilities, to ensure that appropriate steps are taken to protect the alleged victim and to hold perpetrators accountable.

In regard to Community Engagement, OAAPI collaborates actively with community partners, non-profit agencies, stakeholders, advocacy groups, labor groups, providers' organizations and consumers to ensure that the abuse investigation practices and protective service interventions in use around the state are understood and supported by all involved.

OAAPI also conducts regular community outreach to ensure that anyone who may need to report abuse is able to do so. In 2015, OAAPI participated in 31 outreach events at the local, state and national levels, presenting information about recognizing and reporting abuse to a wide range of audiences at events such as the Child Abuse and Family Violence Summit; the Scam Jam events sponsored by AARP, DOJ and DCBS; the OSU Lifelong Learning Institute; and various outreach events scheduled for World Elder Abuse Awareness Day. In addition, OAAPI has recently hired two new bilingual/bicultural staff to help ensure awareness of, and access to, abuse-related services, both directly and through the publication of abuse-related printed materials in Spanish.

OAAPI's program costs are driven by many factors, including the aging of Oregon's population, the increasing demand for services in both community and facility settings, and an increase in the legal, medical and social complexity of abuse cases. Unfortunately, national research shows that elder abuse is vastly under-reported, with only an estimated one in 23.5 cases reported. Financial abuse is one in 44, and neglect one in 57 (Cornell University, 2011[1]). A 2009 study by MetLife reported a "$2.9 billion dollar annual loss" as a result of elder financial abuse, which is a 12 percent increase from 2008. This is supported by OAAPI's research, which indicates that in 2013 financial exploitation comprised 45 percent of all substantiated abuse in Oregon and resulted in significant financial loss to

[1] Testimony by Mark Lachs, Senate Special Committee on Aging, March 2, 2011 Washington, D.C.

Oregon citizens. Ultimately, all of these factors drive up requests for service and lead to increased costs for OAAPI and the programs that OAAPI supports.

Program Justification and Link to Focus Areas

OAAPI is linked to the Outcome goal of Safer, Healthier Communities for all Oregonians, particularly for vulnerable adults and children. Individuals we serve are at the highest risk of abuse or neglect. National research shows that more than half of people with mental illness or developmental disabilities will experience repeated physical or sexual abuse in their lifetime. Older adults who are victims of abuse have been shown to be three times more likely to die in a given time period than their non-abused peers[2]. The goal of Safety is also supported by the use of OAAPI's abuse history information in employment screening, limiting the ability of substantiated perpetrators to actively seek employment with vulnerable populations.

Research shows that:

- Elder abuse victims are four times more likely to go to a nursing home[3].
- Victims of abuse use healthcare services at higher rates[4].
- 90 percent of abusers are family members or trusted others[5].
- Almost one in 10 financial abuse victims will turn to Medicaid as a direct result of their own monies being stolen from them[6].

Considering the direct link between robust abuse prevention efforts and potential reductions in health care services, Medicaid costs and nursing home placements, a quick and effective response to reports of abuse is not only critical to the wellbeing of vulnerable Oregonians but a wise investment as well.

Program Performance

OAAPI participates actively in the DHS Fundamentals Quarterly Business Review, whereby process and outcome measures are identified, tracked and reported enterprise-wide on a quarterly basis. Current process measures include the timeliness of the initial response to abuse reports, timely completion of investigations and the rate of inconclusive findings. Outcome measures include the

[2] Journal of American Medical Association, Vol. 280, No. 5, 428-432.
[3] Testimony by Mark Lachs, Senate Special Committee on Aging, March 2, 2011 Washington, D.C.
[4] Archives of Family Medicine, 1992 (1), 53-59,
[5] National Center on Elder Abuse, 1994.
[6] The Utah Cost of Financial Exploitation, March 2011, Utah Division of Aging and Adult Services.

overall abuse rate by population and the rate of re-abuse within one year. These metrics provide transparency and drive continuous improvement efforts across programs.

As an additional measure of accountability, OAAPI also conducts quality assurance and continuous improvement activities to ensure accuracy of statute/rule compliance, provide mandated oversight to local office investigators, identify abuse and performance trends and target training and community education needs.

# of referrals – beside investigations	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15
Other calls requiring action+	22,198	22,316	31,591	43,469	46,698	49,949

+ Specialized consultation, referral to another agency or source, enhanced screening

Investigations	2003-05	2005-07	2007-09	2009-11	2011-13	2013-15
Number completed	25,444	27,309	27,906	26,901	31,167	33,494

Enabling Legislation/Program Authorization

The Federal Americans with Disabilities Act, Elder Justice Act of 2009, the Older Americans Act, and the Adoption and Safe Families Act all authorize states to protect vulnerable adults and children from abuse and neglect. Oregon statutes further authorize DHS and OHA to provide protection from abuse to certain populations and training for the individuals who conduct abuse investigations. Statutory authorization for investigating abuse of seniors and people with disabilities is found at ORS 124.005 *et seq*. For people with developmental disabilities or mental illness, authorization is at ORS 430.735 *et seq.*, and for children, authorization is at ORS 419b.005 *et seq.*

Funding Streams

As a Shared Service, the services provided by OAAPI staff are paid for by each program under a Service Level Agreement (SLA), which specifies the services to be provided and the method of cost allocation to be used. The services provided by program staff conducting investigations around the state are paid for by their respective programs. OAAPI regularly seeks revenue-supplementing opportunities including grants, and is consulting with our federal partners regarding federal funds that may become available for adult protective services in coming years.

Funding Justification, Significant Changes to 17-19 CSL

This does not include statewide reductions.

OAAPI						
	GF	OF	FF	TF	POS	FTE
GB Build - POPS						
102 - Centralized Abuse Management System		156,444		156,444	1	0.75

102 Centralized Abuse Management System

House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations. This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability to achieve the capabilities and efficiencies of the proposed integrated solution. The Other Funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one-time request for limitation. The General Fund is the best current estimate of costs of the ongoing operations and maintenance of the new system.

The 17-19 GB is 12% higher than the 17-19 CSL, and 4.4% higher than the 15-17 LAB. The increase is due to the addition of one position, as shown in the Policy Option Packages (POPs) described above. The position is added for CAM Project related to HB 4151 requirement. The funding proposal will directly address the Department's core value of safety, and help the Department come closer to meeting the Legislature's expectations regarding the safety of Oregon's older adults and adults with physical and developmental disabilities.

Department of Human Services: State Assessments and Enterprise-wide Costs

Primary Long Term Focus Area: Excellence in State Government
Secondary Long Term Focus Area:
Program Contact: Eric Moore

SAEC Budget	GF	OF	FF	TF
State Government Service Charge	18,959,764	516,247	19,035,012	38,511,023
Risk	12,101,999	503,470	9,617,009	22,222,478
State Data Center	13,605,712	780,716	11,916,271	26,302,699
Facilities	66,274,260	1,921,950	66,555,228	134,751,438
Computer Replacement	3,564,659	74,619	2,989,784	6,629,062
Shared Services Funding	99,577,892	2,679,255	83,275,741	185,532,888
Debt Service	9,243,778	-	-	9,243,778
Telecommunications	2,804,513	53,268	2,161,294	5,019,075
Mass Transit	9,636			9,636
Unemployment	1,389,433	38,233	1,125,392	2,553,058
Treasury Credit Line		31,105,912		31,105,912
Total SAEC GB	**227,531,646**	**37,673,670**	**196,675,731**	**461,881,047**

Note: There are no positions or FTE in the SAEC budget

Program Overview

The SAEC budget includes statewide and other enterprise assessments costs such as State Government Service Charges, the State Data Center, rent, computer replacement costs and the cost of DHS/OHA shared services.

Program Funding Request

SAEC	GF	OF	FF	TF
LAB 15-17	$ 207,796,036	$ 38,893,219	$ 171,527,345	$ 418,216,600
GB 17-19	$ 227,531,646	$ 37,673,670	$ 196,675,731	$ 461,881,047
Difference	$ 19,735,610	$ (1,219,549)	$ 25,148,386	$ 43,664,447
Percent change	9.5%	-3.1%	14.7%	10.4%

Program Description

DHS has statewide assessments that include DAS charges such as the State Government Service Charge, Risk Assessment and State Data Center Charges.

Rent for all of DHS is in the Facilities budget. This budget includes the computer replacement budget. The Shared Services funding is the revenue for the DHS portion of DHS and OHA shared services. When the agency split, DHS and OHA agreed to share information technology, financial, investigations, and other services to avoid cost increases and permit a greater focus on improving performance and efficiency.

Debt services is to pay off Certificates of Participation or Q-Bond loans taken for major DHS projects. Each service, both shared and assessed, are important for DHS to attain its programmatic outcomes. It is critical to continue to look for efficiencies in our systems, processes or staffing.

This budget also includes the costs of telecommunications, unemployment insurance and limitation for a line of credit from the Treasury Department used for cash flow purposes at the end of the biennium.

Program Justification and Link to Focus Areas

There is a direct link between this program and Excellence in State Government focus area. DHS strives to control major support costs. DHS centrally manages many major costs. Some of these costs, like many DAS charges, are essentially fixed to the agency. Others, like facility rents, are managed centrally to control the costs. DHS also strongly supports and actively participates in statewide efforts to locate work across the enterprise and install performance management systems to perform administrative functions more efficiently and effectively.

Program Performance

DHS is committed to customer-driven shared services. When the agency split, DHS and OHA agreed to maintain many administrative functions as shared services to prevent cost increases, maintain centers of excellence, and preserve standards that help the agencies work together. DHS and OHA govern their shared services through a joint committee composed of operational leaders of the two agencies. This approach ensures that shared services are prioritized and managed to support program needs. The board and its subgroups have established service level agreements and performance measures for each service, moved staff in and out of shared services to rationalize service delivery, and begun implementing more integrated systems to support the performance of all our employees.

DHS pays for services from the Department of Administrative services including general charges and costs of the State Data Center. DHS also actively supports

statewide projects like HRIS and the rent renegotiation project intended to make government more efficient and cost effective.

Enabling Legislation/Program Authorization

The authorization for these budgets comes from legislative budget bills each biennium. Spending authority for the agency is a part of the general authority granted to the agency through statute and federal law. General DHS statutes include ORS 409.010, ORS 409.110 and ORS 409.160.

Funding Streams

A mix of state general and federal dollars fund the majority of the services provided in SAEC many of the areas are assessed to federal funds through a cost allocation processes.

Funding Justification, Significant Changes and Comparison to 17-19 CSL

This does not include statewide reductions. The following policy option packages (POPs) are recommended in the DHS Governor's Budget above the current service level for SAEC. In some cases these are costs related to program investments costs related to rent or other enterprise-wide costs or assessments that will be billed to the agency through the SAEC budget.

Many of these investments are the funding for shared services program costs from shared services within both DHS and OHA.

The remaining POPs are described in other "bid" forms in the main program area in which the investment is proposed.

	GF	OF	FF	TF
GB Build - POPS	**10,625,157**	**-**	**1,221,826**	**11,846,983**
102 - Centralized Abuse Management System	157,072	-	-	**157,072**
201 - Integrated Eligibility	4,349,819	-	-	**4,349,819**
205 - Background Check Unit Workload	6,118,266	-	1,221,826	**7,340,092**

Reductions:

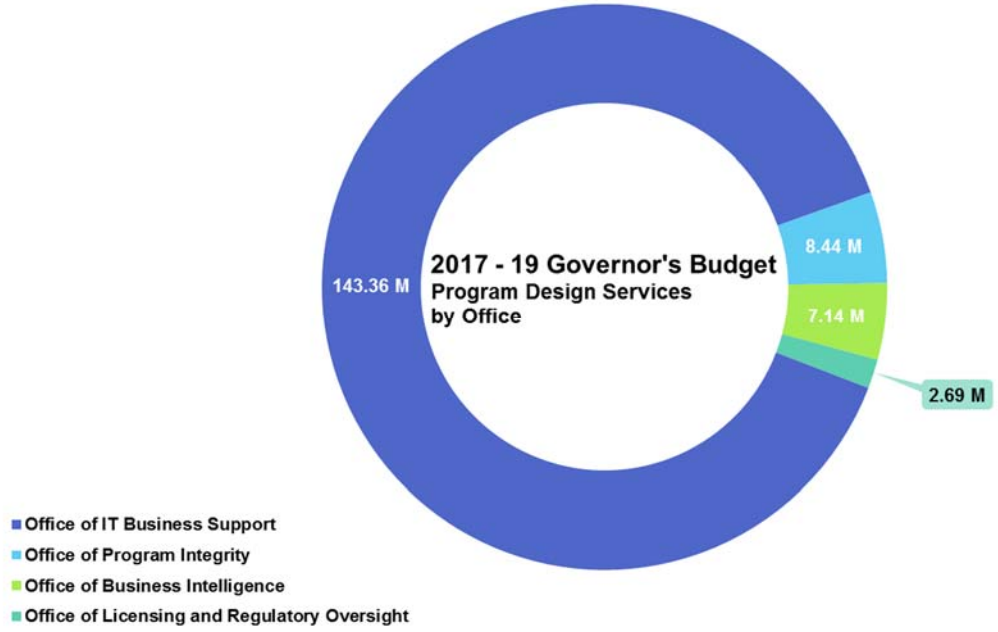
- Disallowed Backfill for Federal Grants - This action assumes that there will be sufficeint federal funding to cover assumed shortfally in capped grants. The agency will be reviewing it's federal grant balances to determine the

impact of this reduction closer to the close of the 15-17 budget when ending balances are more clear. NOTE: This is the Shared Services protion of the reduction. Please also see other Program Areas for remaining portions. ($2,770,443 GF)

- Remove General Assistance from financial services (HB4042) - House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded. NOTE: This is the Shared Services protion of the reduction. Please also see APD Delivery for remaining portions. ($62,597 GF)

Department of Human Services: Program Design Services

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: Excellence in State Government
Program Contact: Don Erickson



Program Overview

DHS Program Design Services support program design offices by centralizing service that require specialized skills. This allows each office to set uniformly high standards for each of these services and to develop its staff to those standards. It facilitates cross-training of staff in multiple programs, flexibility in supporting program offices when needs change or staff turnover occurs, and research into the combined impact of our services on clients served by more than one program.

Investment in centralized infrastructure

Based on the process maps developed in the performance management system, DHS restructured into five programs. DHS Program Design Services include the Office of Business Intelligence (OBI), the Office of Information Technology Business Support (ITBS), the Office of Licensing and Regulatory Oversight (OLRO), and the Office of Program Integrity (OPI).

The five programs were given the essential functions to design and implement their programs within the performance management system. DHS then centralized many support services that previously had been performed separately by each program. This was done with the hope of creating efficiencies, assigning clear accountability for the performance of support services, and allowing targeted investments to improve performance. Better support services ultimately improve performance of all DHS employees and our providers. DHS is in the process of evaluating whether centralizing these services achieved the desired results and may modify certain functions based on the outcome of this work.

Program Funding Request

PROGRAM DESIGN SERVICES	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
2015 - 17 LAB	18,718,013	7,997,929	61,157,921	87,873,863	157	137.83
2017 - 19 GB	29,533,510	18,544,023	110,860,021	158,937,554	141	130.87
Difference	10,815,497	10,546,094	49,702,100	71,063,691	(16)	(6.96)
Percent Change	57.78	131.86	81.27	80.87	(10.19)	(5.05)

Program Description

Office of Business Intelligence (OBI)

OBI maintains a consolidated DHS data warehouse, compiles data reports and conducts research and analysis to determine whether DHS programs are achieving their goals and desired outcomes. OBI specializes in managing data to ensure it is accurate, consistent, and useful to programs in assessing their success and for making decisions to alter their program design. One important part of this role is managing the agency scorecard of outcome and process measures and reporting on legislative Key Performance Indicators. OBI conducts professional research requested by programs to give them a more rigorous foundation for their program design. OBI also provides data for legislative and media requests, and consults and collaborates with researchers in other state agencies and with the Oregon Enterprise Data Analytic unit to ensure DHS data and programs are understood when analyzed.

Information Technology Business Supports (ITBS)

ITBS bridges the gaps between Aging and People with Disabilities (APD), Intellectual and Developmentally Disabled (I/DD) program needs and the technology used by each program to deliver services, benefits and assistance. ITBS leads program efforts to develop functional Information Technology (IT) business requirements, perform solution testing, and implement projects and improvement

efforts. ITBS fields over 15,000 technology support calls every year from program clients, providers and partners seeking assistance with a range of complex eligibility, enrollment, payment and access/security challenges. ITBS is focused on the following areas of concern:

- Stable and reliable IT support and operations;
- Consistent, documented testing of application patches and releases;
- Broad knowledge of key benefit programs, concerns and supporting systems;
- Comprehensive Level of Effort (LoE) estimation for proposed business requirements;
- Accurate business analysis for solution enhancement, development and documentation;
- Expert IT project/solution delivery using a consistent, professional methodology; and
- IT user support (Tier 1, 2, 3) for legacy systems:
    - Oregon ACCESS;
    - eXPRS;
    - ASPEN; and
    - Mainframe (CEP, Pay-in, Client Maintenance, Service Eligibility, etc).

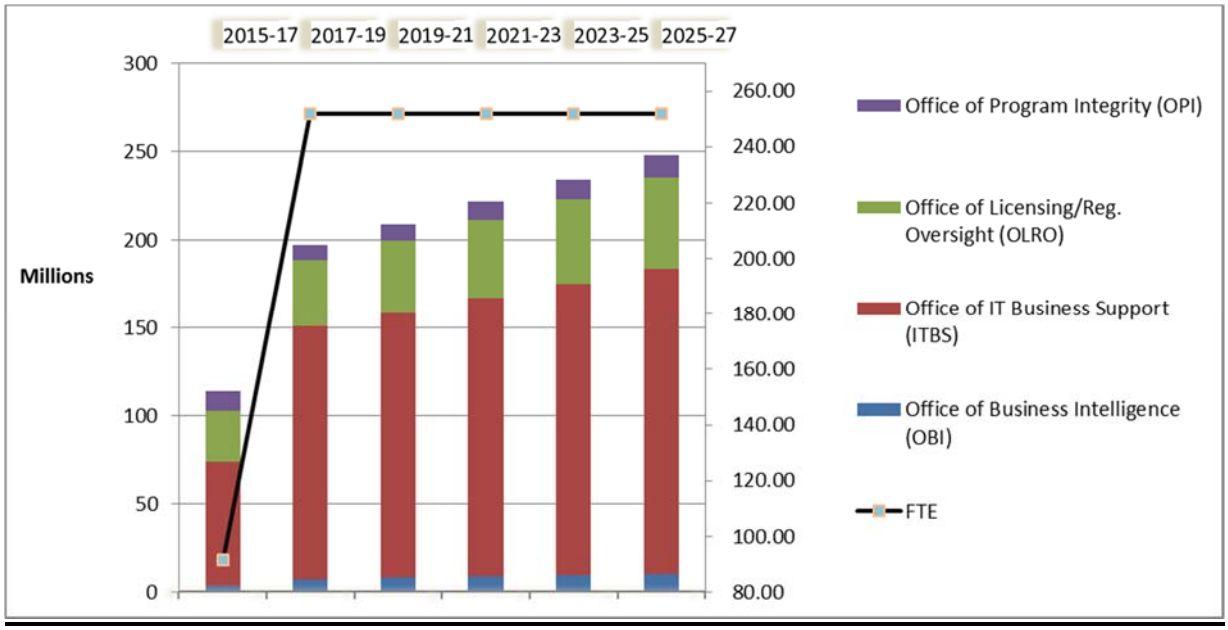
Office of Licensing and Regulatory Oversight (OLRO)

The mission of the Office of Licensing and Regulatory Oversight (OLRO) is to improve the safety, health and quality of care for children and adults served by the Oregon Department of Human Services and others through service providers across the continuum of care.

OLRO provides oversight, investigation of complaints, and reports of potential abuse and corrective action for providers for children, the aging and physically disabled, and people with developmental disabilities served by the Department of Human Services and others. This centralized service is currently under review by DHS as the agency has determined that centralization of the service did not achieved the desired outcomes. The positions will be moved back to program areas during the next "reshoot" of the DHS budget.

Office of Program Integrity (OPI)
OPI conducts analysis and tests to determine whether DHS is implementing programs in the way they were designed and trains caseworkers based on their findings to improve program integrity. The office conducts operational and case reviews as well as field visits, many mandated by federal law, to determine how accurately each program is making eligibility and other determinations.

Program Justification and Link to Focus Areas



To become outcome-driven, an agency must:

- Determine the outcomes it wants to achieve;
- Measure the outcomes;
- Design programs to achieve the outcomes;
- Implement the design through business and IT processes; and
- Systematically review whether the processes are being implemented as designed and how well the outcomes are being achieved.

Program Design Services links primarily to the Safer and Healthier Communities Focus Area. Program Design Services employ professionals who specialize in these tasks who help DHS and its programs perform these tasks. OBI specializes in program data used to measure outcomes, including maintaining the agency scorecard, and conducts professional research on the impact of various program designs on achievement of outcomes. OPI determines whether operating units are implementing the program design accurately provides information necessary to

meet federal reporting requirements, as well as provides information necessary for trainers to conduct trainings to close any gaps. ITBS acts as a translator between program staff and IT technical staff to ensure that IT projects more accurately meet business needs. OLRO uses many of these tools to license residential providers who serve clients of DHS and other agency programs as well as private clients.

Program Performance

Program Design Services are concentrating on improving operations of foundational services and covering gaps in services that existed when the services were split. OBI set targets to put all program data into data warehouses, to organize all warehouse data in a format giving program users more access to get data on their own, to automate reports, and to respond more quickly to individual requests. As of March 2016, depending on the program, 88 percent of identified program data was contained in a data warehouse and report automation was at 72 percent. These metrics are generally improving.

OPI and the agency adopted agency-wide metrics to improve accuracy or quality in 12 different program areas. OPI sets targets to complete all accuracy and client service reviews on time and accurately.

OLRO set targets to complete all licensing reviews within federal timelines. Nursing facility reviews, in particular, have been problematic due to the difficulty of recruiting staff, the extensive training and certification required, and the increasing depth of the reviews. OLRO isolated the various factors influencing the ability to complete the reviews, found some techniques to streamline the process and developed a plan to get in compliance.

Enabling Legislation/Program Authorization

ORS 409.010

Funding Streams

- Allocated Costs – Costs benefiting more than one federal or state program are charged to a cost allocation pool. The allocating grant numbers accumulate costs until the monthly cost allocation process is run.
- Direct Charge – Costs benefiting a single federal or state program are charged directly to the grant number representing the program. There is no additional allocation for these costs.
- Monthly Process – The process runs each month based on actual accumulated costs. On a monthly basis, statistics are generated to complete the allocation process. The cost allocation pools are cleared each month by the operation of

the cost allocation process to transfer the costs to the final grant and cost objective.

- Federal Financial Participation (FFP) Calculation – After costs are allocated to final cost objectives, DHS calculates and records the level of Federal Financial Participation for the specific grant.

Funding Justification and Significant Changes to CSL

102 Centralized Abuse Management System

General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
68,192	0	67,966	136,158	1	.58

House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations. This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability to achieve the capabilities and efficiencies of the proposed integrated solution. The Other Funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one-time request for limitation. The General Fund is the best current estimate of costs of the ongoing operations and maintenance of the new system (corresponding Bid Form noted in APD).

116 Nursing Facility Complaint Investigations

General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
253,993	-	1,519,145	1,773,138	8	7.04

Federal requirements specify that nursing facility complaints and self-reported incidents (when necessary) be investigated by federally trained and certified nursing home surveyors. Currently in Oregon, federally qualified nursing facility surveyors investigate approximately one-third of all nursing facility abuse complaints and self-reported incidents and Adult Protective Services investigates the remaining complaints/self-reported incidents. APS workers are not certified by CMS to perform this work. This POP is necessary in order to transition complaints currently investigated by APS, to the nursing facility survey unit (state survey agency) or to a regional field model with federally qualified surveyors. This POP also includes staff necessary to assume many non-abuse complaints that are currently not being investigated.

201 Integrated Eligibility Project

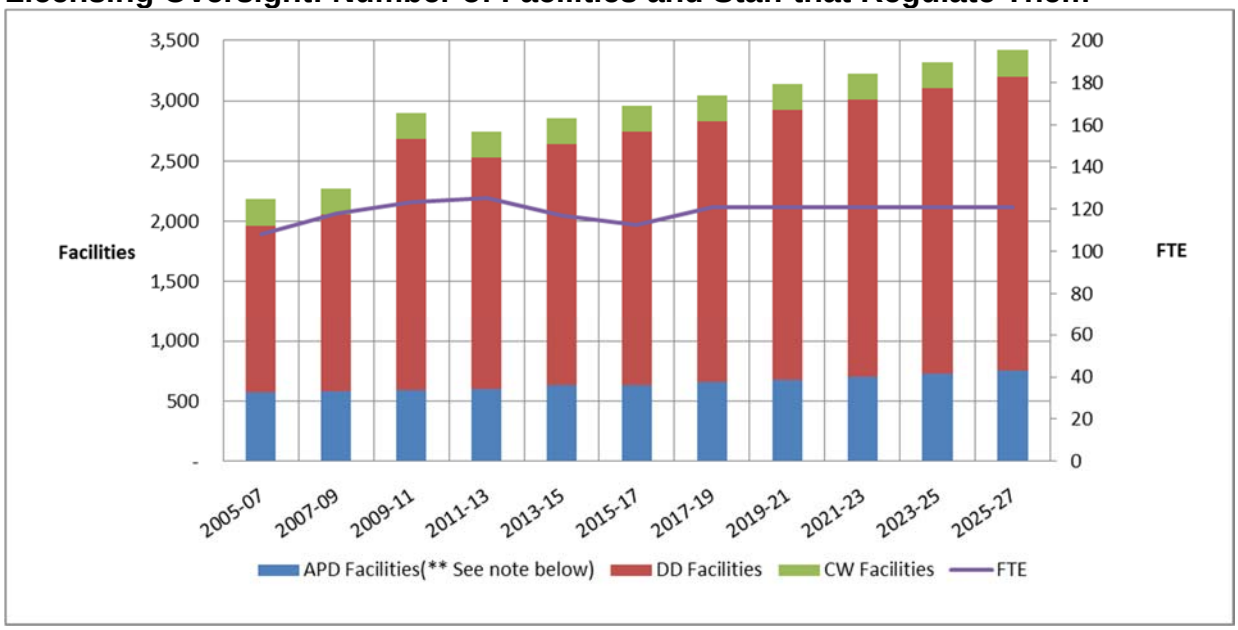
General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
7,609,969	18,275,000	101,794,707	127,679,676	38	28.29

DHS is seeking legislative approval for a project that would transfer human service eligibility determination functionality from Kentucky to add to the new integrated OregONEligibility system (Debt Service is noted on the SAEC Bid form). This will impact eligibility for Non-MAGI Medicaid, ERDC, SNAP and TANF programs.

Department of Human Services: Office of Licensing and Regulatory Oversight

Primary Outcome Area: Safer and Healthier Communities
Secondary Outcome Area:
Program Contact: Tom Van der Veen

Licensing Oversight: Number of Facilities and Staff that Regulate Them



Note: The number of facilities requiring licensure by DHS has grown significantly while the FTE for staff responsible for oversight of these facilities has not kept pace.

Program Overview

The mission of the Office of Licensing and Regulatory Oversight (OLRO) is to improve the safety, health and quality of care for children and adults served by the Oregon Department of Human Services and others through service providers across the continuum of care.

OLRO provides oversight, investigation of complaints, and reports of potential abuse and corrective action for providers for children, the aging and physically disabled, and people with developmental disabilities served by the Department of Human Services and others.

Program Funding Request

OFFICE OF LICENSING AND REGULATORY OVERSIGHT	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
2015 - 17 LAB	12,650,957	10,056	16,607,476	29,268,489	113	112.87
2017 - 19 GB	1,667,114	3,503	1,022,745	2,693,362	9	9.00
Difference	(10,983,843)	(6,553)	(15,584,731)	(26,575,127)	(104)	(103.87)
Percent Change	-86.82	-65.17	-93.84	-90.80	-92.04	-92.03

Program Description

In the past, OLRO has been responsible for the licensing, certification, regulatory and corrective action functions for Aging and People with Disabilities, Child Welfare and the Developmental Disabilities programs. This includes adult foster homes for individuals with developmental disabilities and for the aged and physically disabled, 24-hour residential programs, assisted living facilities, residential care facilities, nursing homes, supported living programs, proctor care for agencies for children, brokerages, provider organizations, employment and alternatives to employment programs, outdoor youth programs, day treatment facilities, adoption agencies, homeless/runaway/transition shelters, foster care agencies, therapeutic boarding schools, academic boarding schools and residential care facilities for children with behavioral, emotional and mental health conditions.

Licensing staff are closely connected to the Office of Adult Abuse Prevention and Investigation (OAAPI). OAAPI conducts investigations and provides protective services in response to reported abuse and neglect of seniors and people with disabilities, and children receiving care from certain licensed provider. When OAAPI conducts an investigation and finds health or safety issues – whether the OAAPI investigation into abuse or neglect is substantiated or not – licensing staff are brought in to determine whether a licensing violation has occurred.

Critical Categories of Oversight														
		Physical Environment: -Fire and Life Safety -Clean and Home Like	**Staffing** - Safe - Trained	**Residents Rights Upheld** Dignity, Respect, Free from abuse	**Protection from Financial Exploitation**	**Adequate food, clothing , and shelter**	**Medical** 24 hour emergent, acute and chronic care	**Plan of Care Exist** Individual, Specialized as well as self directed	**Quality of Life** Independent Choice, Home like settings, Socialization, and Family connections	**Adequate Education**	**Vocational** Skill development	**Policies & Procedures** Exist and are followed	**Admission, transfer or discharge** - Appropriate -Timely	**Activities of Daily Living Assistance** (Timely and Available) -Toileting -Eating -Ambulation -Hygiene
Program Area	People with Developmental Disability	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Nursing Facilities	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔
	Assisted Living and Residential Care Facilities	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔
	Children's Care	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
	Adult Foster Care	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔

✔ Performed

Program Justification and Link to Focus Area

Program Design Services links to the Safer, Healthier Communities focus area. The performance of licensing staff is directly related to the safety of vulnerable Oregonians who find themselves in need of care in a supervised 24-hour living environment. These Oregonians are often unable to protect themselves and they deserve to be free from abuse and neglect by service providers, and free from facilities that engage in practices that are detrimental to their safety and health. Through the timely, thorough and effective oversight of care facilities and homes for children, the elderly and the disabled, licensing staff provide some assurance that conditions exist within these facilities and homes that provide the highest likelihood of safety and quality care. The licensing and certification regulations that are in place are intended to educate providers of required safe practices, prevent unsafe conditions from being perpetuated, and mitigate risk to vulnerable children and adults in care through regular oversight to insure that the regulations are being upheld.

Program Performance

The Department currently measures the timeliness of facility surveys conducted by each individual licensing program. The Department also utilizes several methods of oversight including:

- Initial Licenses
- Renewal/Site Visits
- Corrective Actions
- Civil Money Penalties
- Suspension/Sanction/Revocation
- Investigate Complaints

Enabling Legislation/Program Authorization

Licensure of Nursing Facilities in Oregon is mandated via ORS 441.015 (et seq) "Licensing and Supervision of Facilities and Organizations" and Medicaid Certification via Social Security Act, Title XIX, Sec 1819(g) - "Survey and Certification Process," "State and Federal Responsibility" Medicare Certification via Social Security Act, Title XIX, Sec 1919(g).

Licensure of Assisted Living Facilities and Residential Facilities is mandated via ORS 443.455 "Residential Facilities and Homes" And Memory Care Endorsement within these facilities is mandated via ORS 443.886 "Alzheimer's Disease" "Special endorsement required; standards; fees; rules."

Licensure of Adult Foster Homes for Adults who are Older or Adults with Physical Disabilities is mandated via ORS 443.705 through 443.825.

Licensure of Children's Care Agency facilities is mandated via ORS 418.205 through 418.327 and ORS 418.990 through 418.998.

Certification of Homes for Children with Developmental Disabilities is mandated via ORS 443.830 and 443.835. Licensure of Adult Foster Homes for Persons with Developmental Disabilities is mandated via ORS 443.705-443.825. Licensure of 24-hour Residential Programs for Children and Adults with Developmental Disabilities is mandated via ORS 443.400-443.455.

Endorsement of Employment Services for Individuals with Developmental Disabilities is mandated via ORS 427.007, 430.610, 430.662-430.670.

Endorsement of Supported Living Programs for Adults with Developmental Disabilities is mandated via ORS 430.610, 430.662 and 430.670. Endorsement of Community Living Services is mandated via ORS 417.340-417.355, 427.005, 427.007, 430.610, 460.620, and 460.662-430.695.

Agency Certification and Endorsement to Provide Developmental Disabilities Services in Community-Based Settings is mandated via ORS 427.005, 427.007, 430.610, 430.620, and 430.662-430.695.

Funding Streams

This program and its accompanying positions are funded with a mix of state funding, General Fund and Federal Funding from the following federal grants: Title XIX Medicaid at the Program Rate, Title XIX Medicaid at the Administrative Rate, and Title IV-E.

Funding Justification, Significant Changes to CSL

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also includes staff necessary to assume many non-abuse complaints that are currently not being investigated.

In late 2015, the Department began making specific, targeted organizational changes to increase clarity and safety for consumers, and to enhance the connections between licensing staff and DHS programs and providers. In 2016, OLRO began a multi-phase process to restructure licensing functions within DHS to better ensure the safety of the vulnerable children and adults it serves. The reorganization of OLRO calls for integrating licensing functions into the program divisions whose directors have ultimate accountability for licensing decisions: Aging and People with Disabilities, Child Welfare or Developmental Disabilities. The integration is likely to continue through the 2017-19 biennium.

OLRO functions are being integrated into program divisions as follows:

From OLRO	**To Program Division**	**Licensing Function Description**
Adult Foster Homes	APD	Works with 1,900 homes for Aging and Physically Disabled. These are licensed through APD with technical assistance, corrective action and licensure policy development occurring in the Office of Licensing and Certification.
Nursing Facilities	APD	Works with 139 Licensed Nursing Facilities where licensure is achieved and maintained, in part, through annual on-site review by teams of trained Client Care Monitoring Surveyors using a rigorous oversight, monitoring and corrective action process that is prescribed by the Centers for Medicare and Medicaid Services and Oregon statute and rule. On-site visits are conducted to ensure the safety and well-being of the approximate 5,000 most medically compromised and vulnerable elderly residents served in these facilities. Currently 42 FTE (majority federally funded) are employed to survey all Nursing Facilities on the federally mandated survey schedule. Surveyors are also charged with the investigation of allegations of rule violation, including abuse and neglect.

Residential Care and Assisted Living	APD	Works with 516 Assisted Living Facilities and Residential Care Facilities where licensure is achieved through on-site surveys conducted every two years. These facilities provide 24-hour care and services to elderly and disabled residents. This is the fastest growing level of care within the continuum for seniors and is anticipated to continue to expand within the service delivery system in the years to come. There is currently a capacity for over 23,000 Oregonians who may reside at this level of care, representing the largest population of Oregon's elderly citizens. The purpose of on-site visits is to ensure the safety and well-being of the vulnerable population served in these facilities. There are 15 surveyors that conduct on-site surveys in an industry that continues to increase in capacity each year while the number of FTE allocated for surveyors remains stagnate. There are eight FTE responsible for providing technical assistance to providers, consumers and local office staff. They also apply civil money penalties, sanctions and interventions to facilities that fail to provide adequate care and supervision. Industry growth exceeds our ability to provide adequate staff resource to do risk mitigation for the residents in these care settings.
Homes and Facilities for children and adults with developmental disabilities	DD	Works with 1,929 homes and facilities serving approximately 6,500 children and adults with developmental disabilities where licensure is achieved through reviews. This includes on-site licensing/certification visits, monitoring and corrective action. The Developmental Disabilities Licensing Unit is responsible for the oversight of a variety of facility and program types. The regulatory activity occurs every year for Adult Foster Homes; every two years for 24-Hour Residential Programs and Child Foster Homes; and every five years for Supported Living Programs, Employment and

		Alternatives to Employment programs, Proctor Care agencies for children, Supported Living Program, Brokerages, and Provider Organizations. Adult foster homes and residential facilities for children with Developmental Disabilities are licensed and certified by nine client care surveyors within this office.
Private Child Caring Agencies	TBD	Works with 240 Private Child Caring Agency facilities and programs with a capacity to serve approximately 10,000 children. Licensure is achieved through regulatory reviews every two years. This includes on-site surveying, monitoring and corrective action. Children's Care Licensing Programs are statutorily mandated to oversee a variety of facility and program types, some of which are funded through Federal and State funding streams and others which are private. This includes the Oregon Youth Authority, the Oregon Health Authority and county juvenile departments. Currently this work is done by two Licensing Coordinators. This licensing unit is only able to respond to wrong-doing that has already occurred and is unable to mitigate risk to children through proactive efforts with provider agencies.
Business, Innovation and Resource Unit	APD	Identifies systemic failures and gaps regarding the Department's regulatory responsibilities. Prioritizes and supports systemic improvements regarding regulatory functions within and across program areas. Tests, monitors and reports the effectiveness and quality of statutorily authorized mechanisms to achieve safety, health and independence for people in DHS-regulated settings. Establishes and maintains best practices in regulation across all programs in the Department.

To ensure and improve collaboration and communication across licensing functions and programs, the DHS Director's Office established a Department-wide

Licensing and Safety Review process in November 2015. The Licensing and Safety Review created a cross-program forum to elevate and problem-solve issues with licensed providers the Department has safety, licensing or financial concerns about. The Licensing and Safety Review touches multiple business lines within DHS and outside the Department. At times, it may include the Oregon Health Authority, Oregon Youth Authority or other state agencies. OLRO staff have participated in the process and will continue to do so following their transition into program divisions.

Department of Human Services
Self-Sufficiency Program

Mission

To provide a safety net, family stability and a connection to careers that guide Oregonians out of poverty.

Program

The Self-Sufficiency Program (SSP) is designed to provide low-income Oregonians with services to create stability and prepare participants for employment so they are equipped to work their way out of poverty. The programs emphasize the safety and healthy development of children, and often serve to prevent abuse or neglect that may lead to out-of-home placement in the more expensive foster care program.

Oregonians access SSP services when they are in need and have no other alternatives. SSP participants access services through a network of local offices in every county.

SSP works to achieve its mission by focusing its efforts on five foundational operating principles:

- Family engagement;
- Economic stability;
- Collective impact;
- Integrity and stewardship; and
- Professional Development.

The services offered through SSP are:

- Employment Related Day Care (ERDC)
- Supplemental Nutritional Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- TANF-related programs such as the Job Opportunity and Basic Skills (JOBS) program and Family Support and Connections (FS&C)
- Temporary Assistance for Domestic Violence Survivors (TA-DVS)
- Refugee Program
- Youth Services Program
- Program Design and Delivery

Challenges from the Great Recession linger, and SSP caseloads continue to be higher than they were prior to the recession. Many SSP participants are working but have lower wages or fewer hours than they did prior to the recession and don't earn enough to make ends meet on their own. There continues to be an uneven distribution of poverty based on factors such as geography, race/ethnicity, and age. In Oregon, poverty rates in rural counties tend to be higher than urban areas.

Services

Employment Related Day Care program (ERDC)

ERDC helps low-income, working families arrange and pay for quality child care. The program provides low-income families with the same opportunity for reliable, quality child care as other families with higher incomes.

ERDC helps parents gain self-sufficiency by assisting with the consistent, stable child care parents need to maintain employment. It also contributes to the school readiness of children and supports children with special needs, as well as offering resources to support providers who come from diverse cultural backgrounds.

Providers are required to meet a set of health and safety standards, and pass required background checks before they can become DHS providers and receive payment. In addition, all license-exempt providers are required to take an online health and safety training. License exempt providers who are not related to a child in their care, must take additional pre-service trainings and pass a monitoring visit by the Early Learning Divisions, Office of Child Care.

Supplemental Nutrition Assistance Program (SNAP)

SNAP is a federally funded benefit program to help low-income individuals and families buy food to meet their nutritional needs. Benefits to participants are 100 percent federally funded; however, the administration of the program requires a 50 percent state match. Approximately one in five Oregonians receive food assistance through SNAP.

SNAP is an important and constantly growing anti-poverty program. Recent research has shown that SNAP benefits reduce the depth and severity of poverty, and have a particularly strong effect on reducing child poverty.

Self-Sufficiency offices across the state serve the majority of the SNAP population. The balance of the population includes elderly persons (60 and older)

plus persons with disabilities who require services. They are assisted by Aging and People with Disabilities (APD) Program offices and their contracted agencies: Area Agencies on Aging, Disability Services Offices and Councils of Government.

States administering SNAP are federally required to offer a limited companion employment and training program. Oregon serves voluntary SNAP clients in one of the following programs: Oregon Food Stamp Employment and Training (OFSET) Program, The Able-Bodied Adults Without Dependents (ABAWD) Program, or the 50/50 Employment and Training Program.

Food and Nutrition Service (FNS) within the United States Department of Agriculture regulates SNAP. Although federal regulations do allow a few options, any significant variation from the regulations must be approved by FNS through a formal process.

Commodities Supplemental Food Program (CSFP)
The CSFP Program provides a prescribed nutritious commodity package to help meet the needs of low-income elderly persons (aged 60 or older) in Oregon. Through local agencies, each participant receives a monthly package of commodities. Food packages include canned fruits and vegetables, canned meat, poultry and other protein items, and grain products such as pasta, as well as other foods. While CSFP food packages do not provide a complete diet, they are good sources of the nutrients typically lacking in the diets of the target population. Participants in CSFP are also offered the opportunity to receive nutrition education instruction and information.

The Emergency Food Assistance Program (TEFAP)
TEFAP is a federal program that helps supplement the diets of low-income Oregonians by providing them with emergency food and nutrition assistance at no cost. The amount of food Oregon receives is based on the number of unemployed persons and the number of people with incomes below the federal poverty level. The State of Oregon provides USDA commodities, as well as administrative funds, to the Oregon Food Bank (OFB) who is the State Distributing Agency. The OFB works with a cooperative network of regional food banks, partner agencies, and programs to distribute emergency food to hungry families.

Temporary Assistance for Needy Families (TANF)
TANF is a collection of programs directed at improving the lives of very low-income Oregon families with children. It is a critical safety net program for

families with children living in extreme poverty and helps families from a variety of diverse backgrounds to address their most basic needs. TANF provides eligible families with cash assistance, connections to support and community resources, case management, and employment and training services.

Safety net programs are usually the last step for families with few or no resources left, and any assistance can have an immediate impact on their health, safety and well-being. These families typically use TANF funds to prevent homelessness and to help with other factors contributing to family instability. The goal of the program is to help families address barriers, gain skills and access employment opportunities to become self-sufficient.

TANF-Related Programs

- **Job Opportunity and Basic Skills (JOBS) Program:** Most adults must meet additional requirements to receive TANF services. A TANF family may participate in the JOBS program and access a variety of other programs and services as part of the plan to move a participant towards self-sufficiency. The JOBS Program provides employment and skill-building services to individuals of families receiving TANF assistance. Individuals participate in JOBS to gain skills necessary to join the workforce and retain employment.
- **Family Support and Connections:** Family Support and Connections provides supports to prevent children in the TANF program from entering the child welfare system. Home visiting and community-based services are some of the interventions used to build on family strengths and address family functioning issues.

Temporary Assistance to Domestic Violence Survivors (TA-DVS)

TA-DVS provides temporary financial assistance and support services to families with children affected by domestic violence during crisis or emergent situations when other resources are not available. TA-DVS is used to help the domestic violence survivor and their children address their safety concerns and stabilize their living situation, which reduces the likelihood of the survivor returning to the abuser. These services maintain the safety of these vulnerable children and their parents, and can prevent life-threatening situations. They also help prevent child abuse and the need for child welfare intervention.

Refugee Program
The Refugee Program serves individuals and families who fled persecution in their country of origin and were legally admitted for resettlement by the United States government. The program helps refugees and people who have been granted asylum successfully resettle in this country by providing financial, employment-related and acculturation services. The program guides refugees into self-sufficiency through employment as early as possible. The program serves only those persons in immigration categories approved by the Federal Office of Refugee Resettlement (ORR).

Youth Services Program
The Youth Services Program is an age-appropriate, medically accurate, sexual health education program. This service supports community prevention efforts to help families break the generational connection to public assistance. The Youth Services Program expands on the historical teen pregnancy prevention program to provide education and tools for youth to resist multiple risk-taking behaviors. DHS partners with the Oregon Department of Education and the My Future - My Choice Advisory Committee to develop and implement the program.

Program Design and Delivery
Program Design and Delivery provides program design, personnel and service delivery in addition to oversight, planning, reporting, implementation, training, eligibility and benefit issuance for SSP.

Staff at state and local levels also coordinate closely with other DHS programs, including Child Welfare, with the goal of working with families to increase their stability and prevent Child Welfare involvement. This collaboration helps to support safety by ensuring children are cared for regardless of the system of service.

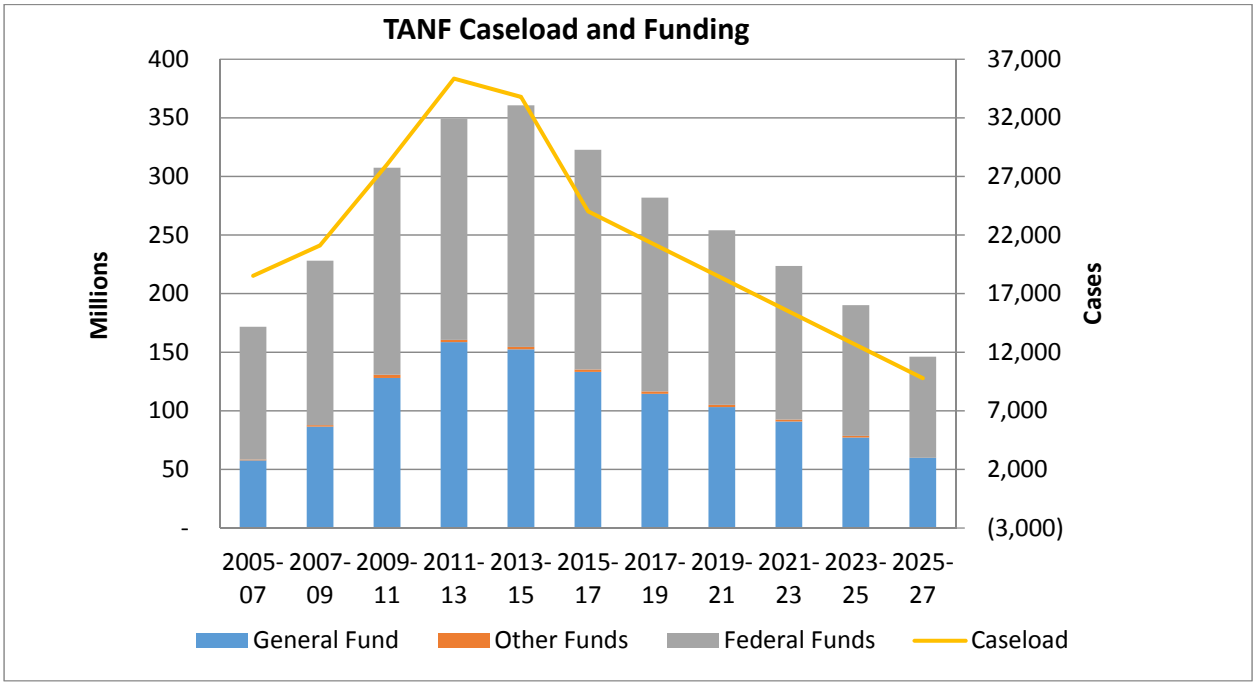
SSP also collaborates with other agencies and statewide initiatives, including the alignment and improvement of the state's workforce system. This effort, supported by the Governor, is to ensure that service delivery and outcomes are improved for both employer and job seeker. Other collaborations have been built around domestic violence, housing, addictions and mental health treatment, vocational rehabilitation, health care and education.

Department of Human Services: Temporary Assistance for Needy Families – Cash Assistance

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: Excellence in State Government
Program Contact: Belit Burke

Program Overview

Temporary Assistance for Needy Families (TANF) is a critical safety net program for families with children living in extreme poverty. TANF helps families, including more than 43,000 children, from a variety of diverse backgrounds to address their most basic needs. TANF provides eligible families with cash assistance, connections to support and community resources, case management, and employment and training services. The goal of the program is to engage families in becoming self-sufficient by helping them address challenges, gain skills, and access employment opportunities.



Program Funding Request

TANF (Basic, UN, Pre SSI, Transition)	GF	OF	FF	TF
LAB 15-17	$ 81,735,030	$ 2,047,112	$ 189,348,240	$ 273,130,382
GB 17-19	$ 117,727,779	$ 2,047,112	$ 165,348,240	$ 285,123,131
Difference	$ 35,992,749	$ -	$ (24,000,000)	$ 11,992,749
Percent change	44.0%	0.0%	-12.7%	4.4%

Program Description

TANF is a collection of programs directed at improving the lives of very low-income Oregon families with children. Our overall TANF program provides immediate cash assistance at a point when families have exhausted all other resources. We also provide employment and training services, linkages to services in the community and short-term interventions, such as support to strengthen parenting skills or the healthy development of children.

Most parents and caretaker relatives must meet additional requirements to continue receiving TANF services, such as participating in the Job Opportunity and Basic Skills (JOBS) program. These individuals participate in JOBS to gain the skills necessary to join the workforce and retain employment. A TANF family may participate in the JOBS program and access a variety of programs and services as part of the plan to move towards self-sufficiency.

To qualify for TANF, a family of three must be below 31 percent of the Federal Poverty Limit (FPL). This means the family's income cannot be more than $616 per month. Currently the maximum monthly benefit for a family of three is $506 (approximately 25 percent of FPL). There is a 60-month time limit for adults to receive TANF.

The TANF program serves a diverse population with a wide range of abilities and challenges. Ninety-five percent of TANF recipients have no current earnings and about 60 percent of TANF households have a person with a disability. 81 percent of families are paying for housing without any assistance from a federal housing program or other subsidy. Culturally appropriate eligibility and case management services are provided in numerous languages on a continual basis. They include but are not limited to Spanish, Russian, Vietnamese, Somali, Bosnian, Mandarin, etc. In situations where the office does not have staff to provide specific language services, interpreters are available.

Young children make up a large number of those served within TANF. Approximately 46 percent of all children in TANF are 0-6 years old. In about 25 percent of TANF households, the adults receive assistance for the children but not for themselves. In these households, many have an adult who is disabled and receives Social Security benefits or a caretaker relative, such as an aunt, uncle or grandparent, who is caring for the children. Many of these families have unique needs in both providing basic support for children and in navigating resources that can help them provide a stable, safe home environment.

The State Family Pre-SSI/SSDI (SFPSS) Program is designed to assist TANF-eligible individuals with disabilities obtain Social Security disability benefits through the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs. The program serves individuals who are not required to participate in the JOBS program. The program provides families with a cash grant, professional assistance with Social Security Administration (SSA) applications and appeals as well as case management services. Once a client is awarded SSI benefits, the department recovers a portion of the payments it made to the family during the application process from the client's initial SSI lump-sum payment.

Recent investments in TANF have brought about additional supports to help families transition off TANF and into employment leading to financial independence. These changes include:

- An increased exit limit – the new exit limit is double the payment standard allowing families to begin earning money before losing the supports provided through the TANF program. For a family of three, the limit goes from $616 to $1,012 per month.

- Employment payments for families exiting TANF with earnings. The payments total $225 and are paid out over three months and provide an additional financial incentive as TANF benefits come to an end.

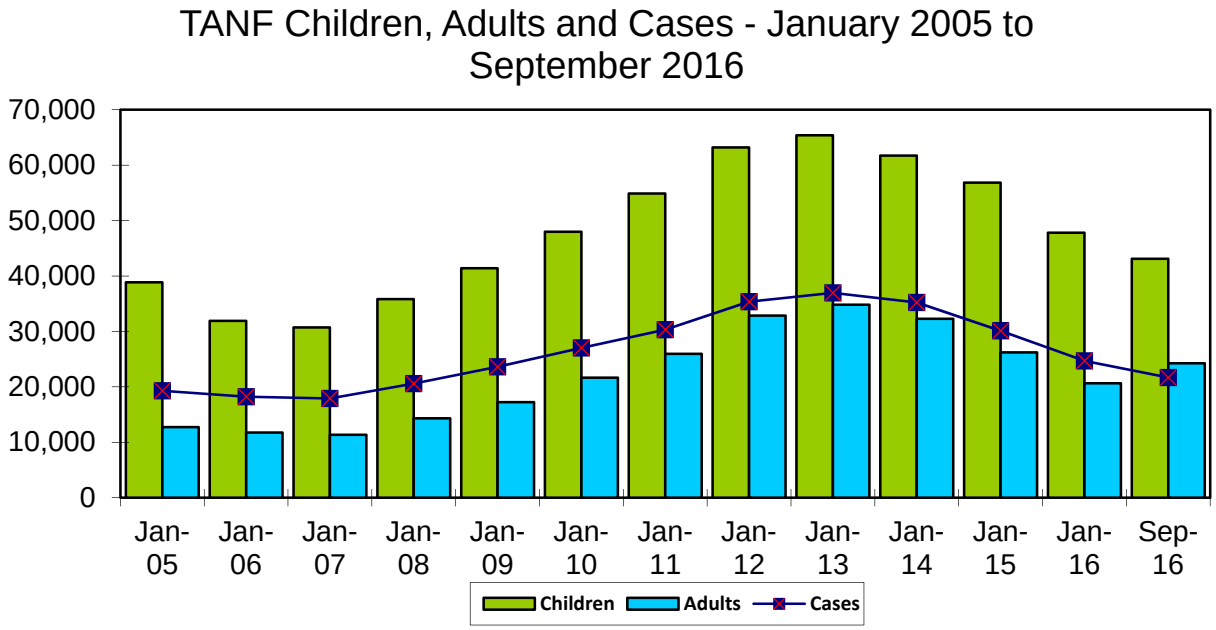
- A reduced Employment Related Day Care (ERDC) co-pay of $27 a month for the first three months after a family exits TANF due to employment allows the family to transition into the full cost of child care.

Program Justification and Link to Focus Areas

The TANF and Pre-SSI/SSDI cash assistance programs are key safety net programs that help provide assistance to the most vulnerable of Oregonians and relate to the safer, healthier communities focus. Without TANF cash assistance, more families would be homeless, which makes finding and maintaining employment extremely difficult. Being in a constant state of crisis can negatively impact children, including their ability to attend school and make progress in their learning. The program works with families to identify a pathway to self-reliance and a reduction in poverty. Providing the cash assistance along with skill development and job placement helps families to meet their basic needs while striving to move forward. Meeting the basic needs of families along with preparing them to be job-ready, or to receive disability benefits, creates safer and healthier communities.

The TANF program has reinvested funds into efforts that maximize the dollars for benefits targeted at building participant progression in work related activities, identifying and building on skills and leveraging community collaborations to provide solid foundations that lead not only to employment placement but retention and advancement.

Program Performance



In September 2016, the TANF and Pre-SSI/SSDI programs served 24,253 families. These households included 43,108 children and 24,253 adults from a diverse range of abilities, cultures and communities.

TANF cash assistance expenditures increased since the onset of the economic recession but are slowly decreasing as the caseload drops. The program was strained during the recession and the immediate aftermath due to a high caseload and insufficient resources, including case management staff. With the support of the Governor and the Oregon Legislature, the Department repurposed a portion of Human Service Specialist 3 positions into case management positions. By July 2014, the level of case management staffing shifted from 35 percent of need to 59 percent of need. As of the spring 2015 forecast, we were at 78% of need for the 2015-2017 Biennium. We will be able to maintain 78% percent of need through the 2017-2019 biennium, even with anticipated changes in workload and 41 more Family Coaches (case managers). The case management resources are critical for improving outcomes of engaging clients in plans to achieve self-reliance, increase family stability, maintain federal participation rates, and achieve enhanced employment placements.

Enabling Legislation/Program Authorization

The TANF program is authorized under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Deficit Reduction Act of 2005. A significant portion of the TANF eligibility criteria is codified in state statute chapters 411 and 412.

Funding Streams

TANF is funded primarily through General Fund dollars and the TANF Federal block grant that requires a minimum state expenditure level, known as Maintenance of Effort (MOE). Oregon's TANF block grant is $166.8 million per year. Oregon's MOE requirement is equal to 80 percent of the state's historic expenditures or approximately $98 million per year. Expenditures counted towards MOE must not be from a federal source and must not be matched to other federal funds. Oregon generally meets MOE through a combination of eligible DHS and other agency expenditures.

Both the TANF federal block grant and MOE expenditures must be spent in a manner reasonably calculated to meet one of the four federally-mandated TANF purposes which are: 1) provide assistance to needy families; 2) end dependence of needy parents by promoting job preparation, work and marriage; 3) prevent and reduce out-of-wedlock pregnancies, and 4) encourage and maintain family formations.

While TANF benefits for most single-parent families are funded with a split of TANF Federal block grant funds and General Fund dollars counted towards Oregon's MOE requirement, TANF benefits for two-parent families are funded solely with General Fund dollars that are not counted towards Oregon's TANF MOE requirement. In addition, the State Family Pre-SSI/SSDI (SFP) program is funded with General Fund dollars not counted towards Oregon's MOE requirement. The Department recovers a portion of SFP funds expended through client reimbursements.

Funding Justification, and Significant Changes to 17-19 CSL:

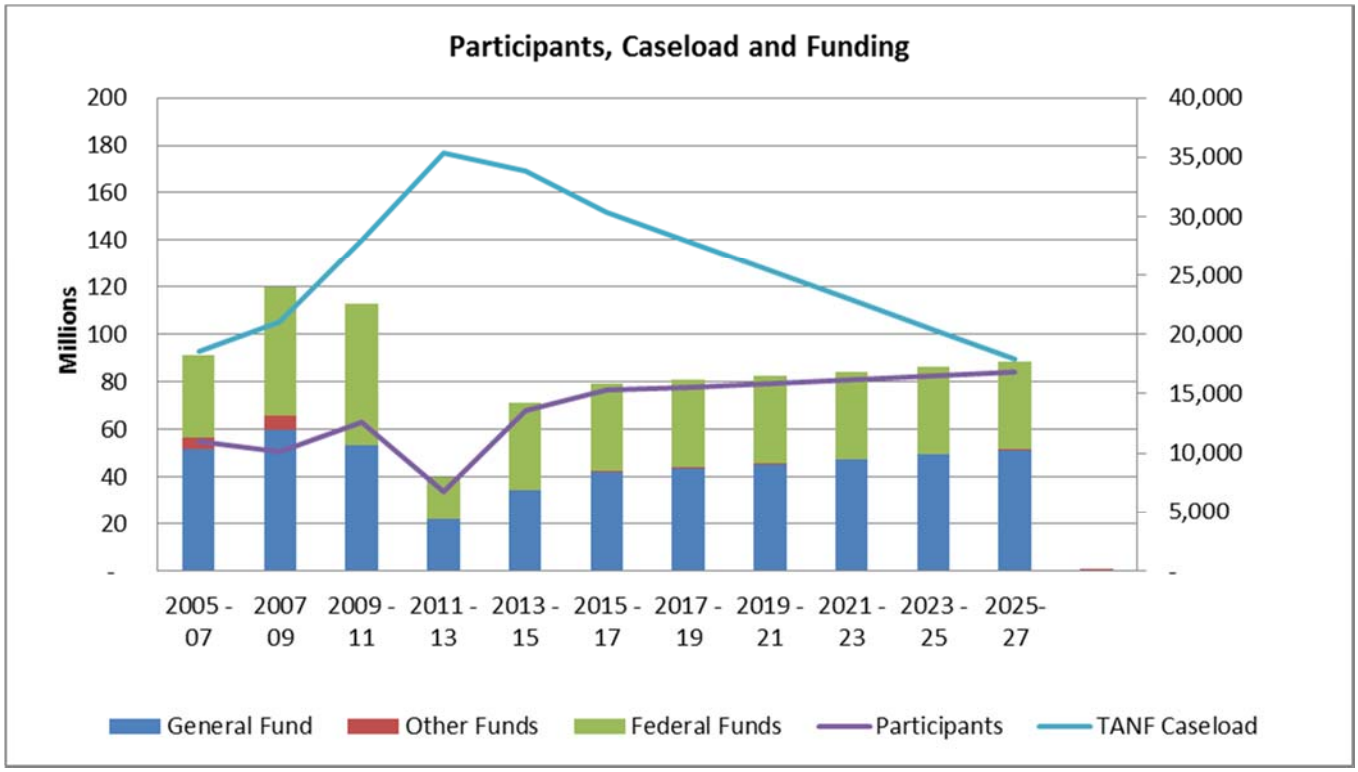
This does not include statewide reductions.

The TANF Program is funded at Current Service Level to include the following:

- TANF Contingency Funds GF Backfill $24,000,000
- TANF Re-Investment Program Phase in: $10,712,043

Department of Human Services: Job Opportunity and Basic Skills – Temporary Assistance for Needy Families

Primary Long Term Focus Area: A Thriving Oregon Economy
Secondary Long Term Focus Area: Safer, Healthier Communities
Program Contact: Belit Burke



Program Overview

The Job Opportunity and Basic Skills (JOBS) program is an employment and training program for those receiving Temporary Assistance for Needy Families (TANF) cash benefits. The goal is to help adults, caretaker relatives, and minor parents in TANF families gain the skills needed to become self-sufficient through employment, training and education, as well as family stability-related services that address other obstacles to employment.

Those who access TANF are extremely poor families with children who represent an increasingly diverse population. Most parents or caretakers in these families are required to participate in the JOBS program to maintain their eligibility for cash assistance. They can face sanctions that include losing benefits if they do not

participate. Job preparation services are provided through the DHS field offices and a network of contracted JOBS program providers in every county.

For the period July 1, 2015 through June 30, 2016 (FY 2016), the average monthly number of TANF families receiving cash assistance was 24,420. The average monthly number of individuals required to participate in JOBS activities was 15,117, which relates to 62 percent of TANF families.

Program Funding Request

JOBS	GF	OF	FF	TF
LAB 15-17	$ 42,203,407	$ 184,320	$ 36,950,298	$ 79,338,025
GB 17-19	$ 44,747,215	$ 184,320	$ 36,958,972	$ 81,890,507
Difference	$ 2,543,808	$ -	$ 8,674	$ 2,552,482
Percent change	6.0%	0.0%	0.0%	3.2%

Program Description

DHS family coaches work with TANF families to develop individualized case plans to achieve self-sufficiency, provide supports and monitor progress in achieving family goals. These plans guide what JOBS activities the participant will engage in and outline any needs for support services, such as transportation and child care. The department coordinates with several organizations to deliver services.

The JOBS program provides an array of employment and training services which include: job preparation and training, work experience, subsidized employment, job placement services, and limited education services to eligible families.

DHS administers the JOBS program through an extensive, statewide network of community partners that help deliver services. Partners include contracted JOBS service providers, Workforce Innovation and Opportunity Act (WIOA) agencies, community colleges, the Oregon Employment Department, Work Source Oregon One-Stop offices, and many local and county-based organizations, including those that can provide services for a culturally diverse clientele. Services are delivered at partner locations and some are available on-site at local DHS offices.

JOBS also offers a Job Participation Incentive (JPI) food benefit to Supplemental Nutrition Assistance Program (SNAP) participants with dependent children who meet the TANF federal work participation rate by working in unsubsidized employment.

Since 2008, the program's capacity has been severely limited through a combination of factors: A high caseload, low staffing levels for case managers, and a struggling economy that triggered severe state program budget cuts and a lack of jobs to transition clients into. The economy impacted the JOBS program services offerings and the number of participants that can be served at any one time. The program's low capacity impacted the state's ability to meet federal work participation requirements. In general, 50 percent of work-eligible adults in the TANF program are required to participate in work preparation activities.

In July 2011, the JOBS program was cut by more than 50 percent, which caused cuts in the program's service offerings and its capacity to serve eligible participants. Approximately 75 percent of contractor staffing was eliminated, greatly impacting the program's capacity to serve those needing to participate in an activity, and the department struggled to meet federal participation requirements for TANF. Reductions made during subsequent legislative sessions made it difficult to maintain elements of the redesign, and funding cuts greatly reduced the program's ability to help parents or caretaker relatives participate in skill-building activities and find work. Effective July 2013, flexibility was afforded the program to add back activities that had been eliminated during the previous biennium; however, it remains difficult with the continued reduced level of base JOBS funding. The JOBS program need remains higher than budgeted as well as the related need for support services such as child care assistance and transportation to get to and from self-sufficiency and employment activities.

Oregon was not compliant in 2007 because the State Legislature was not in session when the federal government established the work participation requirement; preventing Oregon from making a statute change needed to re-design the TANF program in time to meet the requirement. In the subsequent years the program has not met participation targets due to the economic conditions and reduced program resources.

The state had until September 30, 2014 to correct its participation rate violations in order to avoid up to $19.2 million in penalties for FY 2008 and FY 2009. The department submitted a corrective compliance plan that outlined the steps to be taken to meet participation goals. These penalties, had they been assessed, would have meant fewer resources to fund employment and training programs that help TANF families' transition out of extreme poverty through employment. By following the corrective compliance plan, working with partner agencies to employ

participation strategies, and fully utilizing the case management resources to engage more families in the program, the state is projected to meet federal participation requirements and avoid penalties for FY 2008 and FY 2009.

With the passage of HB3535 in July 2015, the projected savings from caseload reduction was reinvested back in to the TANF program resulting in strategies and policy changes to improve outcomes for children and families. Funding was added to: 1) provide community-based collaborative impact contracts with a focus on family stabilization, preventing entry into TANF and promoting job retention and 2) increase flexibility in support services payments and family supportive services. These efforts support increased engagement with families.

JOBS participants include individuals from diverse populations. Program service delivery is designed to ensure when activities are offered service equity is practiced, equal access is achieved, and culturally specific services are available. Contract providers are selected based on having the capacity to provide culturally specific services. Training for cultural sensitivity and service equity is available to all community partners to educate and expand knowledge to develop and provide services that best meet the needs of families served. Language translations/services and accommodations for participants with physical needs are also available.

Program Justification and Link to Focus Areas

The primary focus area of the JOBS program is to impact and actively contribute to a thriving Oregon economy. The JOBS program aims to reduce unemployment (including underrepresented and underserved individuals) and create job-ready communities that contribute to Oregon's overall economic well-being.

There is also a direct link to a secondary focus area of safer, healthier communities. JOBS is an integral part of Oregon's workforce service delivery system by providing employment and training services to low-income families receiving TANF. Many of the parents or caretakers of the children in this program have limited or no work experience. The JOBS employment and training program provides activities and services focused on preparing participants to enter the workforce, help them find employment and support them as they transition off public assistance.

Under the recent WIOA federal authorization of workforce programs, TANF becomes a required partner. TANF was already a participating workforce partner under Oregon statute, so connections and collaborations were in existence. While

WIOA programs serve all Oregonians, the JOBS program provides services geared to address specific needs of TANF participants to obtain job skills and work experience-related training, assist with connections to employment opportunities, and family stability efforts. WIOA affords the state additional opportunities to expand and maximize coordination of employment and training workforce partners at the state and local levels in order to improve outcomes for all job seekers.

Program Performance

DHS tracks performance and outcome measures to gauge its ability to help people become employed or improve their employment situation through participation in the JOBS program. JOBS program outcomes were severely impacted by the 50 percent funding reduction during the 2011-2012 program year and by the low staffing levels for case managers. Many services were eliminated because of these cuts. Eliminated services include vocational training, Adult Basic Education, and life skills classes. Other services were eliminated that helped participants remove other barriers to employment such as home visitor specialists, vocational nurse consultants and specialists who helped parents or caretaker relatives with criminal history or fines work with the courts on expungement. They also provided guidance to clients for talking with prospective employers during job searches about these issues.

In the 2013-15 biennium, the budget provided for added flexibility in contracts and support services so that families in the TANF program can have support in vocational education, GED completion and life skills classes. Among the services that remained were job search, work experience, supported work, and JOBS Plus. Child care, transportation assistance and other supports continue to be available in a reduced manner.

With the support of the Legislature, the added case management resource for 2015-17 is helping test strategies to engage families in ways that improve outcomes in the areas of engagement in a self-sufficiency plan, improving family stability, improving federal participation rates, and increasing employment placements.

The agency measures total employment placements reported by parents or caretaker relatives served by the JOBS program each month. While there is considerable seasonal variation in placements, the number of placements remained relatively constant until 2007. Due to the economic downturn, placements began dropping in FY 2008. The average monthly placements for FY 2010 were 30 percent lower than in FY 2008. Placements gradually increased through the early

part of 2011; however, they dropped again after program reductions, including a loss of 75 percent of contracted staff. Effective July 2013, JOBS program restrictions were loosened to allow districts more flexibility to address the needs of local populations. With these modifications as well as slight improvements in the overall economy, the average monthly placements increased 36 percent since FY 2012. Monthly placements continued to increase with averages of 988 in FY2014 to 1,281 in FY2015. The average monthly placements leveled out slightly in FY2016 at 1,127. The last time that occurred was in FY 2008 (December 2007). The average monthly placements for FY 2016 was 1,128. In FY2016, 17 percent of all placements were benchmark placements, which are those that are at least 30 hours per week and earn at least $11.55 per hour.

In May 2016, the statewide average wage for full or part-time wages combined was $10.94 per hour, ranging between $9.90 and $11.46. The state minimum wage was $9.25.

Another measure is the percentage of parents or caretaker relatives who exit TANF due to employment and do not return within 18 months. Currently, 70 percent of parents or caretaker relatives do not return within 18 months. The average rate for 2013 was 64 percent, indicating a positive increase of 6 percent parents or caretakers who did not return to TANF 18 months after the case closed due to employment. Recent data shows that for cases closed in August 2015, as of February 2016, 84 percent were not receiving TANF.

Enabling Legislation/Program Authorization

The TANF program is authorized under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Deficit Reduction Act of 2005. A significant portion of the JOBS program is codified in state statute chapters 411 and 412.

Funding Streams

The JOBS program is currently funded primarily through the Federal TANF block grant and General Fund dollars that count towards the state Maintenance of Effort (MOE) requirement. Oregon's TANF block grant is $166.8 million per year. Oregon's MOE requirement is equal to 80 percent of the state's historic expenditures or approximately $98 million per year.

Expenditures counted towards MOE must not be from a federal source and must not be matched to other federal funds. Oregon generally meets MOE through a

combination of eligible DHS and other agency expenditures. Both the TANF federal block grant and MOE expenditures must be spent in a manner reasonably calculated to meet one of four TANF purposes, which are: 1) provide assistance to needy families; 2) end dependence of needy parents by promoting job preparation, work and marriage; 3) prevent and reduce out-of-wedlock pregnancies, and 4) encourage and maintain family formations. Federal Child Care Development Funds from the Employment Department's Child Care Division provide Other Funds used for related child care costs.

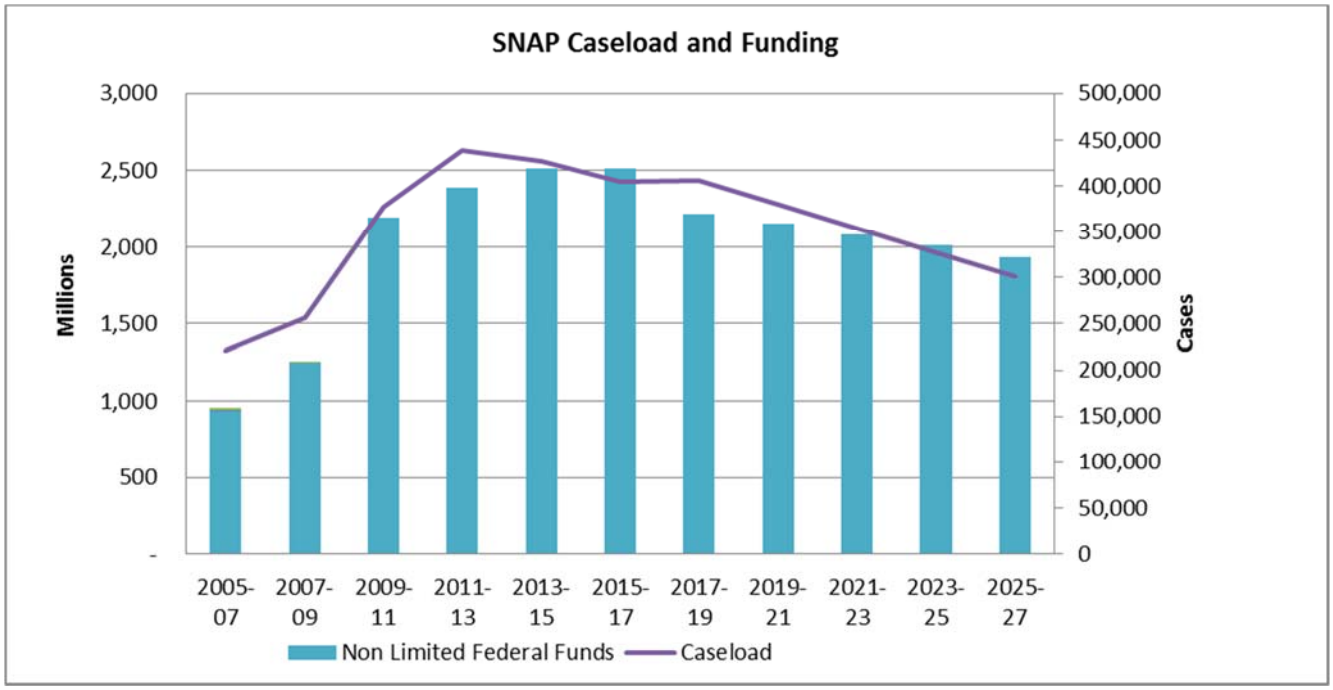
Funding Justification, And Significant Changes

This does not include statewide reductions.

Jobs Program is funded at current service level.

Department of Human Services: Supplemental Nutrition Assistance Program (SNAP)

Primary Long Term Focus Area:	A Thriving Oregon Economy
Secondary Long Term Focus Area:	Safer Healthier Communities
Program Contact:	Belt Burke



Program Overview

The Supplemental Nutrition Assistance Program (SNAP) is a federally funded food benefit program. SNAP provides supplemental food benefit dollars to low-income families, seniors, single adults, people with disabilities, and children to help purchase food to meet their nutritional needs. Currently, one in five Oregonians receive these benefits. Benefits to clients are 100 percent federally funded; the administration of the program requires a 50 percent state match.

Money from the program spreads quickly through the state economy. The United States Department of Agriculture (USDA) calculates that for every $5 of SNAP benefits, there is $9 of total economic activity. SNAP also has been an important and constantly growing anti-poverty program. Recent research has shown that SNAP benefits reduce the depth and severity of poverty, and have a particularly strong effect on reducing the depth and severity of child poverty.

Program Funding Request

SNAP	GF	OF	FF	TF
LAB 15-17	$ -	$ -	$ 2,514,345,331	$ 2,514,345,331
GB 17-19	$ -	$ -	$ 2,214,345,331	$ 2,214,345,331
Difference	$ -	$ -	$ (300,000,000)	$ (300,000,000)
Percent change	0.0%	0.0%	-11.9%	-11.9%

Program Description

SNAP serves as a crucial safety net and food benefits are intended to be a supplement to what families already provide. However, for households with little or no income, it is the primary means to feed their families. Food and Nutrition Service (FNS) within the USDA regulates SNAP. Although Federal regulations do allow a few state options, any significant variation from the regulations must be approved by FNS through a formal process.

For the last three years, even during times of high caseload growth, Oregon has been ranked as one of the top three states nationally for program participation. The participation rate is the percentage of potentially SNAP-eligible persons in the state receiving SNAP benefits. Outreach efforts along with policy and procedural changes have helped significantly increase participation in SNAP in recent years. Non-profit partners such as the Hunger Relief Task Force, the Oregon Food Bank and 211info have been invaluable in helping increase Oregon's SNAP participation rates.

The program caseload is slowly declining as the economy continues to recover. Simplifying policies and making it easier for Oregonians to apply and meet eligibility requirements continues to support timely benefit delivery. Approximately one in five Oregonians or 21 percent of the population receive SNAP benefits. In May of 2016, a total of 719,503 Oregonians received SNAP benefits, which includes 88,658 cases (households). In May of 2016, a total of $88,658,864 SNAP benefit dollars were paid to Oregonians which are spent in clients' local communities. According to the USDA's Economic Research Service, 8,900 to 17,900 full-time jobs are created per $1 billion in SNAP benefits.

Program Justification and Link to Focus Areas

SNAP directly addresses the 10-Year Outcome for Healthy People by providing an important economic boost to struggling households and access to nutritious foods. According to the USDA Economic Research Service, receipt of SNAP benefits reduced the national poverty rate by almost eight percent during the recent recession. The SNAP program can also provide limited assistance with job search and links to employment resources through the Oregon Food Stamp Employment and Training (OFSET) program and the 50/50 Employment and Training Program.

Program Performance

The goals of the SNAP program are to ensure that benefits are delivered accurately and in a timely manner to those who are eligible for the program. It also aims to ensure those who are eligible for the program have access to program benefits. Oregon's program has enabled the state to maintain a high participation rate along with a high Federal Quality Control (QC) rate. Oregon's SNAP program has continually performed above the national average and not paid a performance penalty in eight years.

Oregon has received multiple federal bonuses because of the state's high SNAP participation rate and has also been the recipient of multiple competitive national grants. Oregon was one of six states recognized for the timeliness of SNAP application processing and received two awards with performance bonuses totaling $5 million. Oregon has consistently been among the best in the nation. The bonus award funding has been used over the years to support partner agencies, help meet the program's goals and, frequently, to shore up needs in other programs through the State General Fund.

Oregon is considered a model state by FNS in terms of timeliness and commitment to customer service. One example of this is Oregon's Lean process, which has streamlined and standardized the eligibility process statewide to ensure that most applicants receive benefits within 48 hours of applying. The process continues to receive federal and national recognition resulting in visits from federal partners and other states to observe best practices.

The 2010 census data showed that 15.8 percent of Oregonians lived in poverty, which was slightly higher than the national average of 15.3 percent. SNAP participation in Oregon peaked in August 2012 at 445,374 cases serving 813,556 people. From 2007 when Oregon issued $487,482,626 in benefits, to 2013 when that amount had more than doubled to $1,236,125,996, SNAP has been an important and constantly growing anti-poverty program. Money from the program spreads quickly through the economy. The USDA calculates that for every $5 of SNAP benefits, there is $9 of total economic activity.

Calendar Year	SNAP Benefits Issued in Oregon
2007	$487,482,626
2008	$579,344,356
2009	$910,919,825
2010	$1,098,444,539
2011	$1,211,274,990
2012	$1,262,115,384
2013	$1,236,125,966
2014	$1,165,393,102
2015	$1,144,509,141

Although the American Recovery Reinvestment Act of 2009 (ARRA) stimulus package increased SNAP benefits by 14 percent nationwide, this funding stimulus sunset on September 30, 2013. The stimulus ensured a minimum benefit increase of $16 a month for one- or -two person groups. The result of this funding sunset meant a recalibration of the Thrifty Food Plan Benefit level (an effort to recalculate benefits across the board) which reset SNAP benefit levels and resulted in a net reduction in benefits and the minimum benefit level for households.

Enabling Legislation/Program Authorization

SNAP is guided by federal legislation found in the "Farm Bill" authorized by The Agricultural Act of 2014 (P.L. 113-79, Feb 7, 2014). Program policy is reauthorized every five years through the Farm Bill. The Farm Bill is due for reauthorization in 2018.

Funding Streams

SNAP benefits are 100 percent federally funded. Oregon is responsible for 50 percent of the administrative costs. Oregon's portion of the administrative costs for SNAP comes from the State General Fund.

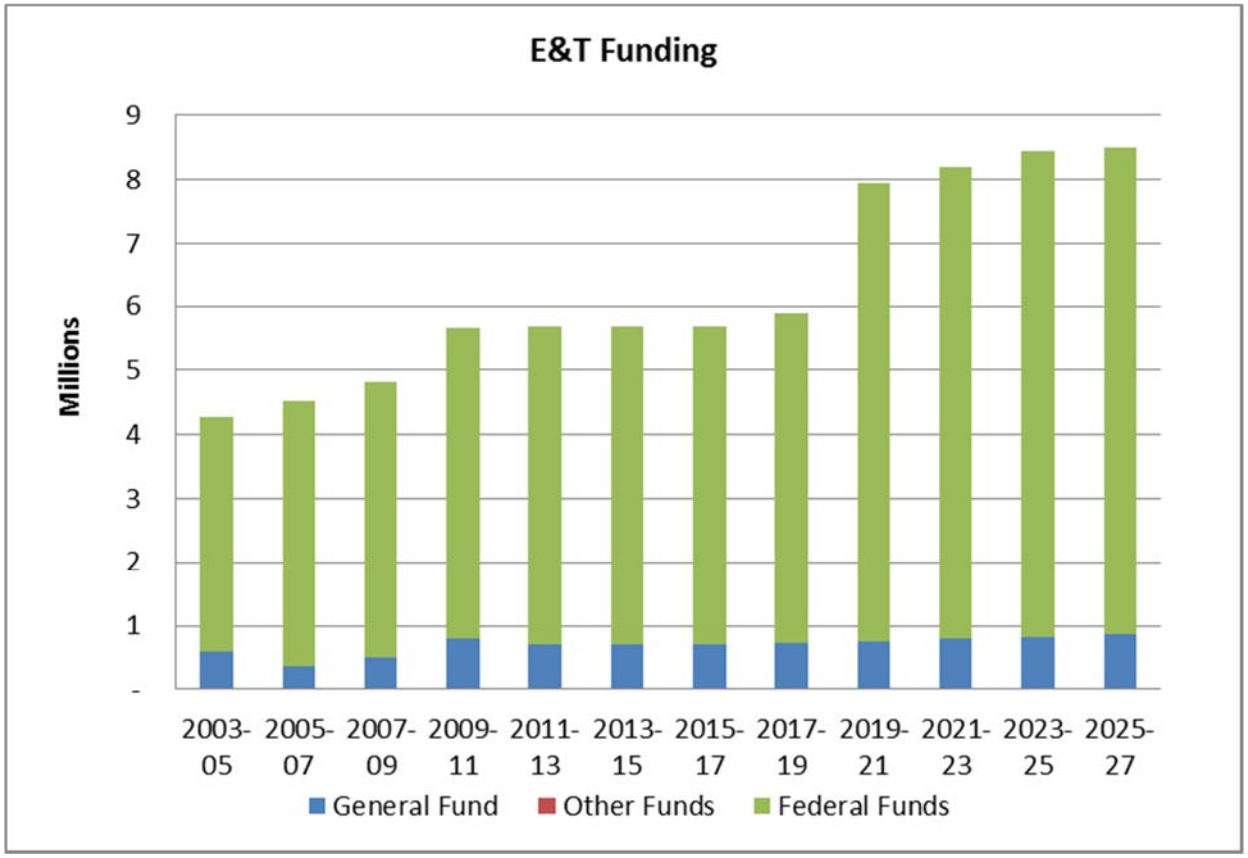
Funding Justification, And Significant Changes

This does not include statewide reductions.

The Youth Services Program is funded at current service level and the department removed $300 million of limitation in base due to reducing caseloads.

Department of Human Services: Supplemental Nutrition Assistance Program – Employment and Training

Primary Long Term Focus Area: A Thriving Oregon Economy
Secondary Long Term Focus Area: Safer Healthier Communities
Program Contact: Belit Burke, Program Director



Program Overview

Oregon is currently undertaking an effort to fully develop and expand the Employment and Training 50/50 Reimbursement Program (E&T) as part of our ongoing investment in the Oregon economy and our communities. Oregon is moving in the direction of building a continuum of services in partnership with key stakeholders engaged in the Workforce Innovation and Opportunity Act (WIOA). Oregon will provide SNAP participants who are unemployed or underemployed, opportunities to lift themselves out of poverty, while strengthening the workforce

system, and employers will benefit from the number of individuals who are fully trained and prepared for employment.

The Supplemental Nutrition Assistance Program (SNAP) has an Employment and Training (E&T) component. In Oregon, there are currently three different types of SNAP Employment and Training programs:

- The **Oregon Food Stamp Employment and Training (OFSET) Program** provides employment-related services to adult SNAP participants. The services for this program are100 percent federally funded. There is a support services component required by the state to be provided to participants participating in OFSET services. Support services can only be funded through a 50/50 match, per the United States Department of Agriculture's (USDA) Food and Nutrition Services (FNS). Participants come from a variety of linguistic and cultural backgrounds from across the State. This program assists participants to gain valuable skills, training or experience that will improve employment prospects leading to self-sufficiency and a reduced reliance on SNAP benefits.
- The **50/50 Employment and Training Program** provides employment-related services to SNAP participants who are exempt from mandatory E&T participation but (voluntarily) choose to pursue training and employment resources. There are currently six sites in Oregon that draw down federal funds with their own non-federal match to provide services in their organizations to the populations they serve. During FFY 2017 the program is anticipating to bring on additional providers. Included in the expansion are six community colleges, Workforce Investment Boards, and the Oregon Employment Department.
- Able Bodied Adults without Dependents (ABAWD) policy was implemented in FFY 2016 for Washington and Multnomah Counties, due to the loss of a federal waiver. This policy is a SNAP benefit time limit for people between the ages of 18 to 49 who do not meet an exemption criteria. This policy will expand to Clackamas County in FFY 2017.

Civil Rights Training is required annually of all DHS staff involved in the administration of the SNAP program (which includes contracted partners and their staff) so they understand civil rights related laws, regulations, procedures, and directives. All publications include the non-discrimination statement. The "And Justice for All" poster is mandatory for all branch offices to display in their lobby.

Participants are informed of their rights and responsibilities at certification, interim change and recertification. This includes the right to receive information in an (alternate) format or language they understand. DHS follows the Americans with Disabilities Act and Section 504 of the Rehabilitation Act and will do its best to meet a participants' special needs if they have a disability.

Contract staff must provide services to DHS clients without regard to race, religion, national origin, sex, age, marital status, sexual orientation or disability (as defined under the Americans with Disabilities Act). Contractor services must reasonably accommodate the cultural, language and other special needs of participants. Contractors that do not have individuals who speak the language, when possible, contact an interpretive service for the customer and provide materials in the participants' language preferences. Participants may file a report of discrimination at any time.

Oregon's SNAP program has a proven record of partnering with a wide variety of organizations to expand and reach underserved populations. The SNAP program works closely with the refugee program. Through the implementation of ABAWD, agreements were modified to allow communication between the Immigrant and Refugee Community Organization (IRCO) and the ABAWD contractor to streamline and minimize potential barriers. A significant portion of the refugee population resettles in the Portland Metropolitan area. As new groups move into the area, local district leadership meet with the leadership from those communities to get a better understanding of the culture and the needs of the community and staff receiving training. In addition to job-related work activities, contractors provide services that enhance the employment skills of clients. These activities include educational programs such as Basic Adult Education, GED preparation, and English as a Second Language (ESL) classes.

To support client access to services and information, the department has increased the number of languages for translation. For example, additional languages were added to the Multilingual Insert for Decision Notices (AFS 97), Amharic, Arabic, Burmese, French, Hindi, Karen, Mandarin, Nepali, Oromo, Pashto/Pashtu, Swahili, Tagalog, Tigrinya, and Zomi. In addition, the specific notices created for ABAWDs were translated in the following languages: Arabic, Bosnian, Burmese, Cambodian, Farsi, Hmong, Korean, Laotian, Mein, Romanian, Russian, Simplified Chinese, Somali, Spanish, and Vietnamese. The department is actively working on how to improve equitable access.

Program Funding Request

SNAP E & T	GF	OF	FF	TF
LAB 15-17	$ 701,925	$ -	$ 4,987,216	$ 5,689,141
GB 17-19	$ 727,896	$ 0	$ 4,987,216	$ 5,715,112
Difference	$ 25,971	$ 0	$ -	$ 25,971
Percent change	3.7%	0.0%	0.0%	0.5%

Program Description - OFSET

Oregon has 19 contracts with employment-related partners in all Oregon counties to deliver E&T components. Contractors specialize in workforce development and job placement. Components are designed to assist SNAP participants to move into employment. Typically participants have an assessment followed by job search training and supported independent job search. Participation is limited to a maximum of eight weeks per year. The two primary program components are:

> **Job search training**: Trains participants on specific skills and strategies for finding and keeping a job. Information is geared towards the local labor market. Topics include resume building, interview skills, and other soft skills for finding or retaining employment.
>
> **Job Search**: Includes job search techniques, referrals to the local Oregon Employment Department for I-Match registration, and the assignment and monitoring of required monthly employer contacts. Participants are required to complete 12 employer contacts per month over the course of eight weeks.

Contractors may ask participants to participate in a combination of components as needed. Other allowable activities include Adult Basic Education (GED), English as a Second Language (ESL), job retention activities, and short-term vocational training. At this time, contractors are not providing services in these areas due to funding limitations.

The USDA FNS determines the annual allotment of E&T administrative funding. FNS has a set amount of funding for all states. Each state's share is based on a formula using, in part, the state's SNAP mandatory client figure. Mandatory participants are defined as those aged 18 to 59 (or age 16 and 17 if the client is the primary person/head of household) and who do not meet a federal exemption. Federal exemptions include the following:

- Caretaker of a dependent child under age six;

- Caretaker of an incapacitated individual;
- Physical or mental barriers to employment;
- TANF participant;
- Receipt of unemployment benefits;
- Participation in alcohol or drug rehabilitation;
- Eligible students enrolled at least half time; and/or
- Employed 30 hours a week at federal minimum wage.

The FNS annual allotment is the major cost driver for the E&T program. As this number is adjusted annually, services provided by contractors are scaled back to stay within budget.

A limited amount of support service funding is available to participants. Support services are provided to pay a participants' up-front transportation expense related to independent job search efforts, such as transportation to job interviews, submitting job applications and informal, in-person job search. The majority of reimbursements are vendor payments in the form of gas vouchers and bus tickets. Contractors use the lowest cost alternative available to maximize the number of participants who may receive a support service payment.

The support service budget is funded by 50 percent General Fund and 50 percent Federal Fund per FNS regulations. Since 2009, the annual Oregon support service budget has been $1.2 million. This figure is based on 20,000 anticipated participants using $60 in support services per participant. Contractors historically serve more than 20,000 participants annually, which bring the average support service cost per person significantly down. For Federal Fiscal Year (FFY) 2015, the average support service payment per participant is $21.

SNAP E&T contractors work to leverage resources with other workforce programs. While E&T dollars cannot be utilized for participants where there is a prior resource available (for example, job preparation activities for TANF participants would be funded with JOBS dollars and not E&T dollars), the program does work with programs funded through TANF and WIOA to coordinate services and refer participants into services that may not be funded by E&T but could benefit the job seeker. An example of this would be a referral of a SNAP E&T participant to a WIOA-funded training program or the leveraging of job openings and referrals with co-located job placement programs.

Program Justification and Link to Focus Areas

The SNAP E&T program's goal is to assist participants to gain skills that will improve their employment prospects and reduce reliance on SNAP benefits. Participants improve job skills, which add to the diversity and strength of Oregon's workforce. Using local contractors to deliver the E&T program results in a higher quality workforce because services can be tailored to the area and local economies benefit from these expenses. The program supports the Thriving Oregon Economy focus area with the goal of long-term economic prosperity and resiliency through people-based strategies.

Program Performance

Current funding supports 20,890 individuals, or 1,741 people monthly. For FFY 2016, DHS projects a total of 82,009 participants are eligible for this program. However, the program is only able to serve about 26 percent of these individuals per year because of the amount of funding received. In FFY 2015, approximately 320 participants are placed into employment each month, about 13 percent of those served.

While not all participants find employment after the eight-week E&T program, participants do become connected to employment specialists in their local area. Some participants choose to continue accessing other services available from local employment specialists once their mandatory participation in E&T ends. This link assists participants in continuing and enhancing job search efforts.

Enabling Legislation/Program Authorization

This program is mandated by federal legislation found in the Food and Nutrition Act of 2008, authorized by the 2008 Farm Bill. In February 2014, President Obama signed the 2014 Farm Bill (aka. the Agricultural Act of 2014). Program policy is reauthorized every five years though the Farm Bill and the next reauthorization will happen in 2019.

Funding Streams

This program is funded primarily through Federal Funds, with a small amount of General Fund dollars. E&T administrative costs are 100 percent Federal Funds based on a fixed formula. For 2017, administrative costs are estimated at $2,024,659. E&T participant support service costs are funded through 50 percent General Fund dollars and 50 percent Federal Funds. For 2017, support service costs are $600,000 General Fund. The total E&T program budget is $3,224,659.

50 Percent Reimbursement Programs (50/50)

SNAP's E&T 50 Percent Reimbursement Program works in partnership with community organizations that offer employment and training opportunities to participants. Each community organization provides wraparound services to compliment E&T services that increase protective factors and success rates. The E&T program is a package of services, which includes assessment, component activities, participant reimbursements and case management. The allowable E&T components activities provided by these organizations include job search-related activities, unpaid work experience or training, short term education such as vocational training, and job retention efforts.

Oregon currently has the 50/50 partnerships with

- Multnomah County, Outside In
- Multnomah County, New Avenues for Youth
- Multnomah County, Central City Concern
- Lane County, Goodwill Industries
- Multnomah and Washington Counties, Worksystems, Inc. (WSI)

Funding Stream(s)

Partner agencies use their own funds to pull down the funding for the match. In other words, partner agencies use their own non-federal funds for the allowable cost of E&T components and receive 50% federal reimbursement money. This allows Oregon to conserve limited resources while expanding the services available to SNAP E&T participants.

Funding Justification, And Significant Changes

This does not include statewide reductions.

This program is funded at the current service level.

Department of Human Services: Food Assistance Programs (TFAP, and CFSP)

Primary Long Term Focus Area:	A Thriving Oregon Economy
Secondary Long Term Focus Area:	Safer Healthier Communities
Program Contact:	Belit Burke

Program Overview

The Emergency Food Assistance Program (TEFAP)

TEFAP is a federally funded program that helps supplement the diets of low-income Americans, including elderly people, by providing them with emergency food assistance at no cost. The Oregon Food Bank is primary grantee in Oregon and works with the Oregon Food Bank network to deliver services across Oregon.

Through TEFAP, the U.S. Department of Agriculture (USDA) purchases a variety of nutritious, high-quality USDA Foods, and makes those foods available to state distributing agencies. The amount of food each state receives out of the total amount of food provided is based on the number of unemployed persons and the number of people with incomes below the poverty level in the state. States provide the food to local agencies that they have selected, usually food banks, which in turn distribute the food to local organizations, such as soup kitchens and food pantries that directly serve the public. States also provide the food to other types of local organizations, such as community action agencies, which distribute the foods directly to low-income households.

Commodity Supplemental Food Program (CSFP)

CSFP is a federally funded program that works to improve the health of low-income elderly persons at least 60 years of age by supplementing their diets with nutritious USDA Foods.

Oregon currently has a case load size of about 1776 elderly people receiving these commodities. Currently all of the service delivery is occurring through partnerships with the Oregon Food Bank.

Oregon Hunger Response Fund

The Oregon Hunger Response Fund is an allocation from the Legislature to the Oregon Food Bank to help build infrastructure and transport food to food pantries and other important efforts to support the Food Bank and Food Bank Networks.

Oregon Housing and Community Services, with legislative approval, transferred the Oregon Hunger Response Fund to the Department of Human Services effective 10/1/2015.

OAR chapter 461, division 192 establishes and implements the Oregon Hunger Response Fund, which is funded by General Fund moneys and carries out the Department's responsibility as the lead public body in administering the state policy on hunger under ORS 458.525 to 458.545. The Oregon Hunger Response Fund is the means by which the Department allocates funds for the statewide network of food banks and emergency food programs to acquire food and new food sources, build network capacities and link emergency food clients to other services.

Oregon Hunger Task Force

The story of Partners for a Hunger-Free Oregon begins back in 1989, when the Oregon State Legislature created the Oregon Hunger Task Force (ORS 458.532). At that time, Oregon ranked high for hunger among states, and the legislature declared that "All persons have the right to be free from hunger." –

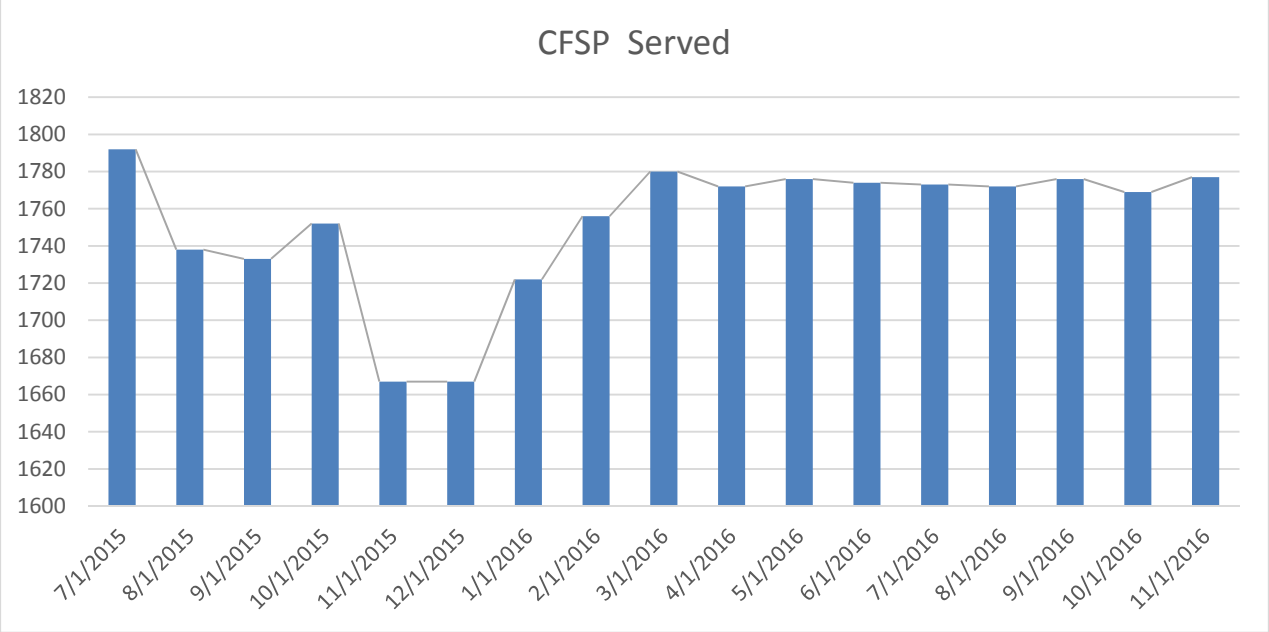
The 28-seat task force was directed to "serve as an advocate for hungry persons," studying the problem of hunger, making recommendations, and helping local communities implement changes.

Working with partners throughout Oregon, the task force has since worked to promote community awareness, compile research, develop proposals for government action, and conduct outreach to expand participation in nutrition programs. ***(Oregon, 2016)***

Program Funding Request

FOOD ASSISTANCE PROGRAMS	GF	OF	FF	TF
LAB 15-17	$ 3,902,578	$ -	$ 1,786,327	$ 5,688,905
GB 17-19	$ 4,637,833	$ -	$ 2,381,769	$ 7,019,602
Difference	$ 735,255	$ -	$ 595,442	$ 1,330,697
Percent change	18.8%	0.0%	33.3%	23.4%

Program Performance



Enabling Legislation/Program Authorization

7 CFR Part 247 and 250;
Emergency Food Assistance Act of 1983;
FNS Instructions 716-3, 410-1, and 113-1;
Oregon Revised Statutes 458.530;
Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.);
Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.);
Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);
Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.);
OHCS Master Grant Agreement;
CSFP State Plan;
CSFP Manual; and
All provisions required by the implementing regulations of the U.S. Department of Agriculture.

(-DHS, 2016)

Funding Streams

OREGON HUNGER TASK FORCE (OHTF) – GF
REPATRIATION PROGRAM - FF

Funding Justification, And Significant Changes

This does not include statewide reductions.

The Food Assistance Program is funded at current service level.

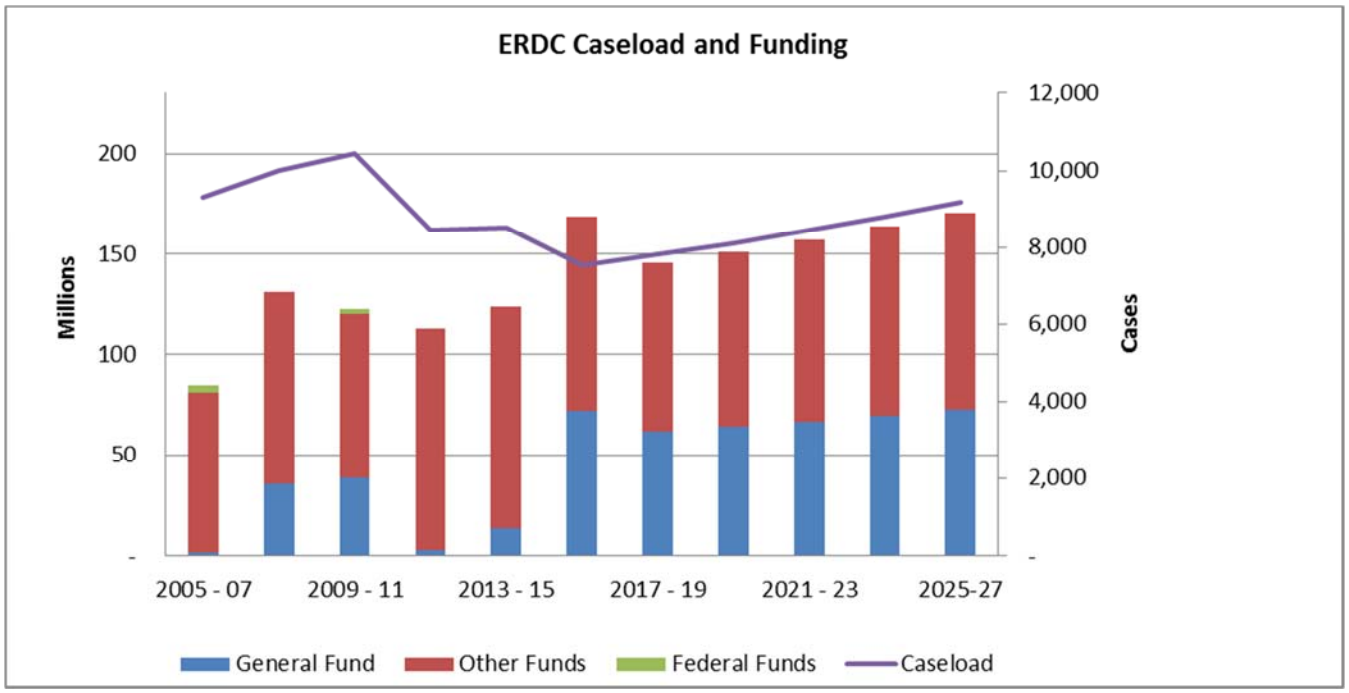
References

-DHS, S. o. (2016). *The Commodity Supplement Food Program.* Salem.
Oregon, P. f.-F. (2016, 08 22). *Oregon Hunger Task Force.* Retrieved from https://oregonhunger.org/oregon-hunger-task-force

Service, U. F. (2016, June). *The Emergency Food Assistance Program* . Retrieved from http://www.fns.usda.gov/sites/default/files/tefap/pfs-tefap.pdf

Department of Human Services: Employment Related Day Care

Primary Long Term Focus Area: A Seamless System of Education
Secondary Long Term Focus Area: A Thriving Oregon Economy
Program Contact: Belit Burke



Note: Out years assume static costs per case with funding inflated each year and invested in additional cases. Added funding could also be used for other quality activities in lieu of increasing the caseload cap.

Program Overview

The Employment Related Day Care program (ERDC) helps low-income working families from a variety of cultural and linguistic backgrounds in urban and rural communities pay for quality child care. Child care helps parents stay employed and gain self-sufficiency by assisting with the consistent, stable child care parents need to remain on the job.

Children in Employment Related Day Care, ages 0 to 6								10/1/2015 – 12/31/2015
	All	African American	Asian	Caucasian	Hispanic (any race)	Native American	Pacific Islander	More than one race
Number	9,835	1,169	139	6,338	1,667	169	93	260

Program Funding Request

ERDC	GF	OF	FF	TF
LAB 15-17	$ 71,734,401	$ 97,037,957	$ -	$ 168,772,358
GB 17-19	$ 84,773,581	$ 87,854,185	$ -	$ 172,627,766
Difference	$ 13,039,180	$ (9,183,772)	$ -	$ 3,855,408
Percent change	18.2%	-9.5%	0.0%	2.3%

House Bill 2015 and the Reauthorization of Child Care and Development Fund act of 2014 have strengthened the Employment Related Day Care Program through several program enhancements. DHS implemented enhancements on October 1, 2015. Working students, and self-employed families can access affordable quality child care while they improve their life circumstances, making it easier to move out of poverty. A 12 month eligibility period, three months of work search for a parent who has lost a job, continued child care coverage while on medical leave and a higher exit income limit allow for continuity of care for children and reduces the cliff affect. A reduced cliff effect offers an easier transition off of subsidy. Additional changes include incentive payments for child care providers who hold a three, four or five quality improvement star rating for each full-time DHS subsidy child in their care and a reduced copay incentive for parents who use a provider who holds a three, four or five star rating. Program improvements have reduced the number of cases lost through attrition, meaning families are staying on ERDC longer allowing for continuity of care for children.

Program Description

ERDC provides low-income families with the same opportunity to have quality child care as other families with higher income. This helps reduce the achievement gap and end the poverty cycle. Quality child care nurtures a child's learning and development so the child is better prepared to succeed in school and later in the workforce, helping them form more stable families of their own.
To be eligible for the program, a family's income must be less than 185 percent of the 2016 Federal Poverty Level. For a family of three, this amount is $3,108 gross income per month.

ERDC subsidy families share the cost of child care. Families choose their child care provider and ERDC pays the approved provider directly on behalf of the family for the subsidy portion of the payment. The amount ERDC pays is based on the location where care is provided, type of care and hours needed. The family's portion of the child care is called a copayment. The copayment is based on a sliding scale depending on family income and size. The family's copay remains

stable during the 12 month certification period. Families who have had an increase in income will see an increase in their copayment at their 12 month recertification. Copayment increases help to prepare the family to pay the full child care amount once child care assistance ends. Parents must pay their copayment to remain eligible in the program. Families may pay additional costs, when a provider charges more than the maximum rate DHS can pay.

Information available to parents and providers about ERDC subsidy or becoming a DHS approved provider is available in English, Spanish, Russian, Somali, and Vietnamese. DHS offers an interpreter line when a language is not available. DHS branch offices have bi-lingual staff to assist families whose first language is not English and offer alternate formats.

Child care providers are self-employed. When they choose to become listed with DHS as an approved provider, they must meet a set of health and safety standards and pass a background check including a criminal history and child protective services check. Licensed providers must pass a background check through the Department of Education, Early Learning Division, Office of Child Care. Providers exempt from licensure (license-exempt) must pass a background check through the DHS Background Check Unit and complete a health and safety training prior to being approved by DHS. Non-relative license-exempt child care providers, as part of the 2014 Reauthorization, are required to take additional training. Training includes both pre-service classes and six hours of ongoing training every two years. All providers have access to, and are encouraged to continue their education by taking additional training.

Providers must be listed with the DHS Direct Pay Unit in order to receive payment through DHS. Licensed family child care providers are represented by the American Federation of State, County and Municipal Employees Council 75 (AFSCME). Licensed-exempt child care providers are represented by the Service Employees International Union Local 503 (SEIU).

DHS collaborates and works with multiple partners in support of child care system activities. The department contracts with 211info to provide consumer education to assist parents, employers, care givers, and others interested in the ERDC program. Consumer education includes components on the importance of maintaining and providing quality child care. 211info helps to educate parents on the importance of choosing the right caregiver. Many parents are not familiar with indicators of high-quality care, as well as licensing standards for child care. This service is also

provided through DHS offices in every county. DHS partners with eight Head Start programs to offer full-day, full-year contracts for ERDC families. The DHS partnership with Child Care Resource and Referral (CCR&R) agencies supports recruitment of new providers and to offer training as well as provides guidance to child care providers statewide. CCR&R offers training to child care providers in multiple languages. Multnomah and Washington County CCR&Rs work closely with the Immigrant & Refugee Community Organization (IRCO) to assist with trainings and working with refugees in need of child care or who are interested in becoming a child care provider. Refugees located in Multnomah and Washington County interested in becoming self-employed as a child care provider have access to additional supports through the Oregon Refugee Child Care Microenterprise Program. This program offers support in accessing provider trainings, becoming licensed through the Early Learning Division, Office of Child Care and approved by DHS to provide culturally relevant care for subsidy children. DHS also works closely with the Oregon Department of Education (ODE), Early Learning Division, Office of Child Care on policy implementation, quality child care and the CCDF state plan.

The major cost drivers for the program are the number of families receiving ERDC, program enhancements, child care provider rates and more families accessing licensed child care. The cost per case prior to October 1, 2015 was $558, current cost per case is $775. The anticipated cost per case by January 2017 is approximately $800. Additional cost drivers are contracted services such as Head Start, 211info and Child Care Resource and Referral.

The ERDC program serves approximately 12 percent of eligible Oregon families. Priority is given to families transitioning from TANF. The number of intakes of TANF transition cases to ERDC in 2014 was approximately 400 per month. The average over the past 10 years has been 245 per month. In 2015, there was a slight decrease from 2014; however, the average per month remained high at 317.

The ERDC program maintains a reservation list for families that are eligible but not served by the program. As the budget allows, families waiting on the reservation list are invited to apply. Program enhancements in October 2015 have decreased the caseload attrition rate from approximate 400 cases per month to an average of 100 per month. This means families are staying on the program longer, increasing continuity of care for children.

DHS coordinates services across its program areas in order to be as efficient as possible in our service delivery. Families receiving services generally are clients of other programs. Maintaining employment for these families is important as they work towards long-term self-sufficiency. In April 2016, there were 7,375 ERDC cases and 6,863 (93 percent) were receiving food benefits through the Supplemental Nutrition Assistance Program (SNAP). In 2014 the percentage of families receiving both ERDC and SNAP was 97.3 percent. The lower percentage in 2016 is due to the ERDC higher exit income limit. More families are continuing on ERDC after their SNAP benefits end when the family goes over the SNAP income limit. In August of 2016 the ERDC reservation list was deactivated. More than 3,000 families were sent letters inviting them to apply for the program. By September of 2016 the caseload had increased by more than 700 cases to 8,034 serving 15,265.

Program Justification and Link to Focus Areas

Quality child care supports children's development. Research indicates children who receive a high quality early childhood education have better math, language and social skills as they enter school. As the children grow older, they require less special education, progress further in school, have fewer interactions with the justice system and have higher earnings as adults. Early learning opportunities for children are generally provided by the parents. Access to quality child care for low-income families is important. All children need the same opportunities to develop cognitive, social, emotional and behavioral skills to be ready for school.

Children who have attended preschool show positive long-term effects on important adolescent and young adult outcomes, such as high school graduation, years of education completed, earnings, reduced crime and teen pregnancy[1]. Low-income families are faced with difficult choices when it comes to child care expenses. They may rely on an older sibling or a variety of family and friends. This may lead to inconsistent or unstable care that interferes with the employment of the parent.

The Governor's Early Learning Council (ELC) and the opportunity through the Race to the Top federal grant embraced the importance of investing in measureable, quality child care. DHS supports improving safety, quality and enrichment of child care programs that support parent engagement and family stability as well as ensuring low-income families have easy access to a variety of

[1] Hirokazu Yoshikawa, Christina Weiland, etc., *From Investing in Our Future: The Evidence Base on Preschool Education,* Society for Research in Child Development, Foundation for Child Development, October 2013.

child care settings. High-quality early childhood education programs are among the most cost-effective educational investments and are likely to be profitable investments for society as a whole. DHS partners with the Early Learning Division, Office of Child Care and other stakeholders to plan continued improvements to DHS programs, to strengthen outcomes for our children and their parents.

DHS offers contracted child care slots for ERDC families with full-year Head Start programs and providers participating in the Early Head Start Child Care Partnership. The goals of the contracted slots are to provide continuity of care for infant, toddler and preschool children in quality programs, access to continuous care for low-income working families and stable funding for quality early learning programs serving low-income children. DHS has expanded contracted child care opportunities as Head Start Grantees partner with Child Care programs in their communities on the Early Head Start Child Care Partnership (EHS CCP) federal opportunity. These partnerships provide more of Oregon's children with the opportunity to have high quality child care and give them the start they need to be successful in school and life.

Research shows that ERDC is critical in helping low-income families maintain employment. Program enhancements have increased the support for a thriving economy, with child care now accessible for low-income working students, working toward a degree, GED or other education to improve their marketable job skills. Self-employed families are also able to receive child care assistance. This enables them to maintain and grow their business. Child care providers employed by ERDC clients are contributing members to local economies throughout the state.

Program Performance

In September 2016 there were 8,034 ERDC cases that served 15,239 children. The average cost per case was $775. This rate fluctuates greatly depending on the specific family needs. As of October 2016 there were 1,621 licensed child care providers actively providing child care for DHS families across the state.

Researchers have identified education and training as an indicator of quality that has been proven to be associated with positive short-term and long-term child outcomes. Parent education on selecting quality care is provided through DHS contracts with 211info. DHS contracts with Child Care Resource and Referral to offer child care provider training to increase the quality of care. DHS provides a

higher maximum rate, above the standard rate, for license-exempt providers who meet the same basic training requirements that are required of licensed family providers.

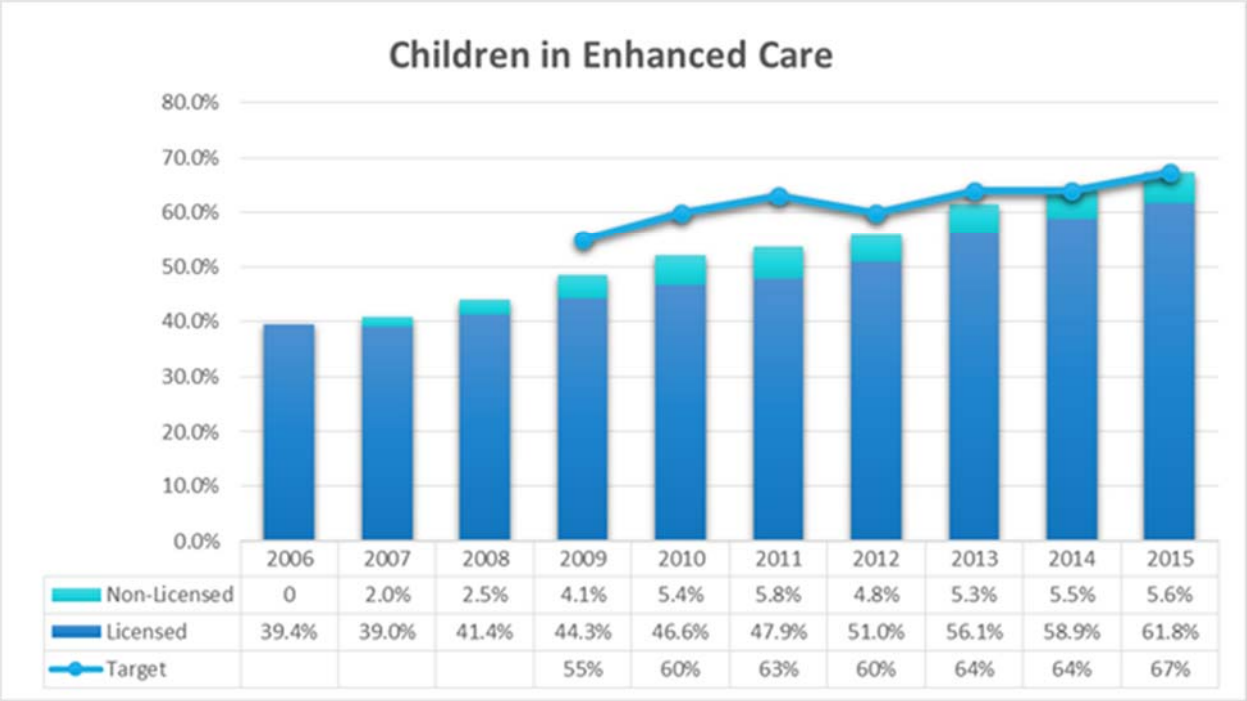
In 2015, 241 license exempt providers took additional classes to become an enhanced provider. These trainings increase quality care available to subsidized families who, may not be able to access licensed care due to non-standard work hours. There has been a steady increase in the percentage of children receiving care from licensed providers. The rate has increased by 11 percent from January 2013 to December 2015. The percentage of children in license-exempt enhanced care has remained stable at just over five percent during the same time frame.

In December 2015, child care subsidy payments were issued for 12,985 children through the ERDC program. Of those children, 61.22 percent were enrolled in licensed care. An additional 5.55 percent of children were in care with providers who are exempt from Office of Child Care licensing but have completed required training through the Oregon Registry. Participation in licensed care is generally highest among preschool aged children (ages three to six) at 68.8 percent in December 2015. Infant and toddler participation (ages zero to three) is slightly lower at 67.92 percent followed by school aged (six through 17) at 51.05 percent.

The earliest years, from birth to age three, are critical for young children's healthy development. Experiences during the infant and toddler years shape the architecture of the brain – including cognitive, linguistic, social and emotional capacities – at a phenomenal rate and lay the foundation for future growth and learning.[2] Subsidy policy improvements need to be made in order to provide parents of infants and toddlers greater access to high quality licensed programs.

The number of children and families the department serves in this program is based on available funding. The program is currently capped at 8,100 through legislative action.

[2] Shonkoff and Phillips, etc., *From Neurons to Neighborhoods: The Science of Early Childhood Development,* National Research Council and Institute of Medicine, 2000.



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Non-Licensed	0	2.0%	2.5%	4.1%	5.4%	5.8%	4.8%	5.3%	5.5%	5.6%
Licensed	39.4%	39.0%	41.4%	44.3%	46.6%	47.9%	51.0%	56.1%	58.9%	61.8%
Target				55%	60%	63%	60%	64%	64%	67%

Enabling Legislation/Program Authorization:

ORS 409.010(2) (c), 411.141 and 418.485 provide statutory authority to DHS for administration of the ERDC program.

Child Care and Development Fund (CCDF) grants are administered by the Department of Health and Human Services, Administration for Children and Families Office of Child Care. They are authorized by the Child Care and Development Block Grant (CCDBG); 45 CFR Part 98 and 99. On November 19, 2014, the president signed into law the CCDBG Act of 2014 (P.L. 113-186), which reauthorizes the program for the first time since 1996. The law adds new state requirements and makes significant advancements by defining health and safety requirements for child care providers, outlining family-friendly eligibility policies, ensuring parents and the general public have transparent information about the child care choices available to them, and activities to improve the quality of child care. In collaboration with the Office of Child Care (OCC), DHS has implemented several program enhancements and is working toward implementation of the remaining federal child care policy reform.

The Department of Education, Early Learning Division, and Office of Child Care[3] is designated as the lead agency in Oregon to administer these funds. CCDF funding is transferred from ODE to DHS.

Funding Streams

The Other Funds are the CCDF Federal Funds that are transferred from ODE. The General Funds are state revenue that is used for our Maintenance of Effort (MOE) as part of the Federal Fund requirement. The department also spends General Funds on our administrative expenses and uses that money for MOE. DHS spends $12 million in General Funds per biennium in order to meet our CCDF MOE requirements.

Funding Justification, And Significant Changes to 17-19 CSL

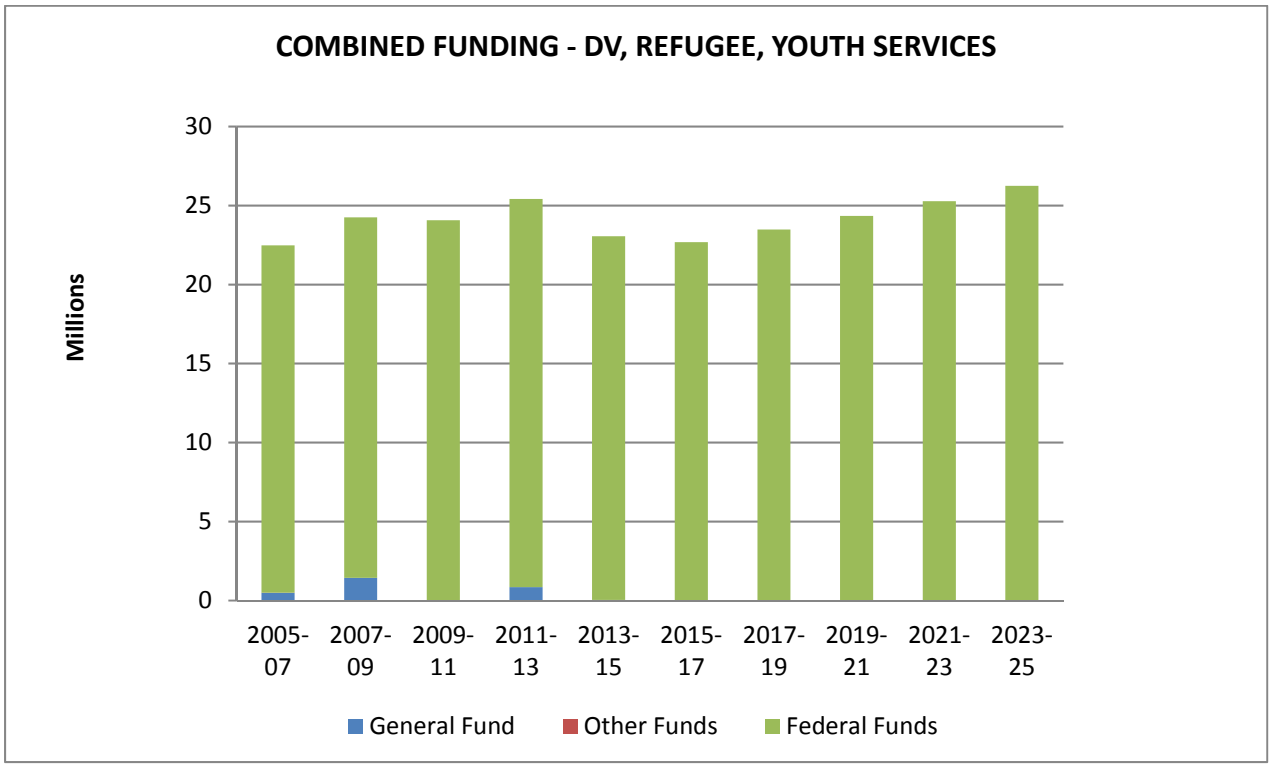
This does not include statewide reductions.

The ERDC Program is funded at Current Service Level

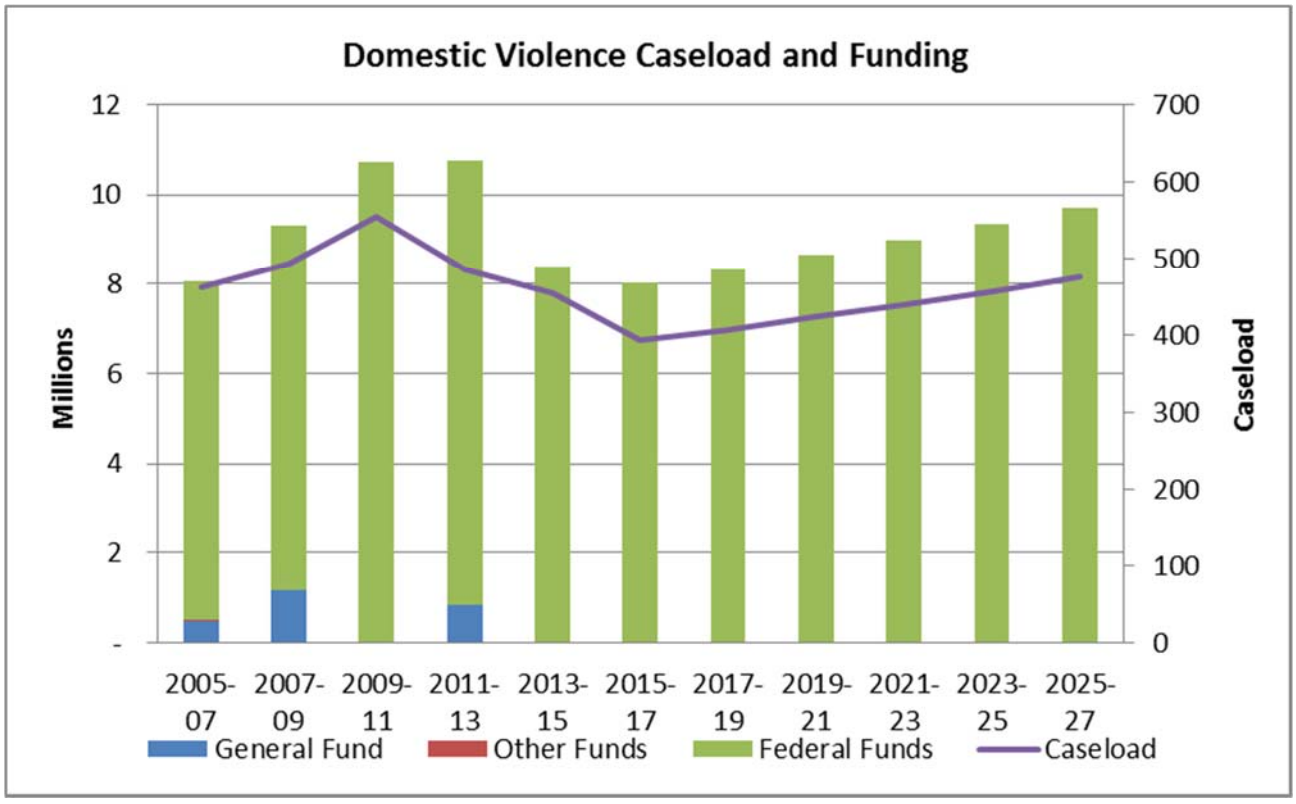
[3] The DHS ERDC proposal needs to be reviewed with OCC's proposal.

Department of Human Services: Domestic Violence, Refugee and Youth Services

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: N/A
Program Contact: Belit Burke



TA-DVS, Refugee, Youth Services	GF	OF	FF	TF
LAB 15-17	$ (651,283)	$ -	$ 23,345,319	$ 22,694,036
GB 17-19	$ -	$ -	$ 23,345,319	$ 23,345,319
Difference	$ 651,283	$ -	$ -	$ 651,283
Percent change	-100.0%	0.0%	0.0%	2.9%



Program Overview – Domestic Violence

Temporary Assistance for Domestic Violence Survivors (TA-DVS) provides temporary financial assistance and support to families affected by domestic violence during crisis or emergent situations when other resources are not available. TA-DVS is used to help the domestic violence survivor and the children address their safety concerns and stabilize their living situation, thus reducing the likelihood of the survivor returning to the abuser. The most common need for TA-DVS is when the domestic violence survivor flees the abuser. Many domestic violence survivors need assistance to create safety and stability in order to be successful in finding and maintaining a job, all keys to becoming self-supporting without public assistance.

Program Funding Request

TA-DVS	GF	OF	FF	TF
LAB 15-17	$ (651,283)	$ -	$ 8,693,857	$ 8,042,574
GB 17-19	$ -	$ -	$ 8,693,857	$ 8,693,857
Difference	$ 651,283	$ -	$ -	$ 651,283
Percent change	-100.0%	0.0%	0.0%	8.1%

Program Description

TA-DVS provides up to $1,200, over a three-month period. Payments can include but are not limited to: Initial months' move-in fees, rent or utilities, moving costs, and items to help address safety. The program serves families with minor children or individuals who are pregnant, who are low-income, and meet eligibility requirements of the Temporary Assistance for Needy Families (TANF) program. Case managers, through DHS field offices, meet with the clients to review their situation and develop a safety plan. Depending on the service needs, payments are made directly to vendors including landlords, truck rental companies, or other retailers. DHS also works in partnership with local non-profit domestic violence and sexual assault service providers who assist families with additional safety planning and emergency shelter.

Program Justification and Link to Focus Areas

The TA-DVS program is directly linked to the Safer, Healthier Communities focus area. Futures without Violence (formerly the Family Violence Prevention Fund) indicates that about 30 percent of women receiving public assistance have experienced domestic violence. Research has shown that individuals impacted by domestic violence have more chronic health issues[i] including depression and post-traumatic stress, more difficulty obtaining and maintaining employment[ii], and that these impacts can be mitigated by addressing safety.[iii] This program provides economic support to very low income families who are seeking services to meet basic needs while they are working towards self-sufficiency. Ensuring safety and stability helps the domestic violence survivor be more successful when they engage in job training or job search.

Program Performance

For the fiscal year ending in June 2016, the TA-DVS program served on average 1,584 cases per month. Of these 1,584 cases on average 404 received TA-DVS funds. The average payment per family was $720.96. The low number of eligible individuals accessing the funds is primarily the result of a lack of affordable housing.

Enabling Legislation/Program Authorization

Domestic violence emergency assistance also known as TA-DVS is mandated under ORS 411.117 (1) (e). Federal authorization through the TANF block grant includes use of the TANF funds to meet non-recurrent, short-term benefits to deal with specific crisis situations including domestic violence. (See 45CFR 260.31 (b))

Funding Streams

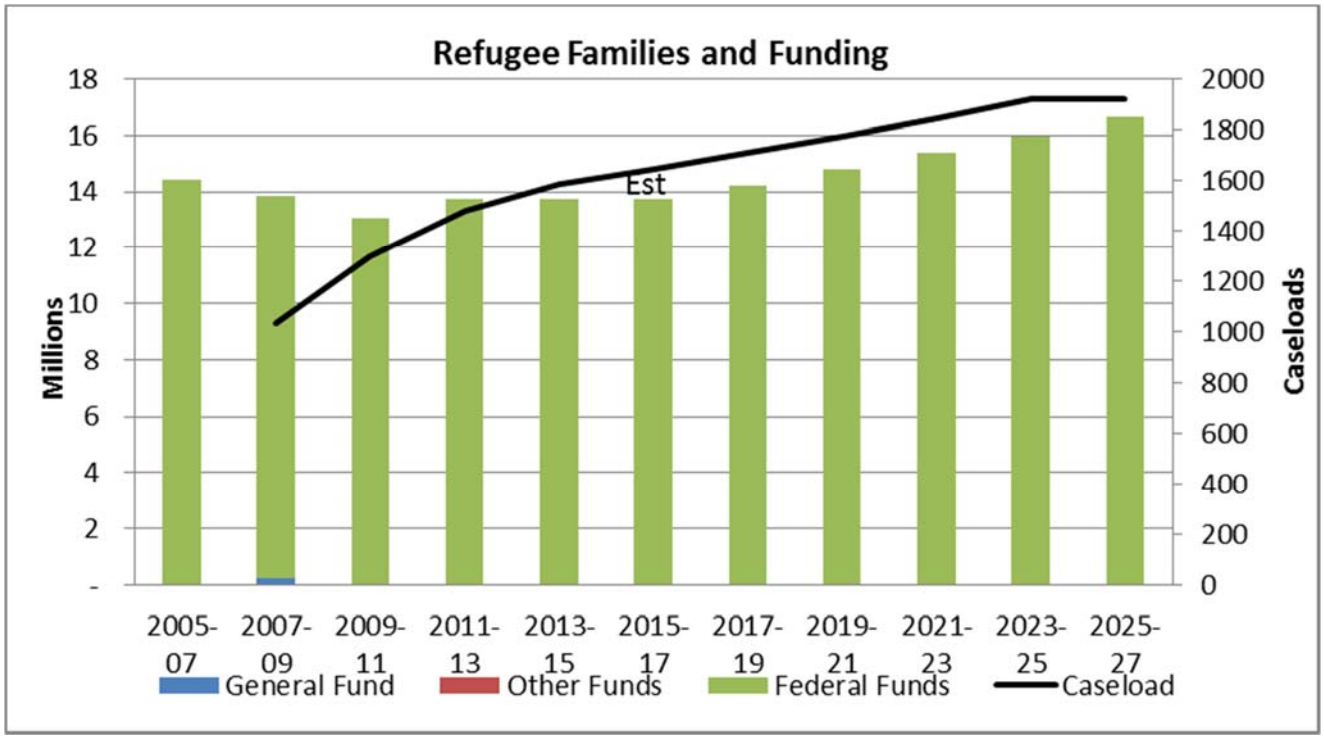
TA-DVS is funded with the Federal TANF block grant. (See 45CFRPart260)

Funding Justification, And Significant Changes to 17-19 CSL

This does not include statewide reductions.

The TA DVS Program is funded at Current Service Level

Refugee Services



Program Overview – Refugee Services

The Refugee Program serves individuals and families who fled persecution in their country of origin and were legally admitted for resettlement by the United States government. The program guides refugees into self-sufficiency through employment as early as possible by providing financial services, employment related services, and acculturation services, so they can become independent and contributing members of Oregon's economy.

Program Funding Request

Refugee	GF	OF	FF	TF
LAB 15-17	$ -	$ -	$ 13,740,633	$ 13,740,633
GB 17-19	$ -	$ -	$ 13,740,633	$ 13,740,633
Difference	$ -	$ -	$ -	$ -
Percent change	0.0%	0.0%	0.0%	0.0%

Program Description

The Refugee Services Program can serve only those persons in immigration categories approved by the Federal Office of Refugee Resettlement (ORR): Refugees, asylees, Cuban/Haitian entrants and parolees, Amerasians, victims of human trafficking (international) and certain family members, and Iraqi/Afghan special immigrant visa holders.

Resettlement services are comprehensive. Initial resettlement and most case coordination services are delivered by non-profit resettlement agencies located in the Portland tri-county area (Multnomah, Clackamas and Washington counties), where the majority of refugees seek services. These services may include essential tasks such as picking up refugees at the airport, finding them a place to live and helping to furnish their home with basic necessities. There has been some expansion of resettlement outside of the tri-county area in an effort to locate available affordable housing.

During Federal Fiscal Year (FFY) 2015, the average monthly caseload for all resettlement agencies was 376 refugee cases. Employment-related services are delivered by the Immigrant and Refugee Community Organization (IRCO) in Portland. IRCO services may include: assistance with job search, employment acculturation, pre-employment training, English language classes, citizenship, and naturalization help. During FFY 2015, these services assisted an average of 900 refugees per month. Those refugees who resettle outside the tri-county area are served through a local DHS field office.

Those served through the Refugee Program come from all over the world. During FFY 2015, Oregon's Refugee Program assisted people from over 18 different countries. Most refugees who are resettled in the U.S. speak little to no English. Limited English capacity is expected and integrated into Refugee Program services.

Program Justification and Link to Focus Areas

This program is directly linked to Safer, Healthier Communities. Refugees receive help to become safe, healthy, and independent by learning how to understand and navigate the prevalent culture, become self-sufficient through employment as early as possible and become contributing members of Oregon's thriving economy. These services enhance the ability of arriving refugees to succeed in the U.S. and also helps them become integrated members of the community. Most services are

provided for up to eight months after arrival. Employment services can extend to a maximum of 60 months after arrival.

Program Performance

ORR requires states to establish goals related to self-sufficiency of refugees. Two of the more significant measures are the percentage of clients who become employed and the percentage who remain employed 90 days after placement. During Federal Fiscal Year (FFY) 2015, the Refugee Program was able to help gain employment for about 67 percent of the on-going caseload, with the goal being 72 percent. The retention goal of 73 percent fell short of the goal with only 70 percent for those still employed after 90 days.

Enabling Legislation/Program Authorization

The Refugee Program is authorized and operates under the Federal Immigration and Nationality Act and the Refugee Act (8 U.S.C. 1522). The Refugee Program operates as a public assistance program under ORS 411.060, 409.010(2) (c), and 409.010(2) (h).

Funding Streams

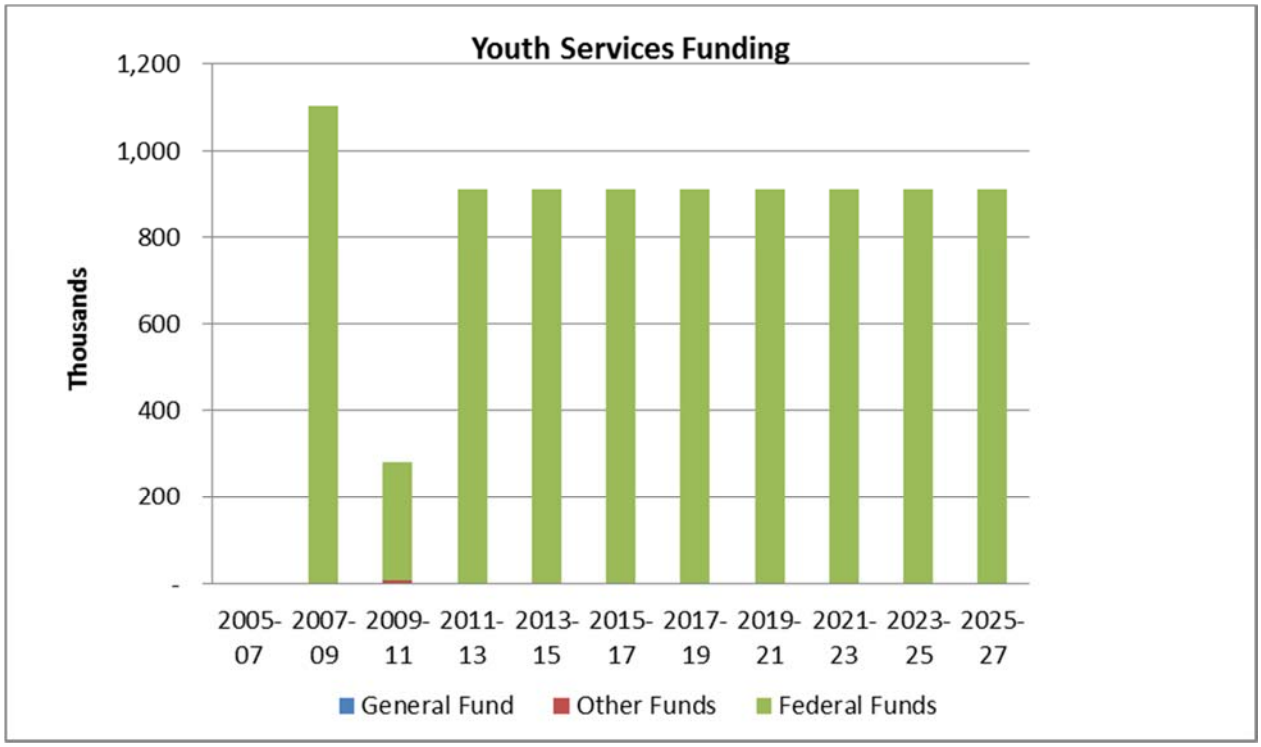
During the initial resettlement period, the Refugee Program serves two different populations of refugees: those refugees who are eligible for Temporary Assistance for Needy Families (TANF) and those refugees who are eligible for ORR-funded services. The TANF eligible refugees receive cash assistance and services paid with TANF funding, and all other refugees are served with ORR funds, which are federal funds. (8 U.S.C. 1522)

Funding Justification, And Significant Changes to 17-19 CSL

This does not include statewide reductions.

The Refugee Program is funded at Current Service Level

Youth Services



Program Overview - Youth Services

Youth Services include sexual health education, leadership and mentor programs. These services support community prevention efforts to enable Temporary Assistance for Needy (TANF) families to break the generational dependence on public assistance.

Program Funding Request

Youth Services	GF	OF	FF	TF
LAB 15-17	$ -	$ -	$ 910,829	$ 910,829
GB 17-19	$ -	$ -	$ 910,829	$ 910,829
Difference	$ -	$ -	$ -	$ -
Percent change	0.0%	0.0%	0.0%	0.0%

Program Description

The "My Future-My Choice" program includes age-appropriate, medically accurate sexual health education curriculum and services for sixth and seventh grade, and a high school leadership and mentor component. These services support community prevention efforts to enable TANF families in breaking the generational dependence on public assistance. The "My Future-My Choice" program expands on the historical teen pregnancy prevention program to provide education and tools for youth to resist multiple risk taking behaviors. DHS partners with the Oregon Department of Education and the My Future-My Choice Advisory Committee to develop and implement the program. During the 2015-2016 school year this curriculum was implemented in 15 counties and 24 school districts. Various school districts implement the program throughout the year; the 2015-2016 school year data will be available August 1, 2016.

Program Justification and Link to Focus Areas

The "My Future-My Choice" program is directly linked to the Safer, Healthier Communities focus area. An analysis from the National Campaign to Prevent Teen Pregnancy shows that teen childbearing (ages 19 and younger) in Oregon cost taxpayers (federal, state and local) at least $88 million in 2010. Of the total 2010 teen childbearing costs in Oregon, 32 percent were Federal costs and 68 percent were state and local costs. Investing in preventing teen pregnancy reduces the risk to teen pregnancy, which can lead to a lifetime of poverty for both the teen parent and the child. The teen birth rate in Oregon declined 49 percent between 1991 and 2010. The progress Oregon has made in reducing teen childbearing saved taxpayers an estimated $116 million in 2010 alone compared to the costs they would have incurred had the rates not fallen.

Program Performance

Oregon teen pregnancy rates have consistently stayed below the national average. The teen birth rate in Oregon declined seven percent between 2013 and 2014. According to national data from the U.S. Department of Health and Human Services, the 2015 national rate for births to teens between the ages of 15 and 19 is 22 per 1,000 teen girls. The Oregon rate is 20 births per 1, 000 females. Teen Pregnancy rates among Oregon females aged 15-17 years have declined from 25.8 per 1,000 in 2008 to 12.4 in 2014.

Enabling Legislation/Program Authorization

The Oregon Legislature passed HB 2509 in 2009, which requires that all schools provide comprehensive sexual health education. The My Future–My Choice curriculum complies with all requirements of this legislation for sixth and seventh grades. DHS partners with Oregon Health Authority and Oregon Department of Education to share in responsibility for collaborative efforts to increase youth sexual health education and services.

Funding Streams

The Title V Federal Abstinence Education Program grant provides annual funding of approximately $818,000 to the My Future–My Choice Program through 2018. DHS submits a request for funding each year and continued funding is contingent on federal budget approval.

Funding Justification, And Significant Changes

This does not include statewide reductions.

The Youth Services Program is funded at Current Service Level

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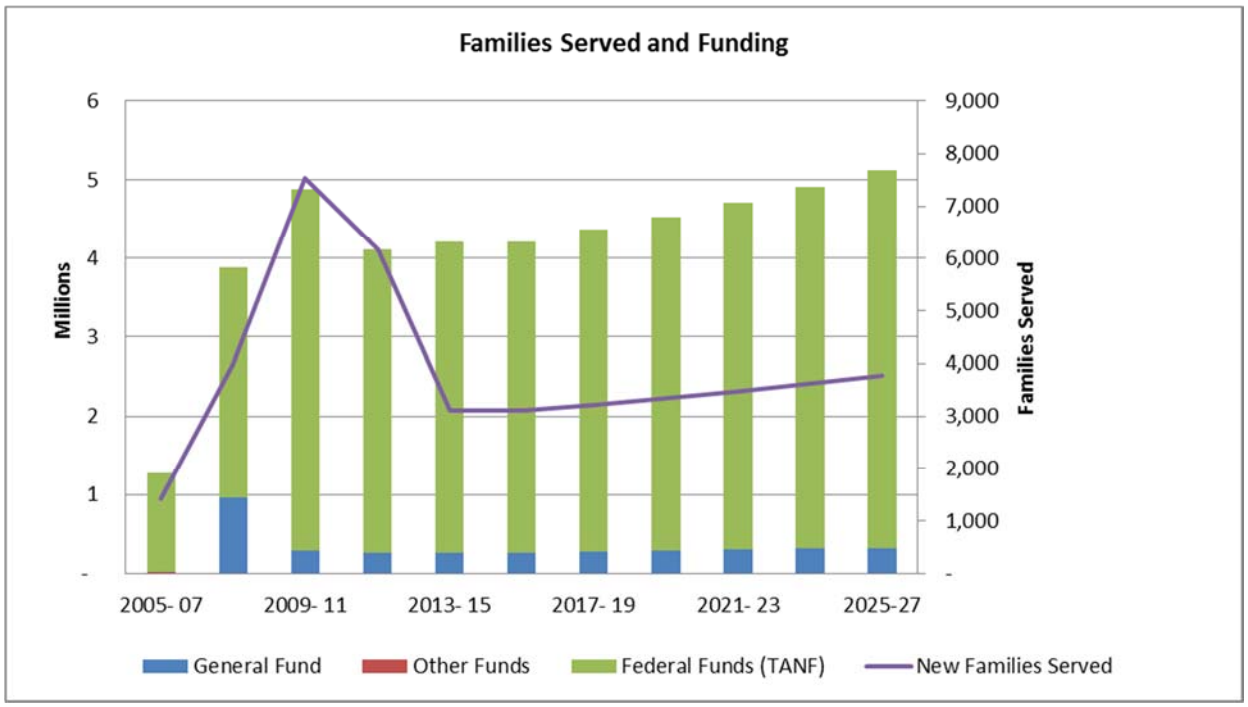
[i] Depression, Substance Abuse and Domestic Violence; National Center for Children in Poverty; Sarmila Lawrence; Michelle Chau; Mary Clare Lennon; June 2004

[ii] Welfare and Domestic Violence Against Women: Lessons from Research – Eleanor Lyon, PHD; August 2002

[iii] Self-Sufficiency & Safety; Lee McKean, PHD; Center for Impact Research; October 2004

Department of Human Services: Family Support and Connections Program

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: N/A
Program Contact: Belit Burke



Program Overview

Family Support and Connections (FS&C) is a child abuse and neglect prevention program that provides a wide array of services including home visits, resource brokering and parenting classes. These families primarily are eligible for the Temporary Assistance for Needy Families (TANF) program, which is a safety net program that provides cash assistance to parents. FS&C services are generally provided to families with barriers or issues putting them at a higher risk of involvement with the Child Welfare system.

Program Funding Request

FAMILY SUPPPORT & CONNECTIONS	GF	OF	FF	TF
LAB 15-17	$ 265,881	$ -	$ 3,943,763	$ 4,209,644
GB 17-19	$ 275,719	$ -	$ 3,943,763	$ 4,219,482
Difference	$ 9,838	$ -	$ -	$ 9,838
Percent change	3.7%	0.0%	0.0%	0.2%

Program Description

FS&C is a component of the continuum of community supports to prevent child abuse and neglect. This program focuses on TANF families who may be at risk for involvement with the child welfare and foster care systems. DHS collaborates with numerous local and state, informal and formal prevention services, and activities to meet families' needs. Program staff work within the existing community structure to coordinate referrals and deliver direct services where gaps or needs exist for a family.

Services are designed to increase parental protective factors and decrease the risk factors of child abuse and neglect. Services are delivered in part through use of home visit models proven effective with this population. For the fiscal year ending June 2015, the program served 3,102 new families. This program provides home visiting services in all 36 counties and works collaboratively with Self Sufficiency and Child Welfare program staff, contracted staff and other community partners.

FS&C also provides services and supports for families helping them move towards greater independence while promoting the health and well-being of all family members. The service array focuses on immediate crisis needs of families but also provides prevention and early intervention services to help families avoid reaching a crisis.

Because a diverse population is served through the program, FS&C providers are asked to design their program in a culturally appropriate way to best meet the needs of the families served. This is achieved, in part, by hiring staff who reflect the demographics of the local community. Local FS&C Steering Committees give guidance and direction on how services are provided to ensure community linkages are established. The local steering committees are also required to have membership representative of the cultural diversity in the district they serve. The steering committees also include representatives from local agencies working with minority and special needs populations, and faith-based organizations.

Occasionally referrals are made to Child Welfare but in the cases where risk does exist, the early intervention and assistance from FS&C can help keep children safe and stabilize families sooner.

The program provides short-term interventions including home visits, family assessments, advocacy for services in the community, supports to strengthen parenting, coping and other skills to support the healthy development of children, individualized interventions and joint outcome-based case planning. The services are community-based and tailored to meet a family's needs. FS&C advocates support the family by working with them to identify risks and strengths. Together they tackle issues before there is irreversible damage, reducing the incidence of child abuse and neglect.

FS&C aims to build genuine partnerships with families that recognize their strengths in the context of the family's culture. This program combines the best practices of a family strengthening model with a unique partnership providing joint case planning with FS&C, Self Sufficiency, and Child Welfare programs. FS&C also uses a combination of principles with an empowerment approach and building a helping alliance with the family. Families may volunteer for the program.

The major cost drivers are the number of families in need of child abuse and neglect prevention services as well as the number of contracted staff needed to provide the preventative interventions. The program has a small budget which does not accommodate the actual need.

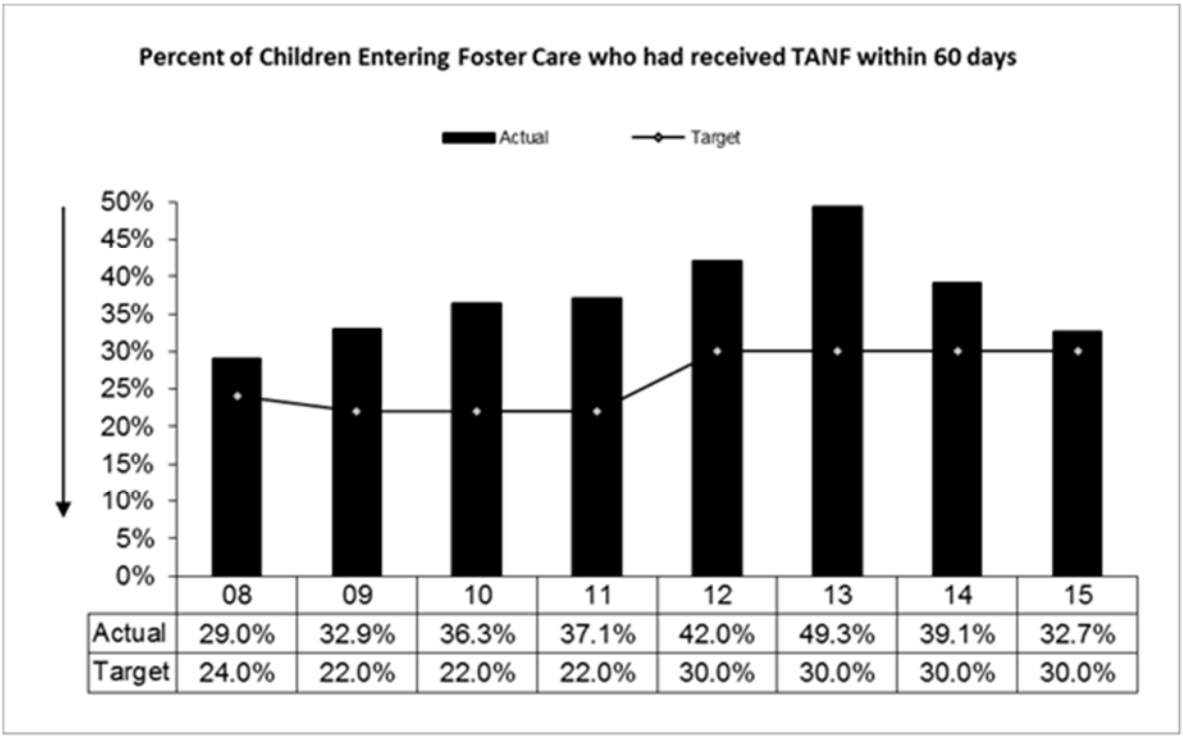
Program Justification and Link to Focus Areas

This program focuses on building safer, healthier communities by promoting its goal of increasing child safety and contributing to family stability. By achieving this goal, the program helps to reduce or prevent TANF children from entering the child welfare and foster care system. Children who enter foster care are more likely to struggle with school, experience homelessness and unemployment, and may become part of the juvenile and adult corrections system. Most TANF families served through FS&C have significant needs that include needing help with parenting, housing or other stabilization services. TANF is an important part of the service array, providing cash assistance, case management, and employment and training services to families with children living in extreme poverty.

Program Performance

The primary performance measure is the percentage of children entering foster care who received TANF 60 days prior to foster care entry. Since the recession and the slow economic recovery, more families have been accessing programs for low-income Oregonians such as TANF. The display below shows the percentage of children entering foster care who had received TANF has also been increasing.

There continues to be a high percentage and disproportionate number of African-American children who received TANF prior to entering foster care. The TANF program and FS&C is aligning with Child Welfare, and other family stability efforts such as the Strengthening, Preserving and Reunifying Families (SPRF) initiative to better serve all at-risk families and improve equity in outcomes for populations which are overrepresented in both TANF and Child Welfare. The SPRF funding has increased local service provision availability in communities specific to this population. Applicants had to demonstrate in their request that the community demographics were included and plans to implement programs equitably.



	08	09	10	11	12	13	14	15
Actual	29.0%	32.9%	36.3%	37.1%	42.0%	49.3%	39.1%	32.7%
Target	24.0%	22.0%	22.0%	22.0%	30.0%	30.0%	30.0%	30.0%

Enabling Legislation/Program Authorization

Title II of the Child Abuse Prevention and Treatment Act (CAPTA), as amended by P.L. 111-320, authorizes grant funds to be released to the states and names the program Community-Based Grants for the Prevention of Child Abuse and Neglect (CBCAP). The grant requires a 20 percent match of State General Funds.

The TANF program is authorized under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Deficit Reduction Act of 2005.

Funding Streams

The FS&C program is funded with a blend of TANF Federal Funds, CBCAP grant funds and State General Fund dollars. The CBCAP grant awards additional leveraged funds each year based on a formula giving credit for the previous year's contribution of state General Fund dollars. In addition, individual contracted programs in the DHS districts add leveraged funds on the local level from agency donations, grants and fundraising.

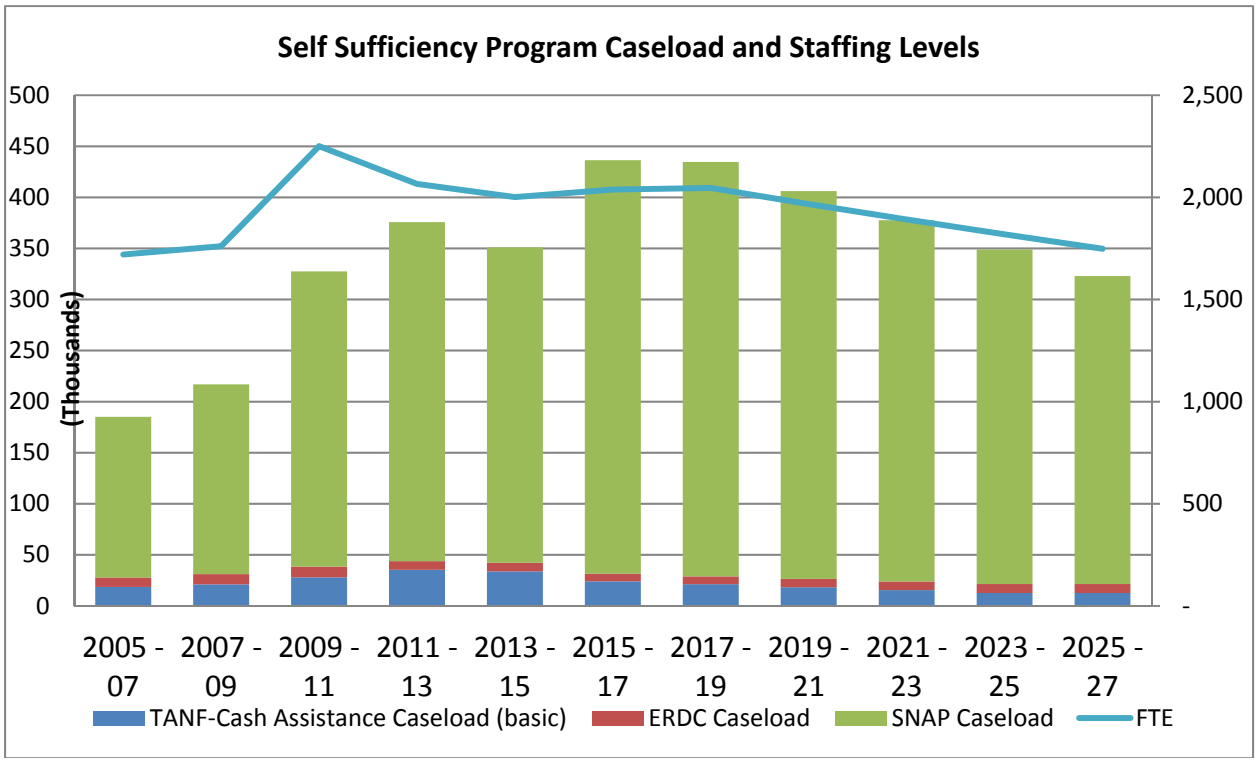
Funding Justification, and Significant Changes

This does not include statewide reductions.

Family Support and Connections is funded at Current Service Level

Department of Human Services: Delivery and Design

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: Excellence in State Government
Program Contact: Dan Haun



Program Overview

This program provides design, personnel and service delivery in addition to oversight, planning, reporting, implementation, training, eligibility and benefit issuance for programs that support a diverse, low-income population in need of economic supports and self-sufficiency services to meet their basic needs. The last economic recession triggered a dramatic increase in demand for these services which include food and cash assistance, and other programs that enhance employability and support job retention among clients.

Self Sufficiency reallocated staff resources to meet client demand and increase positive outcomes for TANF clients. This was accomplished by staff reallocation approved in the 2013-15 biennium. These positions provide families, who are

living at an estimated 37 percent of the federal poverty Level, with services to stabilize their living situations and increase their earning potential to move them off of state-provided services. This investment increased case managers from 35 percent of workload to 59 percent of workload by the end of the 2013-15 biennium. As of the spring 2016 forecast, we were at 78 percent of need for the 2015-2017 Biennium. We are projecting to maintain 78 percent of need through the 2017-2019 biennium,

The TANF program has reinvested funds into efforts that maximize the dollars for benefits that are targeted at building participant progression in work related activities, identifying and building on skills and leveraging community collaborations to provide solid foundations that lead not only to employment placement but retention and advancement. The recent investments in the program have led to consistent employment placements of 13,531 for the SFY 2016.

House Bill 2015 and the Reauthorization of Child Care and Development Fund act of 2014 have strengthened the Employment Related Day Care Program through several program enhancements. DHS implemented enhancements on October 1, 2015. Working students, and self-employed families can access affordable quality child care while they improve their life circumstances, making it easier to move out of poverty. A 12 month eligibility period, three months of work search for a parent who has lost a job, continued child care coverage while on medical leave and a higher exit income limit allow for continuity of care for children. Additional changes include incentive payments for quality rated child care providers and a reduced copay incentive for parents who use a quality rated child care provider. Program improvements have reduced the number of cases lost through attrition, meaning families are staying on ERDC longer allowing for continuity of care for children.

Program Funding Request

	Self Sufficiency Healthy People Total (Design/Delivery)					
SELF SUFFICIENCY - DESIGN & DELIVERY	**GF**	**OF**	**FF**	**TF**	**Pos**	**FTE**
LAB 15-17	175,459,134	603,763	183,995,645	360,058,542	2,044	2,035.49
GB 17-19	188,262,978	974,809	194,834,655	384,072,442	2,046	2,045.63
Difference	12,803,844	371,046	10,839,010	24,013,900	2	10.14
Percent Change	7.30%	61.46%	5.89%	6.67%	0.10%	0.50%

Program Description

This program encompasses and supports the personnel necessary to provide eligibility and family engagement services to vulnerable Oregonians who request assistance to meet basic needs such as food and shelter, and need access to employment programs. Self Sufficiency family stability and work support programs include the following:

- Temporary Assistance for Needy Families (TANF) provides cash assistance, job preparation services and community connections to low-income families with children while they strive for self-sufficiency.
- TANF Jobs Opportunity and Basic Skills (JOBS) program is an employment and training program.
- Supplemental Nutrition Assistance Program (SNAP) helps low-income families buy healthy foods to meet their nutritional needs.
- SNAP can also provide limited assistance with job search and links to employment resources through the Oregon Food Stamp Employment and Training (OFSET) program and the 50/50 Employment and Training Program.
- Employment Related Day Care (ERDC) helps low-income, working families with quality child care.
- Family Support and Connections (FS&C) provides local advocates who work with families to help those overcome parenting challenges in order to create family stability and reduce the risks of Child Welfare involvement.
- Temporary Assistance for Domestic Violence Survivors (TA-DVS) provides up to $1,200 to help pregnant women and families flee or stay free from domestic violence.
- Refugee Services support the successful resettlement of families in the U.S. who are fleeing persecution in their countries of origin.

Since the start of the last recession, demand for these services grew dramatically. The department continues to handle high caseloads in its primary self-sufficiency programs. In 2015, on average, 759,119 people – or one in five Oregonians – got help purchasing food for their families through programs like SNAP. Approximately 62,897 individuals are receiving cash assistance through TANF to cover their family's basic living expenses such as rent and utility payments. Other programs, such as the child care subsidy, help parents provide the safe, reliable child care that keeps parents employed.

Major cost drivers for the personnel need for Self-Sufficiency Program Delivery and Design are federal or state program mandates, economic conditions which affect caseload size, such as the number of Oregonians needing assistance, personnel turnover, the related training and travel costs, the work effort required to provide services, and personnel packages such as position cost, infrastructure improvements, etc.

Program Justification and Link to Focus Areas

This program primarily supports the Safer, Healthier Communities focus area by helping Oregonians meet their basic needs such as food, housing and medical care referrals in order for people to be healthy and have the best possible quality of life at all ages. It also links to the Economy and Jobs, and Safety Outcome areas.

Staff supports basic needs programs such as financial assistance, food assistance, medical insurance (referral only), child care, domestic violence services, employment and training, refugee and youth services. Also, staff is responsible for disaster program delivery when needed and as identified by the federal program.

Staff at the state and local levels coordinates with Child Welfare to work with families to increase their stability and prevent Child Welfare involvement. This collaboration helps to support the focus by ensuring children are cared for regardless of the system of service. Other collaborations have been built around domestic violence, housing, alcohol, drug and mental health treatment, workforce development, vocational rehabilitation, health care, and education.

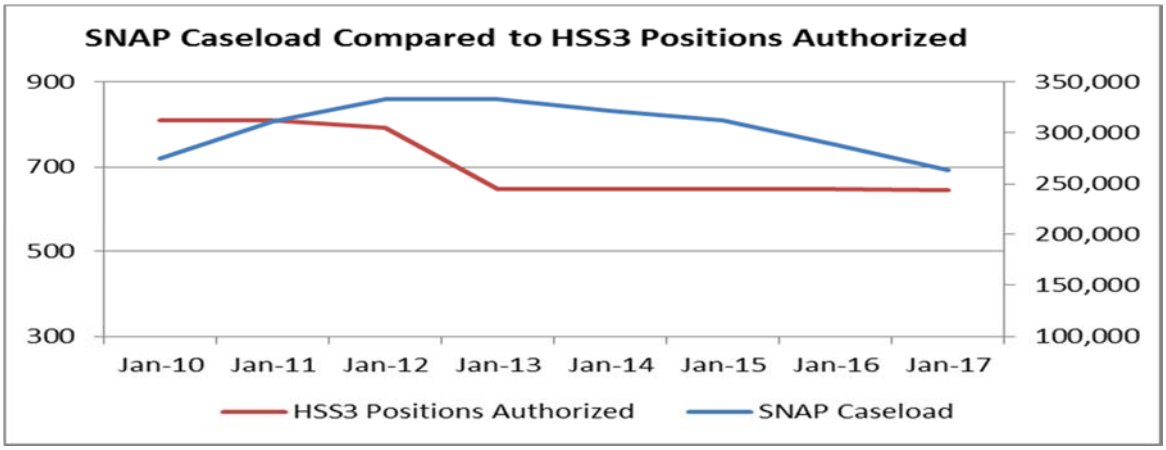
Program Performance

Personnel resources provide performance in the delivery of programs within Self Sufficiency. A workload model is used to provide a basis for determining personnel needs to adequately support those seeking services. The spring 2016 forecast below provides a comparison of the delivery positions authorized by the 2015-2017 Legislature, showing the investment of reallocating positions, and the need based on work effort to meet the service delivery need:

SSP	Workload Model 17-19 budget build calculations				17-19 GB FALL 2016 FORECAST			
	2015-17 (post-LAB)				2017-19 GB			
POSITION TYPE:	Current Position Authority	Positions Earned Forecast (S15)	Percent of Earned	Difference Current to Workload Forecast	Current Position Authority 17-19	Positions Earned Forecast (F16)	Percent of Earned	Difference Current to Workload Forecast
Eligibility Workers	648.00	848.60	76%	(200.60)	648.00	820.51	79.0%	(172.51)
Case Managers	400.00	511.80	78%	(111.80)	441.00	602.24	73.2%	(161.24)
Eligibility Leads	58.00	53.00	109%	5.00	58.00	74.59	77.8%	(16.59)
Support Staff	548.41	680.20	81%	(131.79)	432.38	569.1	76.0%	(136.72)
Community Resource Coordinators	37.47	32.00	117%	5.47	37.00	54.75	67.6%	(17.75)
Engagement Specialists	33.00	32.00	103%	1.00	59.00	54.75	107.8%	4.25
Support Lead	24.00	56.68	42%	(32.68)	38.00	51.74	73.4%	(13.74)
Supervisors	117.47	123.10	95%	(5.63)	141.63	185.64	76.3%	(44.01)
Totals	1,866.35	2,337.38	79.8%	(471.03)	1855.01	2413.32	76.9%	(558.31)

The work of staff in administration and central support is not included in the workload model; however, the work of central support staff is vital to the delivery of services in field offices. Central support provides the oversight of policy development, program design, and changes required through legislation, as well as federal reporting compliance, and has not been adequately staffed for several years.

The chart below provides a comparison of the caseload growth to the personnel growth providing a stark display of how our current resources are struggling to keep pace with the need of vulnerable Oregonians.



The above chart represents only SSP. It does not show the total SNAP Caseload nor the staff associated with APD.

We are committed to continually evaluating how to work in a more lean and efficient way to help streamline our efforts and improve outcomes for our clients and our budgets. As an example, improvements continue in how we interview and

determine eligibility for SNAP and TANF. This greatly improved the capacity of staff to see clients and issue benefits quickly, and helps us gain monetary performance awards to further benefit the state. The United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) recognized Oregon as a national model for effective administration of the SNAP program. FNS awarded Oregon performance bonuses totaling $3.2 million for its timeliness in issuing benefits and for program accessibility.

This active process of identifying ways to improve efficiencies allowed the Self Sufficiency Program to reinvest staff resources to close the gap between positions needed and those authorized in the 2013-2015 biennium. The Self Sufficiency Program continues to identify opportunities for other efficiencies as the delivery programs are at 66 percent of needed positions based on client demand. We are developing new models of delivery that will include online applications, electronic workflow and distribution which, over time, will allow staff to spend less time on paperwork and more time working directly with clients providing services such as referrals to community resources, employment and training assistance, and case management.

Additionally, program areas are developing strategic plans for program delivery, including high priority areas where breakthroughs are desired in either outcomes or the way work is done. One high priority area we share with the Vocational Rehabilitation and the Aging and People with Disabilities programs is on increasing employment outcomes for clients. We can best meet the needs of our clients by collaborating across programs to help them progress quickly along the road to self-sufficiency.

Enabling Legislation/Program Authorization

Self-sufficiency programs have varying levels of mandates from federal law and the Oregon constitution. SNAP and Medicaid are federally mandated programs. TANF is a federal block grant program. It is authorized under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Deficit Reduction Act of 2005. A significant portion of the TANF eligibility criteria is codified in State statute chapters 411 and 412. DHS has statutory authority to administer the ERDC program through ORS 409.010(2) (c), 411.141 and 418.485. Family Support and Connections services are authorized through the Title II of the Child Abuse Prevention and Treatment Act (CAPTA), as amended by P.L. 111-320.

Funding Streams

Funding for personnel for Program Delivery and Design is determined through Random Moment Sampling Surveys to identify which programs are being worked on in the moment and the funding split for administration of the program. With RMSS, field delivery staff are required at random intervals to indicate the time spent on various activities to determine the level of federal funding which directly supports our ability to provide Self Sufficiency Program services. The funding is a mixture of Federal and General Funds that cover the work done by the employees to support the programs that they work in. The main grant used is SNAP Administration funded 50 percent Federal and 50 percent General Funds. TANF and CCDF funds also are used and both are 100 percent General Fund for administration.

Funding Justification, And Significant Changes to 17-19 CSL

This does not include statewide reductions. Self Sufficiency Design & Delivery is funded at current service level.

Department of Human Services
Child Welfare Program

Mission

Protect Oregon's children by assisting families in improving their capacity to provide safe and nurturing living environments for their children; and providing for the safety, well-being and permanency for children experiencing out of home care.

Goals

Safe and equitable reduction in the number of children experiencing foster care.

- **Safety:** Protect children from abuse and neglect, keeping them safely at home whenever possible and appropriate
- **Permanency:** Find safe, permanent stable homes for children
- **Well-Being:** Ensure children in foster care are well cared for, remain connected to family, siblings and support networks, and receive appropriate services
- **Service Equity:** Provide culturally appropriate, equal access and equitable treatment for all children served by the Department
- **Quality Assurance/Continuous Quality Improvement:** Continue an integrated practice of quality assurance and continuous quality improvement for defining, measuring, and improving outcomes for Oregon's children and families

Program

Child Welfare Programs serve children and families when children are subject to abuse and neglect. Trained child welfare staff respond to all reports of child abuse and neglect, and if a child cannot be safe at home, a foster care placement is made. The primary goal of child welfare is to keep children safe, while providing services to support timely and safe return to their families. Whenever possible, services are provided to prevent out-of-home placements.

The program areas within Child Welfare are:

- Safety
- Well-Being
- Permanency
- Program Design & Delivery
- Federal Program Performance & Reporting

Individuals We Serve
Children served in Federal Fiscal Year (FFY) 2016:

- 11,493 children spent at least one day in foster care
- 73,359 reports of abuse and neglect were received
- 34,045 reports were referred for investigation
- 7,679 reports were founded for abuse or neglect involving 10,004 victims
- 46.1 percent of the victims were younger than 6 years old

Child Safety

The Child Safety program provides protective and social services to children and families when allegations of child abuse or neglect are reported. Specially trained workers conduct comprehensive safety assessments and make determinations about the following: child safety, the presence of abuse, if services would benefit a family or whether safety intervention is required due to the presence of safety threats. Safety services are delivered through Department staff or contracted providers in a linguistically and culturally appropriate way.

With very few exceptions, a child abuse report begins with a call to a child abuse hotline. Trained Social Service Specialists screen reports and collect key information. If the report meets criteria to be assigned for an in-person investigation, the family's information is given to a trained Child Protective Services (CPS) worker who will conduct a comprehensive safety assessment.

Family Support Teams (also referred to as Addiction Recovery Teams or ART Teams)
These teams provide coordinated, culturally appropriate multi-disciplinary services to substance abusing family members whose issues are identified through a comprehensive safety assessment.

Domestic Violence/Sexual Assault
DHS makes grants available to domestic violence and sexual assault service providers throughout Oregon. These providers offer crisis lines, crisis response, emergency shelter and other related services to survivors of sexual assault, survivors of domestic violence, and their children, in a culturally and linguistically appropriate manner.

Strengthening, Preserving and Reunifying Families (SPRF)
The Strengthening Preserving and Reunifying Families law (ORS 418.575-418.598) allows funding for an array of services for families through collaboration between DHS and local community partners. The Department has developed outcome-based contracts for services to specifically address the needs of children and families who come to the attention of child welfare through a screened in report of abuse or neglect. These outcome based contracts are foundational for an overall ability to report on results associated with SPRF services and funding.

In-Home Safety and Reunification Services (ISRS)
This program provides culturally appropriate intensive, short term services to families with children who can remain safely in their homes, or communities, and to children and families who are safely reunited. ISRS provides a combination of safety and strengths-based services that lead to lasting safety changes within the family. These services are time limited and are complemented by SPRF services for families in need of longer term or more intensive services.

System of Care (SOC)
System of Care funds support Oregon's most vulnerable children by providing local child welfare offices with the flexibility to purchase specific services to meet a family's needs; to assure the safety, permanency and well-being of their child(ren). Services are identified and planned for through family involvement in case planning. Whenever possible, shared funding of custom-designed services is achieved through collaboration with community partners.

Differential Response (DR)
Differential Response is a family-centered approach which focuses on protecting children to ensure a successful future. DR occurs at the front end of the child welfare system and allows for an alternative path of intervention for a family with a screened in report of abuse or neglect when safety can be assured at home.

There are three parts to Oregon's implementation of DR:

1. Continued focus on practice fidelity to the Oregon Safety Model (OSM);
2. Strengthening, Preserving and Reunifying Families (SPRF) services; and
3. Staged implementation of Oregon's DR model.

The goals of implementing Differential Response in Oregon are as follows:

- More children will be kept safely at home and in their communities
- The community and DHS will work in partnership with a shared responsibility for keeping children safe
- Families will partner with DHS to realize their full potential and help develop solutions to their challenges
- Fewer children will re-enter the child welfare system
- Disproportionality will be reduced among children of color

Differential Response started in Lane, Klamath and Lake Counties in May of 2014. DR is now in place in 12 counties with four more, including Multnomah County, in the readying stage. DR was put on hold in May of 2016, pending the arrival of the new Child Welfare Director. Although the new Director began in early November 2016, it is likely a final decision regarding DR will not occur until the spring of 2017, pending the findings of the interim evaluation report due in January 2017. DHS has contracted with an external evaluator to conduct this analysis.

For more information please visit the Differential Response website: http://www.oregon.gov/DHS/CHILDREN/DIFFERENTIAL-RESPONSE/pages/index.aspx

Interstate Compact on the Placement of Children (ICPC)
The Interstate Compact was adopted into law by the 1975 Oregon Legislature. At this time, all states are members of the Compact, as well as the District of Columbia and the U.S. Virgin Islands. The Compact requires entities seeking to place children with out-of-state families, or into certain types of out-of-state treatment facilities, to obtain approval from the Child Welfare authority in the receiving state before making the placement.

Well-Being

Foster Care
Foster Care services include Relative Care, Family Foster Care and professional level of care such as Shelter Care and Behavioral Rehabilitation Services provided in therapeutic home settings or residential settings, through contracted Child Caring Agencies (CCAs). The foster care system operates 24 hours per day, seven days per week to accept and care for children who cannot remain safely at home. Oregon's goal aligns with the federal requirement of placing a child in the least

restrictive, most appropriate setting that meets the child's individual needs when the child cannot safely be cared for by his or her parent(s).

This program focuses on the Well-Being of children while they are in foster care and is responsible for recruitment, certification, training, and providing support to retain families that provide foster care (both general applicants and relative providers). Families are trained by agency staff and through contracted providers. They participate in, and must pass, a Structured Analysis Family Evaluation (SAFE) home study, designed to evaluate a family's suitability and readiness to meet the needs of children that enter the child welfare system, they must also pass a criminal background check, reference checks, and a review of Oregon's abuse registry which includes all prior abuse reports on children or adults. In addition to the above, this program provides recruiting, contracting, training, support and monitoring of all contracted child caring agencies.

DHS partners with community members, local and national foster care organizations, provider organizations, youth led organizations and organizations representing diverse cultural perspectives to deliver services throughout the State.

DHS works in collaboration with multiple State and local government agencies such as the Oregon Healthy Authority, Oregon Department of Education, local law enforcement, community programs, schools, the faith community and volunteer programs to identify and develop a local array of services. The Well-Being program is responsible for the overall well-being of children in DHS care by addressing behavioral, emotional and social functioning, meeting core educational needs, assuring appropriate physical, dental and mental health care, and maintaining safe family and community connections.

Youth Transition Services

The Independent Living Program (ILP) serves current and former foster youth up to age 21. Services include assistance with developing life skills including money management and budgeting, communication and social skills, establishing community connections and healthy supportive relationships, informed decision-making, parenting, health, education support, housing, and job readiness. A primary focus is to develop transitional plans to ensure high school completion and a successful transition to post-secondary education or employment at a level that allows youth to be self-sufficient. Housing support options are available to eligible

youth through the federal Chafee housing and independent living subsidy programs.

Youth Transition Services also include services for Homeless and Runaway Youth. The Department has a dedicated Homeless Runaway Youth program coordinator responsible for leading a quarterly advisory committee, contracting with and otherwise supporting statewide services for Homeless and Runaway Youth.

Medical Services
DHS puts a high priority on assuring that children in out-of-home care receive appropriate medical, dental and mental health care. Effective August 15, 2016, DHS established a program requiring that every child placed in out-of-home care receive an assessment by a contracted registered nurse shortly after their placement. This in no way eliminates the need for a child to be seen by a physician, dentist and mental health provider as required by policy, but is an additional step to assure that children's needs are being met upon their entry into care, and that any conditions are identified and acted upon as early as possible. In addition, annual medication reviews are completed for every child in out-of-home care that is prescribed three or more psychotropic medications and for every child under age six prescribed any psychotropic medication to assure appropriate care.

Permanency

DHS' first goal always is to safely and successfully reunify children their parent(s). Unfortunately this is not always possible and when a child is unable to safely reunify with his or her parent(s), DHS helps find a permanent family through adoption or guardianship. Once children are placed with a permanent adoptive or guardian family, the Permanency program continues to provide services and supports up to age 18, to help meet the special needs and challenges children who have been abused and neglected may experience.

DHS is also responsible for the coordinating the Voluntary Adoption Search and Registry Program for Oregon's public and private adoptions. This registry may also include adoptions for children with relatives living in other countries pursuant to The Hague Convention and the Inter-country Adoption Act.

Title IV-E Waiver Demonstration Project
Oregon's Title IV-E Waiver project is titled *Leveraging Intensive Family Engagement (LIFE).* LIFE is a locally-developed values-based intervention

focused on addressing gaps and challenges to reduce the time to permanency for high risk children. LIFE has four key features:

- Family Finding: identify and engage a broad network of family support and placement resources
- Case Planning Meetings (CPMs): case planning and monitoring support informed by child and family voice
- Peer Parent Mentors: help parents engage in CPMs and services to assist them in navigating the child welfare/service systems
- Collaborative team planning between service providers, DHS, and the family involved with the case

The goal of the LIFE project is to safely and equitably reduce the number of children who might otherwise remain in care for three years or longer. Eligible children and their siblings are identified shortly after removal based on key indicators. Then the Family Engagement Facilitator begins intensive work with the caseworker, child, parents, and family to develop a plan of reunification, adoption, or guardianship in a timely manner.

Program Design & Delivery

Oregon has a state run, county administered child welfare program. Staff in the central office support field staff through policy and rule development, assuring compliance with federal and state regulations, quality monitoring, technical assistance, evaluation and program analysis, developing consistent business processes and standards, and identifying best practices. Other services provided include coaching, training and continuous quality improvement aimed at improving outcomes for Oregon's children and families.

Managers and supervisors in local child welfare offices provide clinical supervision of direct service staff. Whenever possible Child Welfare staff coordinate service delivery with staff from our Self -Sufficiency offices to support family stability and prevent entry/re-entry into the child welfare system. In addition, child welfare staff coordinate with other child and family serving systems including Housing, Oregon Health Authority, Oregon Department of Education, county-based health and support services, and others.

Child Welfare employees provide direct services in local offices. For a list, see: http://www.oregon.gov/DHS/children/child-abuse/Pages/Reporting-Numbers.aspx

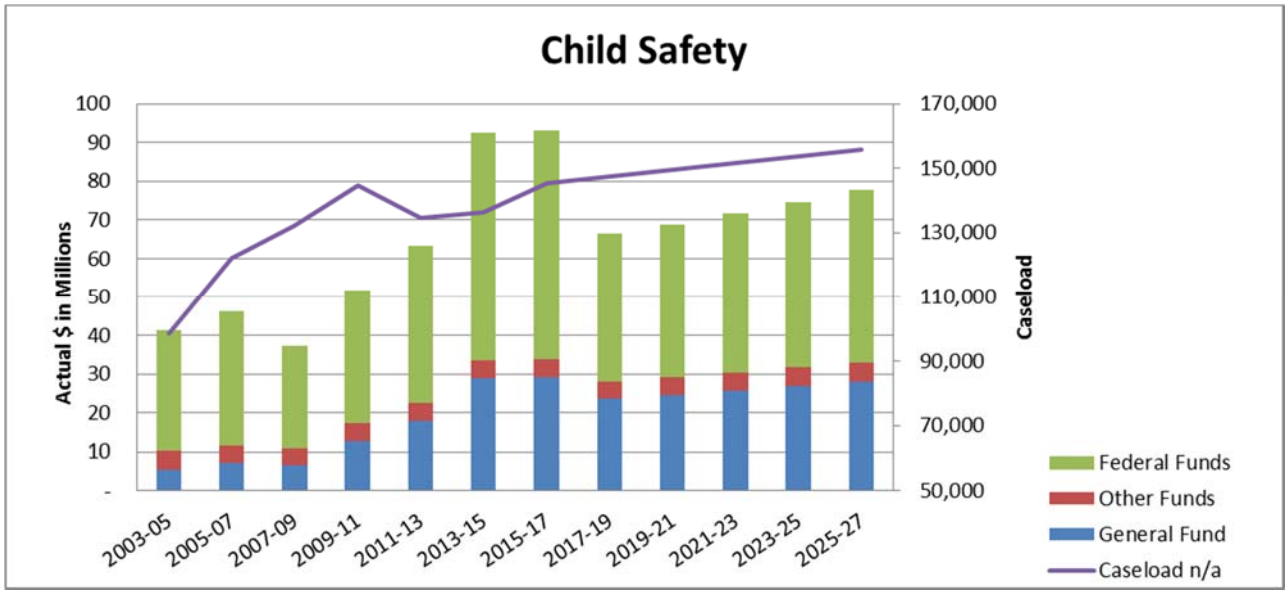
Indian Child Welfare Act (ICWA)
Native American children are currently over-represented in Oregon's child welfare system. Compliance with the Indian Child Welfare Act is a Federal mandate. DHS has Tribal Liaisons in the child welfare field offices to enhance relationships with Tribal governments and to work with Tribal children and families to reduce disparities, improve compliance with the Act, and improve outcomes for Tribal families.

Federal Program Performance & Reporting (FPPR)
This program is responsible for ensuring Child Welfare remains in compliance with federal program standards to assure continued federal financial support for the Child Welfare programs and services described above. In addition, FPPR is responsible for all required federal reporting. The primary goal of FPPR is to maximize the use of federal funds while assuring the following funds are used solely for allowable services, administrative costs, and activities.

- Title IV-B, Subpart 1 & 2
- Title IV-D – Child Support
- Title IV-E – Foster Care, Adoption Assistance and Guardianship Assistance
- Title XIX – Medicaid
- Title XX – Social Services Block Grant
- TANF EA – Emergency Assistance

Department of Human Services: Child Safety

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Stacey Ayers, Child Safety Manager



Program Overview

This program provides protective and social services to children and families when allegations of child abuse or neglect are reported. Specially trained workers conduct comprehensive safety assessments and make determinations about the following: child safety, the presence of abuse, if services would benefit a family or whether safety intervention is required due to the presence of safety threats. Services are delivered through DHS staff or contracts that require linguistically and culturally appropriate service provision. They are delivered in a manner that is designed to keep children safely with their parents, whenever possible, and to quickly and safely reunite children with their parents when they have been removed.

Program Funding Request

CHILD WELFARE - Safety	GF	OF	FF	TF
LAB 15-17	$29,047,673	$ 4,633,896	$ 59,334,690	$ 93,016,259
GB 17-19	$23,772,113	$ 4,359,548	$ 38,194,735	$ 66,326,396
Difference	$ (5,275,560)	$ (274,348)	$ (21,139,955)	$ (26,689,863)
Percent change	-18.2%	-5.9%	-35.6%	-28.7%

Program Description

The Child Safety Program is comprised of Child Protective Services (CPS) and Differential Response (DR); and is responsible for assuring child safety throughout the State. On May 1, 2014, the Department officially began DR in three Oregon counties: Lane, Klamath and Lake. As of November 1, 2016, DR is being practiced in a total of 12 counties, which includes 9 additional counties: Linn, Benton, Lincoln, Washington, Clackamas, Coos, Curry, Jackson and Josephine. Approximately, half of the DHS child welfare staff in the state are practicing DR. In May 2016, DR was put on hold pending a decision on how to move forward by the incoming child welfare director. The new director started in November, 2016 and will make a decision regarding further implementation of DR based on a review of the first Outcomes Evaluation, and a recommendation from the DR Advisory Committee, meeting early in 2017. In the traditional response, CPS staff in field offices respond to and assess allegations of child abuse and neglect and are usually the first contact for families with the child welfare system. DR provides more than one way for CPS workers to respond to allegations of child abuse and neglect. One way is the traditional response and the other is the alternative, response. By design, the alternative response has the potential for engaging families differently from the beginning to assess child safety and provide a better connection for families with preventive, community based services that may prevent further contact with the child welfare system.

The alternative response allows CPS workers to seek safety through more intentional family engagement and collaborative partnerships with community organizations. This approach also focuses less on investigative fact finding and more on assessing and ensuring child safety, and helping families identify their needs to keep their children safe. Whether a family receives a traditional response or an alternative response is a decision that will be made by a specially trained child welfare screener. That response decision will depend primarily on the severity of the reported abuse and neglect. More severe allegations like sex abuse, and allegations of severe physical abuse will receive a traditional response, while allegations of neglect with no severe harm to a child will be assigned an alternative

response. Comprehensive safety assessments will occur in both the traditional response and the alternative response. DR is one of the Department's strategies for safely and equitably reducing foster care.

Generally, the Child Safety Program is the program area where children enter the State foster care system. Foster care is a temporary service, designed to keep children safe while we work to manage safety threats and enhance the parents' protective capacities. We work with families to make sure that children are only removed when they cannot safely remain at home. When children are placed in care, which can only be done with court approval, we place urgency on ensuring that children get home quickly and connect to family or other relatives whenever possible. Child abuse investigations are not voluntary. They are inherently intrusive and can be traumatic to families. The DR system is being implemented with an emphasis on reducing the intrusive nature of child abuse investigations, when possible and focusing on family engagement. The Child Safety Program can best be described in three sections: Screening, Assessment and In-Home services.

Screening

Screening is the front door of the service delivery system that with few exceptions, begins with a child abuse report at a child abuse hotline. Trained staff screen approximately 69,972 child abuse reports from all across the State each year and collect key information from the reporter of the abuse in order to determine how the report of child abuse and neglect should be handled. If the report meets the criteria to be assigned for an in-person investigation, the family's information is given to a DHS Child Protective Services (CPS) trained worker who will conduct a comprehensive safety assessment of the family in a respectful and sensitive manner. If DR continues to be implemented in Oregon, screeners will have increased responsibilities once a determination has been made that a report meets criteria to be assigned. In counties where DR has been implemented, screeners will also be required to determine the type of response a family will receive.

Assessment

Of all reports of child abuse or neglect, approximately 32,682 cases per year were referred for investigation. As part of the comprehensive safety assessment the DHS CPS worker gathers information in the following categories: Extent of the maltreatment, circumstances surrounding the abuse, adult functioning, child functioning, parenting practices and disciplinary practices. With DR, this type of comprehensive safety assessment will continue to be required with a traditional or alternative response assessment. Cultural and linguistic considerations are also

factored into the process. This important information is used to determine overall child safety. In counties where DR has been implemented, in addition to the comprehensive safety assessment, families with safe children may receive additional voluntary services based on their level of need. This approach is based on two key principles: 1) Identifying family issues and intervening early leads to better results than waiting until a family is in greater crisis. 2) Families can more successfully resolve issues when they voluntarily engage in solutions and drive service selection and supports.

In-Home Safety and Reunification Services (ISRS)

The ability to keep children safely at home is in large part dependent on the services that can be wrapped around the family to support them while safety concerns are addressed. Services are available to families during the course of child abuse assessments when child safety issues are present. Services are designed to ensure a safe environment for children without removing them from their parent or caregiver. If circumstances require a child be removed from their parent or caregiver, these services provide necessary support to the family so the child can be safely reunited with their family. These services are specifically intended to help families remove barriers to managing identified safety threats with the goals of prevention of foster care placement by maintaining a child safely in the home with a parent or returning a child home to a parent.

These services support crucial child welfare initiatives to increase the number of children who can remain safely at home after a safety threat is identified, and decrease the length of time a child spends in foster care if removal is required. By contracting with a wide variety of providers, ISRS also allows for a culturally and linguistically specific approach in an effort to reduce the disproportionate placement of children of color in foster care.

Legislation in 2011 created Strengthening, Preserving, and Reunifying Families (SPRF) programs and identified them as another primary program to serve families involved in the child welfare system. The goal of these programs is to foster collaborations between state and community programs and resources, as well as help children remain safely with their families. This must occur through partnerships and collaborations with State and community programs and resources that will stabilize the family in their time of need, work with the family to develop goals for family preservation services, family reunification services and empower the family to make changes which may alleviate the need for an out-of-home placement.

These programs are potentially an enhancement to ISRS services, and are delivered through contracts with community providers. Parents and families benefit from DHS and communities working together to provide stronger up front services and use voluntary engagement in solutions, services, and supports to achieve more successful resolution of issues.

An additional anticipated outcome will be the safe and equitable reduction of children in the foster care system by increasing the number of African American and Native American children remaining home with their families by providing culturally relevant and linguistically specific whenever available.

A key necessary partner for program success is the Attorney General's Office who provides most of the legal representation to DHS for all children under its jurisdiction. DOJ also files and litigates termination of parental rights cases. In most cases, the local County District Attorney office provides legal services representing the State, from the petition until jurisdiction.

Program Justification and Link to Focus Areas

There is a direct link between the Child Safety Program and the Safety Outcome that Oregonians will be safe where they live, work and play. Each year, thousands of Oregon families come through the child welfare system due to allegations of child abuse or neglect.

The services are designed to strengthen families and to prevent further child abuse and neglect. We provide support to prevent the unnecessary removal of children from families, and promote the reunification of families where appropriate. Drug and alcohol abuse, together with domestic violence, are the two major family stressors contributing to children entering foster care in Oregon. By supporting families early with services designed to keep children safely with their parents, costly foster care placements are avoided. The average monthly cost per child in foster care is approximately $2,500.

Without the services and interventions that are provided to parents and their children there are costs that will be felt at a later date in the Safety and other Outcomes areas. For example, often it is the risk of having their children placed in foster care that motivates parents who are deep into drug or alcohol addiction to seek treatment and maintain sobriety. Not only does seeking treatment and maintaining sobriety help keep their children in their home, but it also allows

parents to take the steps needed to be self-sufficient, reducing costs in the Economy and Jobs Outcomes area. It decreases the likelihood that these parents will engage in illegal activities and any resulting criminal proceedings or incarceration, reducing future costs to the Safety Outcomes area.

Similarly, helping a family deal with their domestic violence issues so that the children and non-offending parent can live without fear and further violence reduces long-term costs that are associated with the child's education performance (Education Outcomes Area) and the child's and non-offending parent's health and well-being (Healthy People outcomes area). Being able to provide In-Home and Reunification Services reduces the costs of foster care (Safety Outcomes area).

Program Performance

The Child Safety Program measures its performance in three primary categories:

- **First contact**: As a way to measure how well DHS assures initial child safety, the timeliness of first contact is measured for those reports of child abuse and neglect that are assigned for in-person investigation. In 2014, timeliness of first contact dropped to 60.1 percent. The Department will be developing a Program Improvement Plan to improve this measure.
- **Assessment**: DHS measures the comprehensiveness of the CPS assessment, the level of services that were provided and the appropriateness of safety planning for the child by monitoring whether the child experienced repeat maltreatment within 12 months of a prior abuse. The time period for this measure recently changed from 6 months to 12 months which has changed the outcome of this measure.
- **Re-abuse** From 2007 through 2010 re-abuse rates improved incrementally. Since 2012 the re-abuse rate has remained between 2.6 percent and 4.2 percent. By expanding the time frame the actual rate has also increased. Currently the department is equal to the national standard for this measurement at 9.1 percent. The number is trending in a positive which suggests that CPS assessors are doing a better job assessing child safety and intervening to prevent additional incidents of abuse.

Enabling Legislation/Program Authorization

ORS 419B.020 is the statute that mandates the Department and Law Enforcement to conduct investigations upon receipt of reports of child abuse or neglect.

The Federal Child Abuse Prevention and Treatment Act (CAPTA) is one of the key pieces of legislation that guides child protection. CAPTA, in its original inception, was signed into law in 1974 (P.L. 93-247). It has been reauthorized in on multiple occasions since then with multiple amendments that have strengthened and refined the scope of the law.

ORS 418.575 through 418.598, Strengthening, Preserving and Reunifying Families legislation, was passed during the 2011 legislative session. The Federal Indian Child Welfare Act (ICWA) also applies.

Funding Streams

Funding for this program area comes from a combination of sources that are dedicated and do not require a match, as well as leveraged funds which are matched. The following list is inclusive of each of the funding sources:

- Federal Social Security Block Grant (SSBG) accounts for 11 percent of the child safety budget
- Federal Title IV-B part 1 makes up 5 percent
- Federal Title IV-B part 2 makes up 14 percent
- State only General Fund makes up 13 percent
- Federal Family Violence Prevention and Services Program makes up 4 percent
- Federal Title IV-E Waiver makes up 46 percent

Funding Justification and Significant Changes to CSL

This does not include statewide reductions**.**

Significant reductions are caused by moving two areas (System of Care $11.4 M Total Funds; and Youth Investment Program $11.9 M Total funds) to the Well Being Program area. Additionally, we phased out the Designated Health Service Program ($5.0 M Federal Funds) as it was the end of the 5 year Medicaid waiver program.

Reductions:

- Sexual Assault Victims Services is funding that is specifically designed to assist adult sexual assault survivors with shelter and support services. These services are provided to the community at large, not just Child Welfare involved families. In 2015, Oregon domestic and sexual violence programs

answered 134,888 calls for help, a 3 percent increase over 2014. This included calls about domestic violence, sexual assault, stalking and other issues with 1,484 adult sexual assault survivors receiving services. An elimination of these services would leave many adult victims of sexual assault unable to find safety and support.

- Domestic Violence Services is funding that is specifically designed to assist victims of domestic violence and their children in accessing safe shelter, community based services such as hospital accompaniment and support groups, and in an effort to end violence before it begins, programs provide education and awareness events. In 2015, Oregon domestic and sexual violence programs answered 134,888 calls for help, a 3 percent increase over 2014. This included calls about domestic violence, sexual assault, stalking and other issues. These services are provided to the community at large, not just Child Welfare involved families. In 2015 there were 10,196 requests for shelter unmet with no reduction. An elimination of these services would leave many adult victims of domestic violence and their children unable to find safety and support.
- Recovering Family Mutual Homes - A cut of 30% is larger than appears as these budgets have a Federal match. These services currently provide payment directly to housing for child welfare parents, with their children, coming out of residential A&D treatment settings in three counties. Any cut in these services leads directly to the elimination of housing for individual parents with small children. This reduction will create immediate instability for families whose parent has recently completed A&D treatment. Cutting these services will result in increased barrier to children remaining with their parents which means increases in foster care. Additionally, it will increase length of stay in foster care.
- Recovering Family Mutual Homes additional 15% reduction: A cut of 15% is larger than appears as these budgets have a Federal match. These services currently provide payment directly to housing for child welfare parents, with their children, coming out of residential A&D treatment settings in three counties. Any cut in these services leads directly to the elimination of housing for individual parents with small children. This reduction will create immediate instability for families whose parent has recently completed A&D treatment. Cutting these services will result in increased barrier to children remaining with their parents which means increases in foster care. Additionally, it will increase length of stay in foster care.

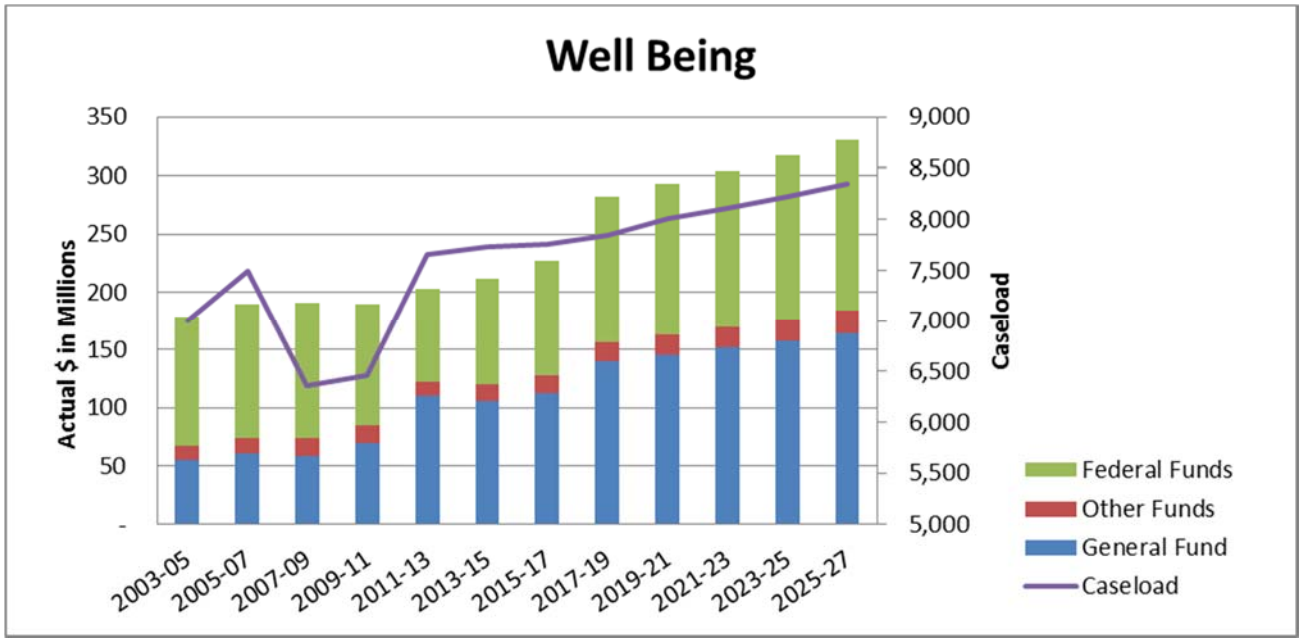
- Reduce ISRS budget by 15%, eliminating in-home supports for approximately 390 abused children each year. - ISRS provides services to help manage the safety threats within the family, stabilize the family and provide for the immediate safety of children at risk of maltreatment or when children have been placed in protective custody or foster care this service is to help them return to their parents. A 15% reduction to In-Home Safety and Reunification Services will impact child welfare's ability to: 1) safely keep children at home; 2) return children home in a timely manner; and 3) provide the family supports and services to ensure children aren't re-abused and don't re-enter the foster care system. This reduction is estimated to impact approximately 847 children each year who will now need to enter or remain in foster care rather than safely remain in the home with their parents or safely reunify with their parents. This reduction will impact the department's ability to meet Indian Child Welfare Act and other court-ordered requirements. This reduction will also mean more ""no reasonable efforts"" or ""failure to meet active efforts for ICWA children"" findings by the courts, which would impact federal funding for Oregon's foster care (out-of-home care) program. In addition to increased costs in foster care, there will be an increase in costs to courts, defense attorneys, Citizen Review Boards, and others involved in the dependency system. Finally, contractors who provide these services will be impacted and may lay off staff.
- Reduce Strengthening, Preserving, & Reunifying Families (SPRF) budget by 15%. SPRF programs provide a broad array of services that are designed to maintain children safely at home with their parents or caregivers, safely and equitably reduce the number of children in the foster care system, reduce child trauma, reduce the length of stay in foster care, and to reduce the referral or reentry rates of families in the Child Welfare system. SPRF also provides services to families with safe children and moderate to high needs through Admin Only cases through Differential Response and this is the only way these families would be able to access Child Welfare services. A reduction in these services will result in approximately 487 children coming into foster care, staying longer periods of time in foster care or coming back to the attention of child welfare. This reduction will also impact the department's ability to meet Indian Child Welfare Act and other court-ordered requirements. This reduction will also mean more "no reasonable efforts" or "failure to meet active efforts for ICWA children" findings by the courts, which would impact federal funding for Oregon's foster care (out-of-home care) program. In addition to increased costs in foster care, there will

be an increase in costs to courts, defense attorneys, Citizen Review Boards, and others involved in the dependency system. Finally, contractors who provide these services will be impacted and may lay off staff.

- Eliminate Family Support Teams / Addiction Recovery Teams (ART) program, impacting services to approximately 13,400 families and 22,800 abused or neglected children. A 70% reduction would eliminate the statewide program. Elimination of these services will mean more and longer foster care placements; higher re-abuse rates, a decline in parents entering treatment quickly, and an increase in the number of parents who struggle with sustaining their recovery. It will also increase caseworker workload, including A&D referral, treatment monitoring, transport, client tracking and case management, making it more difficult for caseworkers to meet other state and federal mandates. This would eliminate any ability of DHS to respond to clients in relapse, require more children remain in foster care, and eliminate the majority of personnel who serve as DHS liaison to local treatment providers. Longer stays in foster care will increase costs to the state, result in poorer outcomes for children and poorer treatment outcomes for their parents. This would also result in eliminating approximately 50-55 contracted jobs at local employers. Cutting these services will result in increased barrier to children remaining with their parents which means increases in foster care. Additionally, it will increase length of stay in foster care.

Department of Human Services: Well Being

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Kevin George, 503-945-5987



Note: On average, there are 8,524 children in substitute care on any given day in Oregon.

Program Overview

The Child Well-Being Program, also known as the Foster Care Program, is designed as a critical safety net for children with immediate safety needs for their basic care. DHS is responsible for accepting and caring for children who cannot remain safely with their parents per ORS 418.015. These children are dependent, neglected, mentally or physically disabled, and placed in the legal custody of DHS by a court. Under limited circumstances and for a short time, a family may place a child in State custody on a voluntary basis. However, most of the children served in foster care are there involuntarily as a result of abuse or neglect they experienced in their family home.

Program Funding Request

CHILD WELFARE	GF	OF	FF	TF
LAB 15-17	$ 112,535,882	$ 15,139,405	$ 98,745,968	$ 226,421,255
GB 17-19	$ 140,201,838	$ 16,535,001	$ 125,042,253	$ 281,779,092
Difference	$ 27,665,956	$ 1,395,596	$ 26,296,285	$ 55,357,837
Percent change	24.6%	9.2%	26.6%	24.4%

NOTE: significant changes are caused by moving two areas (System of Care $11.4 M Total Funds; and Youth Investment Program $11.9 M Total funds) to the Well Being Program area from the Safety Program.

Program Description

The foster care services program operates 24 hours a day, seven days a week to accept and care for children and youth who cannot remain safely in their family homes. The children and youth range in age from birth to 21 years old. A total of 11,238 children spent at least one day in some kind of foster care in federal fiscal year 2015. The vast majority of these children and youth (88.2%) reside in family foster home settings. There are 3,847 (on 9/30/2015) Oregon families who have stepped forward to be a foster parent for the children. Approximately 40.6% of these certified families are relatives or friends known to child's family who become certified to care for the children.

DHS partners with community members and organizations representing diverse community and cultural perspectives to deliver foster care services to children and youth across the State. The agency has federal and state mandates to provide efforts to reunify children to their parents. Just over 56 percent of children entering care return home to a parent in FFY 2015. There are approximately 30 licensed private child placing agencies in Oregon who are caring for children and youth, most often because the child or youth has a significant behavior or mental health need. Approximately 320 children are placed with Licensed Child Caring Agencies to provide a higher level of therapeutic care.

The Child Well-Being program also responds to the overall well-being of the child or youth in care. Well-being is identified as caring and attending to child's behavioral, emotional, education, health and social functioning. This is best identified through meeting the core educational needs, physical, dental, and mental health needs, needs for family, and community connections.

To be successful in meeting the needs of the children and youth for their safety and well-being, we support current programs while expanding the available service

array. DHS works in collaboration with multiple state and local governmental agencies such as the Oregon Health Authority, Oregon Youth Authority, Oregon Department of Education, and local law enforcement in addition to a significant number of community programs, schools, business and faith communities, and volunteer programs. The Department continues to focus on safely and equitably reducing the number of children that enter the foster care system, and provide for the care and well-being of children who enter the system. Those children who must enter the foster care system generally have greater needs than those who can remain at home or with relatives. The ability of staff to meet the needs of these children and adequately support the foster families caring for them is directly related to staffing levels in the program.

The average monthly cost per child in foster care is approximately $2,500. There are multiple cost drivers to this program area including the number of children entering the substitute care system due to abuse or neglect, and the number of children who remain in the substitute care system due to the inability to be reunified with family or successfully transitioned to an adoptive family. A significant cost driver is the increased cost of living within the community and daily expenses for providing food, clothing, shelter, education or other support services for children and youths. As an example, foster parents caring for a 10 year old child are currently reimbursed at a rate of $21.53 per day. This is intended to cover the cost of providing food, clothing, shelter, school supplies, and the cost to participate in activities, etc. Often the additional costs for the child are paid for by the foster parent which remains a barrier for many families and the private child caring agencies across the state. Oregon has not increased the daily rate for family foster care since 2009. In 2009 the rates were increased to reach a percentage of what it would cost to raise a child in 2007. Then in 2011, these rates were decreased by 10%.

Efficiencies to improve outcomes include planning and beginning implementation of Differential Response (described in the Safety Program bid sheet), and a reinvestment in local community services to strengthen families to reduce the need for foster care. In addition, for children who are in foster care, increased attention on the need for educational supports and school placement continuity, increased access and continuity of comprehensive health care (physical, mental and dental health), and increased financial and structural support for foster families, and private agencies who care for the children and youth.

The Well-Being program is also responsible for the certification and support of foster families that care for children in the Department's custody. This includes recruitment, assessment, retention, training, and support. Training of these families is conducted both by agency staff and through contracted providers. Families participate in a Structured Analysis Family Evaluation (SAFE) home study assessment, designed to evaluate a family's readiness to meet the needs of children that enter the system.

Program Justification and Link to Focus Areas

The Child Well-Being Program is an integral part of the State's Plan to achieve a Safer, Healthier Community for the residents of Oregon. As a state policy Child Well-Being programs are necessary to ensure safety for children if and when they are unable to remain safely with their families. The reliance on the foster care system over the years has reached a capacity that is no longer sustainable in Oregon. The Financial support for this system has not kept up with the growing costs which has negatively impacted the ability for potential foster families to step forward to provide family foster care.

Ongoing research indicates if substantive preventive services can be immediately put into place, many children can safely remain at home which reduces the need for children to be placed into the foster care system. Re-directing resources away from the removal of children from families and increasing the capacity of families who currently have children in the substitute care system by investing in upfront and in-home services within communities will pay far greater dividends to Oregon in meeting the outcomes identified in the state's plan.

Program Performance

Program performance is measured in the following ways:

- The number of children entering foster care (3,793) during FFY 2015 increased by 9.3 percent from the FFY 2014 level. The number of children leaving foster care has decreased by 3.2 percent in the same time-frame.
- 56 percent (56.1) of children who left foster care were reunified with their families.
- Median months to exit foster care is 18.3 months, a slight decrease from the year before.

- The numbers of foster families in 9/30/2015 was 3,847 families. This is continuing a downward trend of available foster families from 4,006 in 2014 & 4,229 foster families in 2013.

Enabling Legislation/Program Authorization

There are a number of Federal acts that are centered on the care for children through substitute care programs. Some of the more prominent Federal acts and Federal regulations are noted below.

- *Adoption Assistance and Child Welfare Act P.L. 96-272*. To establish a program of adoption assistance, strengthen the program of foster care assistance for needy and dependent children, and improve the child welfare, social services, and aid to families with dependent children programs. Requires states to ensure and the Courts to determine that reasonable efforts continue to be made on each individual child to mitigate the need for continued foster care.
- *Indian Child Welfare Act (ICWA) PL 95-60*. To establish standards for the placement of Indian children in foster and adoptive homes and to prevent the breakup of Indian families.
- *Adoption and Safe Family Act PL 105-89.* To promote the adoption of children in foster care by placing limitations and timelines.
- *Fostering Connection to Success and Increasing Adoption Act PL 110-35*. To support and connect relative caregivers, improve outcomes for children in foster care.

Title IV-E, The Federal Foster Care Program, helps to provide safe and stable out-of-home care for children until the children are safely returned home, placed permanently with adoptive families or placed in other planned arrangements for permanency. Title IV-B provides grants to States and Indian tribes for programs directed toward the goal of keeping families together. They include preventive interventions so that, if possible, children will not have to be removed from their homes. Finally, the Social Security Act contains the primary sources of Federal funds available to States for child welfare, foster care and adoption activities.

Oregon Revised Statutes that specify which children are involved in the Substitute Care Program can be found under ORS 418.015 Custody and Care of Needy Children by Department and ORS 418.312 When Transfer of Custody Not

Required; Voluntary Placement Agreement; Review of Children Placed in Certain Institutions.

Funding Streams

There is a combination of funding sources in the Well-Being Programs. Leveraged funds include: Title IV-E, 28 percent; Medicaid, 25 percent; Title IV-E Waiver three percent; Independent Living, three percent; Other Federal Funds, three percent; TANF 12 percent; Chafee one percent; Social Service Block Grant Federal Funds, four percent; Title IV-B, two percent. The remaining funding is General Fund State Only, approximately 20 percent.

Funding Justification and Significant Changes to CSL

This does not include statewide reductions.

108 Family Foster Care Rate Reimbursement

General Fund	Other Funds	Federal Funds	Total Funds
7,817,214	0	4,729,612	12,546,826

Reimbursement rates for Family Foster Care have not been adjusted to the cost of living for a decade. In 2009 rates were adjusted to 90% of the cost of care based on a 2007 rate methodology. In 2011, these rates were reduced by an additional 10% due to department budget cuts. The number of families coming forward to provide foster care has continued to diminish over the last 5 years in part due to the low reimbursement rates. The current daily rate is $18.90 per day for a child under age 5 years old or $24.36 per day for a teenager. This is intended to cover the costs of food, shelter, clothing, school supplies, extracurricular activities, etc. Based on the methodology created in 2009 Oregon is currently providing only 40-46% of the actual cost of care. Other states have been sued due to the low rate of family foster care payments and Oregon continues to increase the risk of a class action lawsuit. Additional funding for this POP is included in the Permanency bid form.

109 BRS rates

General Fund	Other Funds	Federal Funds	Total Funds
2,116,547	0	3,823,804	5,940,351

Update the rate model for Behavioral Rehabilitation Services (BRS) program to pay contracted providers for cost increases above inflation. Rates directly impact state agency's access to these programs. The BRS rate model has not been kept current since first established in 1998. Simply adding inflation to the previous biennium rate has not kept pace with significantly increasing costs. Some of the most heavily used programs have closed over the past two biennia. More programs have signaled if they don't receive more financial support from the state they will have to close soon. This package is most importantly about child and youth safety as well as maintaining access to this essential part of the system serving Oregon's most needy children. Without increases to the rate state agencies will continue to have pressure on the BRS system as provider costs increase and the rate remains inadequate.

Reductions:

- Reduce Client Transportation Program by 15%. Any reduction to funding for Client Transportation will have a negative impact on direct services for children, negatively impact their education outcomes, and potentially delay child and family reunification. Currently 69% is being spent on transportation for visits between child(ren) and parents, another 20% for transporting children to and from their school of origin, 2% for transportation to medical appointments, and 9% for transportation to/from activities such as court hearings, and case planning activities. A 15% reduction would result in fewer visits between children and their parents, negatively impacting the child's well-being and causing unnecessary delays in reunification. Any delay in reunification could cause the department to fail the Adoptions and Safe Families Act (AFSA – Public Law 105-89) requirements of moving to terminate parental rights for children who have been in foster care for 15 out of the past 22 months, or cause the department to move toward termination of parental rights without proper and consistent visitation having occurred between a child and their parents.
- Reduce Court Ordered Other Medical Program by 15%. Other Medical funds are used by DHS to obtain services to assist the caseworker in making good case planning decisions for the child and family and to better inform the Courts. Currently, 53% of Other Medical funds are spent on case consultation services, with licensed experts to review case information accumulated over time and assist in developing a timely well-focused case plan; and 47% is spent on psychological evaluations and other testing of parents (including drug testing), used to inform case planning. Other

Medical funding also allows the department to request medical records for a child in care and to request formally supervised parent/child, and sibling interactions.

- Reduce System of Care (SOC) by 15% - flexible fund resource dollars to meet the individual needs of foster children and their families. System of Care flexible funds are used by local offices to address not only the individualized service needs of children and parents, but also and more recently payments that promote a parent's ability to maintain housing while working toward reunification with their children. Cutting SOC by 15% will likely result in reduced ability to meet the unique needs of children and families through client specific services.
- Personal Care: 50% this is closely tied to the reduction of Nursing Assessments. Personal Care is a Medicaid State Plan option in Oregon that allows us to maintain children with medical needs safely in a home-like setting. "This is closely tied to the reduction of Nursing Assessments. Personal Care is a Medicaid State Plan option in Oregon that allows us to maintain children with medical needs safely in a home-like setting. Payment is made under this state plan option to compensate the foster care provider for the delegated medical services they perform for the child in their care. These services are matched at the Federal Medical Assistance Percentage (FMAP) rate of 64.47% in FFY 2017. A 15% reduction = a loss of $313,056 GF and a total fund loss of $881,103 in direct medical services provided to children in their foster home. Resulting in the need for these children to be placed, and remain, in a hospital like setting. An additional 15% reduction = a loss of $313,056 GF and a total fund loss of $1,762,206 in direct medical services provided to children in their foster home. Resulting in the need for these children to be placed, and remain, in a hospital like setting. An additional 20% reduction = a loss of $417,409 GF and a total fund loss of $2,937,013 in direct medical services provided to children in their foster home. Resulting in the need for these children to be placed, and remain, in a hospital like setting. An additional 50% reduction = a complete elimination of the program and the need for all children with medical needs requiring 24 hour per day care to reside in a hospital like setting.
- Youth Investment Program: 50% Runaway and Homeless Youth programs provide Street Outreach, Drop-in Center, and Shelter services which improve the safety and wellbeing of unaccompanied youth under the age of 18. Runaway and Homeless Youth programs provide Street Outreach, Drop-in Center, and Shelter services which improve the safety and wellbeing

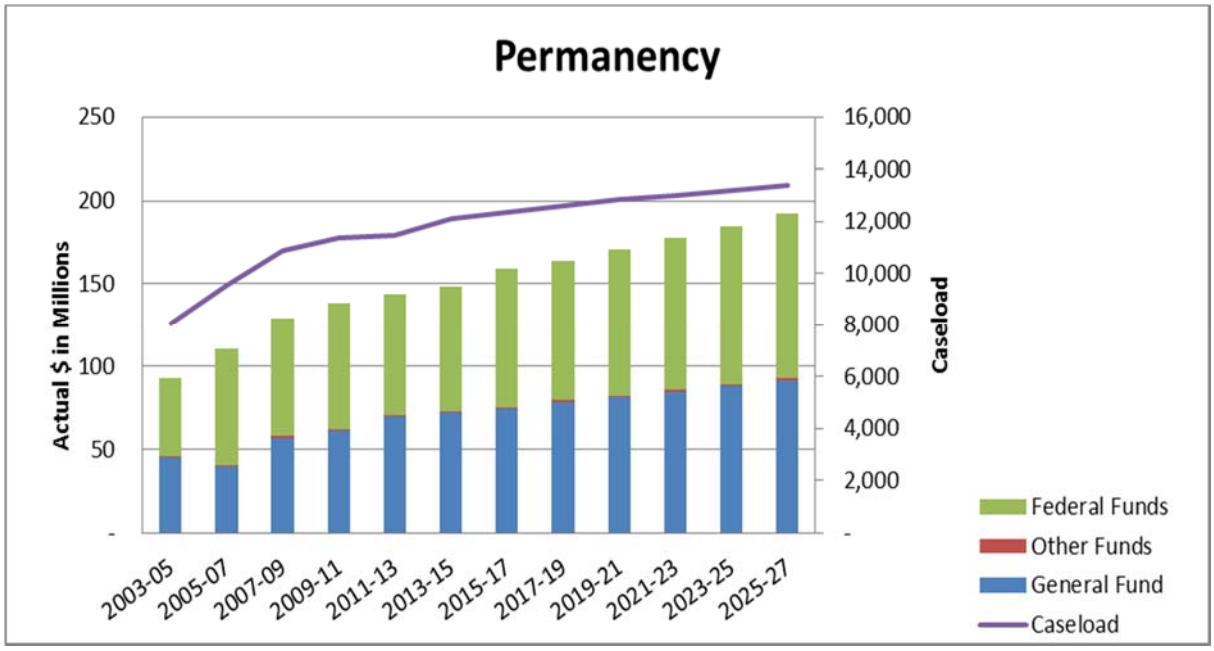
of unaccompanied youth under the age of 18. In the past year, Street Outreach and Drop-in services have resulted in 79% of youth accessing food, shelter, educational, job and life skills services. Shelter services have resulted in 81% of youth exiting to a safe home, 60% of those reuniting with family; 53% accessing medical and dental services, and 69% getting connected to educational services. A reduction in funding will result in fewer youth being served by these effective programs resulting in an increase of unaccompanied youth in our State and potentially result in upstream costs, in Child Welfare, Self Sufficiency, and/or the Juvenile Justice and Adult Corrections systems.

- Enhanced Foster Care – elimination The Department reimburses a level of care payment to a certified family on behalf of a child or young adult when the child's behaviors require additional supervision to keep them placed at this lowest level of care. The Department reimburses a level of care payment to a certified family on behalf of a child or young adult when the child's behaviors require additional supervision to keep them placed at this lowest level of care. The department uses process controls of allowing this enhanced supervision only after the 20th day in foster care, requires an annual review and use of a standardized screening instrument tool CANS to determine which level of care for the enhanced supervision needs. Approximately 38% of the children have an enhanced level of supervision needs. The current daily rates are $7, $13 and $28 per day based on the level. A complete elimination of this program will further the negative attitude toward the department for not supporting foster parents, increase placement disruption rates for children, decrease the number of foster families willing to care for children and increase the placement crisis for children in Oregon.
- Shelter Foster Care: 50%. The Department reimburses a certified family a shelter care payment on behalf of a child or young adult during the first twenty days of substitute care in a certified family home. "The Department reimburses a certified family a shelter care payment on behalf of a child or young adult during the first twenty days of substitute care in a certified family home. This is the only source of funding support to the foster family in the first 20 days. The daily rate is $24, $28, or $31per day based on the age of the child. These funds cover the food, clothing, shelter, school supplies, hygiene supplies, transportation, additional supervision and other incidentals that are necessary when coming into foster care. The department has process controls in place to allow this service for only the first placement

into foster care and for a maximum of 20 days. A 25% reduction in this program will likely increase the negative attitude toward the department in supporting foster families for children when the department rates are so low to start with and any reduction will be seen as a negative toward foster parents. The 25% reduction will be $1.50, $1.75, or $1.75 per day based on age. A second reduction of an additional 25% reduction (50%) in this program will further the negative attitude toward the department in supporting foster families for children and will likely start to experience foster families who will no longer accept foster children on an emergency basis. A third reduction of an additional 50% (total of 100%) will further the negative attitude toward the department in supporting foster families for children and foster families who will not accept children in care or add ultimatum that unless a CANS rate exception can be granted they will not accept children into a shelter care placement. At this stage the department should also anticipate some foster families this is merely too much and end being foster parents.

Department of Human Services: Permanency

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Kathy Prouty



Program Overview

Children in foster care receive assistance through the Child Permanency and Post-Adoption/Guardianship Support Programs. DHS helps foster children achieve legal permanency through reunification, adoption or guardianship. If children achieve legal permanency through adoption or guardianship, this program continues providing support to the families to meet the special needs and lifelong challenges of children who have been abused and neglected.

Program Funding Request

CHILD WELFARE - Permanency	GF	OF	FF	TF
LAB 15-17	$73,932,070	$1,280,038	$83,611,136	$158,823,244
GB 17-19	$77,974,749	$1,293,015	$84,805,811	$164,073,575
Difference	$ 4,042,679	$ 12,977	$ 1,194,675	$ 5,250,331
Percent change	5.5%	1.0%	1.4%	3.3%

Program Description

The first and primary permanent plan for all children who enter the foster care system is reunification with a parent. Reunification services are delivered through the efforts of field staff with consultation, support, training, and technical assistance from central office consultation staff. Only after it is determined that a foster child is unable to be safely reunited with a parent, will the alternate plans of adoption or guardianship be implemented.

Adoption and guardianship services are delivered through the joint efforts of field and central office staff. When children are unable to return to their parents' custody, the Department's efforts are directed to finding a permanent family so the children can leave the foster care system. Research shows that children who turn 18 and age out of the foster care system have poorer outcomes than children who are raised in a permanent home. The process of preparing children for adoption or guardianship, searching for an appropriate family, transitioning the children and monitoring the placement until the adoption or guardianship is finalized is work that is carried out by field staff. The process of ensuring the completeness of the file for adoption or guardianship, supporting the field in determining which children are not able to return to their parents, finalizing the adoption and supporting families after the adoption or guardianship is carried out by central office staff.

During the last biennium, DHS completed 1630 adoptions and 655 guardianships. Most children adopted or placed in guardianships through Oregon's foster care system are eligible for ongoing financial support and medical coverage. Overall, approximately 12,000 families receive ongoing adoption and guardianship financial support to meet children's special needs. We also provide administrative oversight in all private, international, and independent adoptions, and operate a Search and Registry Program, which is mandated by law. This adds program responsibility for an additional 700-900 children who are adopted privately or independently each year in Oregon.

DHS works closely with the Department of Justice (DOJ) who provides legal representation for DHS caseworkers. DOJ also represents the department in termination of parental rights cases and in guardianship petitions. Other key partners include county District Attorneys, private mediators and attorneys, private adoption and recruitment agencies, the Child Protective Services and Foster Care programs of DHS, and the Division of Medical Assistance Programs at the Oregon Health Authority.

Primary cost drivers for the Permanency and Adoption/Guardianship Assistance Programs include the legal costs of freeing and placing children for adoption or filing for legal guardianships and the number of eligible children for adoption and guardianship subsidies. Based on their history of abuse and trauma, almost 100 percent of the children adopted annually from the child welfare system are considered special needs children and eligible for an adoption subsidy. Families for approximately 95 percent of the eligible children choose to receive some monetary adoption assistance to assist in meeting these children's special needs. Children entering into legal guardianships have the same history of abuse and trauma and are also eligible for subsidies. Most families accept the monetary support and medical coverage to meet the ongoing special needs of their guardian children.

Program Justification and Link to Focus Areas

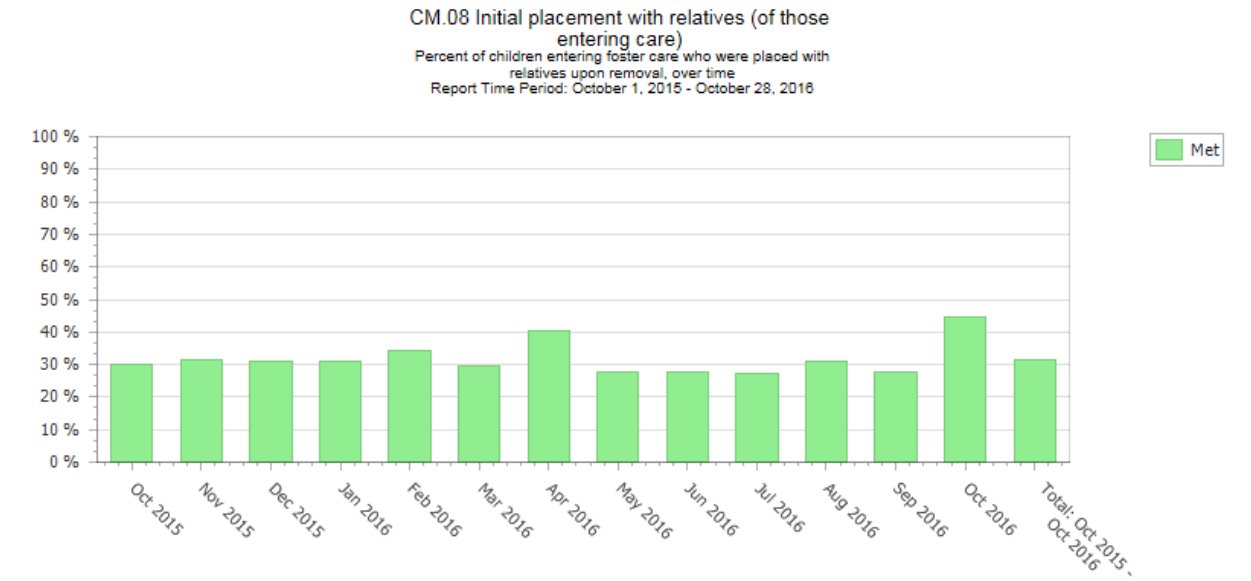
The Child Permanency and Adoption/Guardianship Support Programs are designed to impact the safe and equitable reduction of children in foster care which promotes safer and healthier communities. Children in the foster care system need targeted, family focused, timely, and culturally responsive services in order to achieve reunification. Those who cannot safely be reunified with their biological parents need safe and appropriate alternate forms of permanency. Evidence shows that children who do not have permanency experience issues in the future such as lack of education, unemployment, homelessness, and incarceration at much higher rates than the general population. Specifically, former foster children who age out have high rates of mental illness with over half having clinically diagnosed mental health problems, including depression and Post-Traumatic Stress Disorder. These former foster children have a greater chance of coming into contact with the corrections community, experiencing early parenting, and/or using the services provided by the Oregon Health Authority and the Addictions and Mental Health program. The safety and stability that come with a permanent home help mitigate the risk of poor future outcomes for those who were abused and placed into foster care as children.

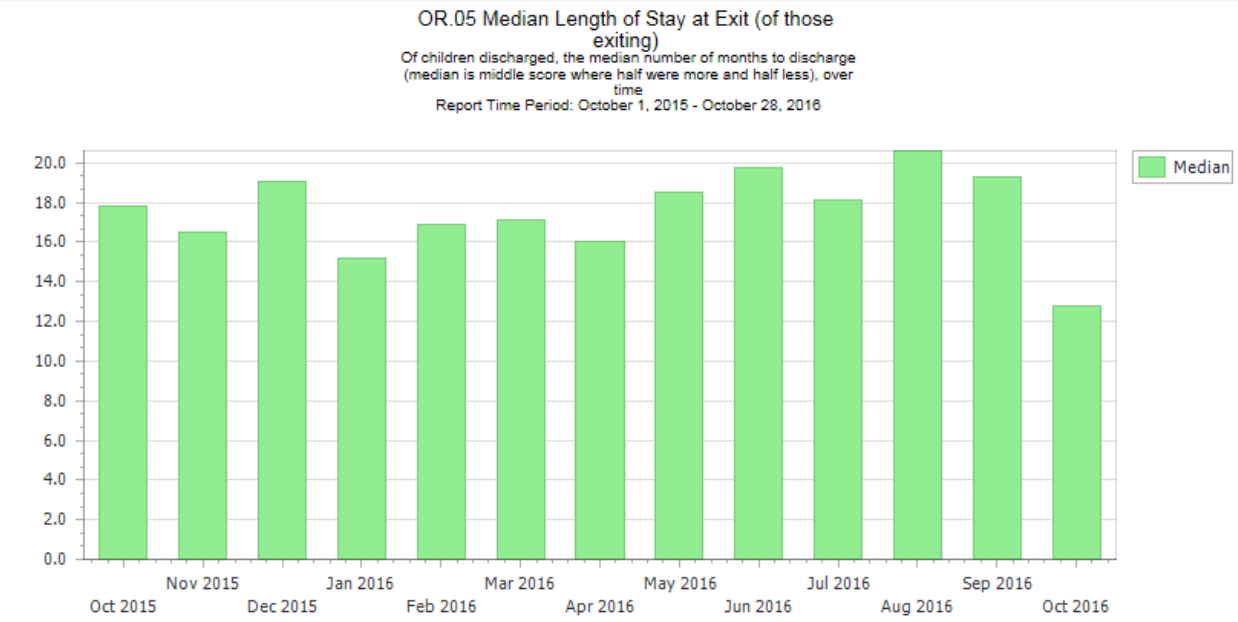
The Education and Economy focus areas may also be impacted if children cannot find permanency through adoption and guardianship. Grown former foster children who age-out tend to complete high school at a rate comparable to the general population. However, more of the high school completion is done via a GED versus a high school diploma, known to lead to lower wage jobs. Further, completion of post-secondary education is low for this group, affecting the lifelong earnings and living standards of these former foster children. The low educational achievement and mental health issues result in many of the former foster children who age-out living at or below the poverty level and requiring more public assistance. A 2005 study shows that one-third of the former foster children who age-out lived in poverty and one-third had no health insurance. The rate at which these foster children used Temporary Assistance to Needy Families (TANF) was five times higher than the general population.

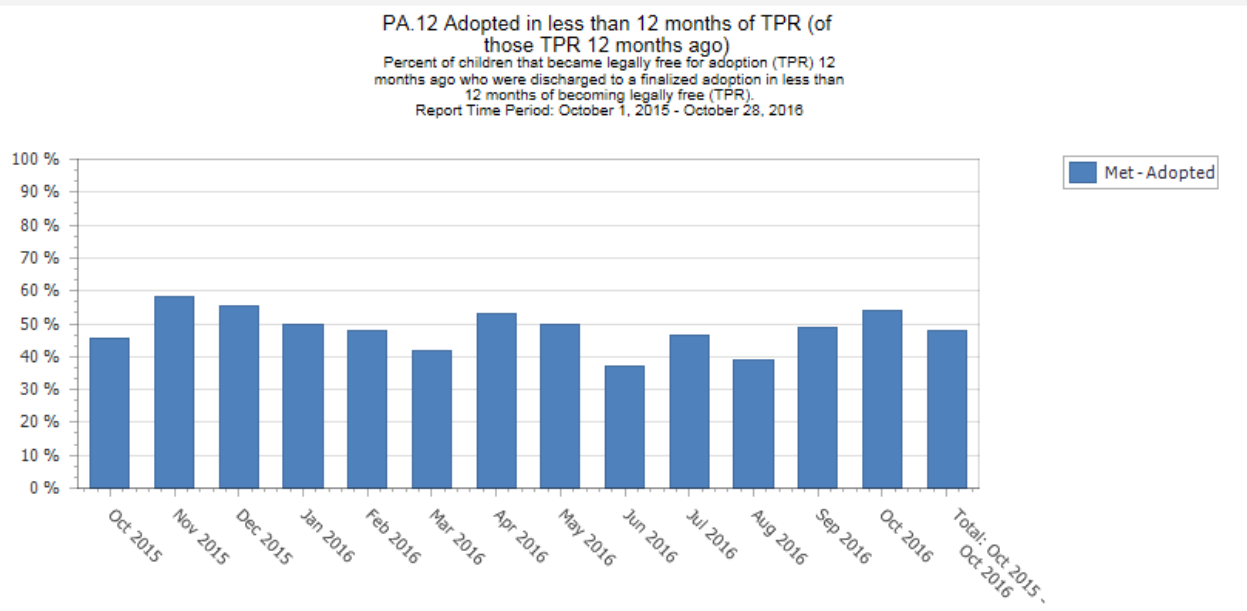
Other non-monetary post-adoption and guardianship services are also important in assisting families in providing care for children who often enter adoption and guardianship with significant special needs. Children who have experienced significant abuse and neglect will be challenged to address their history as they move through different developmental stages. Ongoing support of the families who are parenting these children is essential to preserve the placements. Post-adoption and guardianship services include information and referral, consultation in response to imminent and current family crises, in-home family therapy, support groups, training, and a lending library. Each year, approximately 1,400 to 1,600 contacts are made to the post-adoption services program for help. Some of these contacts are for reported crises or disruption-related issues. Children who disrupt from adoption or guardianship re-enter the foster care or residential treatment system at a significant cost to the state.

Program Performance

Program performance is measured in a number of ways and data is consistently used to evaluate effectiveness. Currently the Child Permanency program is focusing on some specific performance measures and designing its program activities to impact these areas. They include early placement with relatives and siblings, reducing the median months for children to exit the foster care system to reunification, adoption and guardianship, and improving the number of legally free children who are adopted in less than 12 months.


CM.08 Initial placement with relatives (of those entering care)
Percent of children entering foster care who were placed with relatives upon removal, over time
Report Time Period: October 1, 2015 - October 28, 2016
100 %
90 %
80 %
70 %
60 %
50 %
40 %
30 %
20 %
10 %
0 %
Met
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Apr 2016
May 2016
Jun 2016
Jul 2016
Aug 2016
Sep 2016
Oct 2016
Total: Oct 2015 - Oct 2016


OR.05 Median Length of Stay at Exit (of those exiting)
Of children discharged, the median number of months to discharge (median is middle score where half were more and half less), over time
Report Time Period: October 1, 2015 - October 28, 2016
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Median
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Apr 2016
May 2016
Jun 2016
Jul 2016
Aug 2016
Sep 2016
Oct 2016



Oregon is doing pretty well with initial placements with relatives but the other measures show that the Department has work to do in getting children out of the foster care system in a timely manner, and in timely matching children to the family who can best meet their long-term needs for safety, well-being, and permanency.

Enabling Legislation/Program Authorization

The following Federal and State laws mandate the operation of permanency planning for children in the foster care system:

- Public Law 96-272 Adoption Assistance and Child Welfare Act of 1980 which established the program of adoption assistance and introduced the requirement to make reasonable efforts to keep children out of foster care
- Public Law 105-89 The Adoption and Safe Families Act which set federal time lines for moving children out of foster care
- Social Security Act , Section 473 which mandates the payment of adoption assistance for eligible children
- Social Security Act, Section 473 which allows non mandatory payment of guardianship assistance for eligible children
- Oregon Revised Statute 418.330 which provides state funded guardianship assistance
- The Indian Child Welfare Act (ICWA)

- ORS 419A and 419B which provide a series of requirements for services to children in the foster care system
- ORS 109.309 which mandates the Department of Human Services to provide administrative services for independent adoptions and to operate a state Search and Registry program

Funding Streams

A combination of General and Federal Title IV-E funds the adoption and guardianship subsidy programs. Title XIX Medicaid funds the provision of medical coverage for children in adoptions and guardianship subsidies. A combination of General Fund and Title IV-B funds support programs such as recruitment and retention of foster and adoptive homes, post-adoption support and services and training.

Funding Justification and Significant Changes to CSL

This does not include statewide reductions.

108 Family Foster Care Rate Reimbursement

General Fund	Other Funds	Federal Funds	Total Funds
108,976	0	128,375	237,351

Reimbursement rates for Family Foster Care have not been adjusted to the cost of living for a decade. In 2009 rates were adjusted to 90% of the cost of care based on a 2007 rate methodology. In 2011, these rates were reduced by an additional 10% due to department budget cuts. Families coming forward to provide foster care has continued to diminish over the last 5 years in part due to the low reimbursement rates. The current daily rate is $18.90 per day for a child under age 5 years old or $24.36 per day for a teenager. This is intended to cover the costs of food, shelter, clothing, school supplies, extracurricular activities, etc. Based on the methodology created in 2009 Oregon is currently providing only 40-46% of the actual cost of care. Other states have been sued due to the low rate of family foster care payments and Oregon continues to increase the risk of a class action lawsuit. Additional funding for this POP is included in the Well Being bid form.

Reductions:

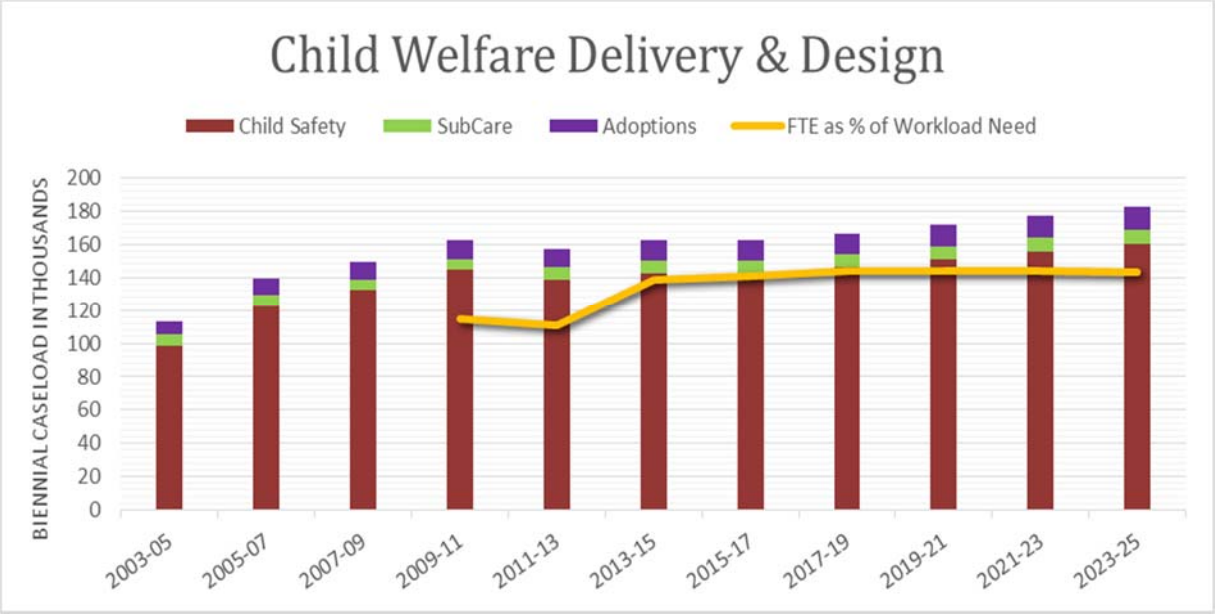
- "Private Adoptions: 25% Cut Fee for services, budgeted at $1,202,890 per biennium. Payment for placement and supervision services for DHS foster

children in in-state and out-of-state adoptive families studied and supervised by private agencies. Reduce the number of in-state private agency placements but keep out-of-state private placements at the current level. General applicant Oregon families can get home studies through their local DHS offices (although waiting times will increase), but out-of-state general applicants (non-relatives) would have no means to get a study through their local child welfare office for Oregon children, as ICPC covers home studies with relatives only. Reductions impact the number of adoptive families overall and reduces the overall number of adoptive placements being made.

- Contracted Adoption Services - 25% Reduction The Multnomah County District Attorney contract, Whitney Investigations contract, and Black Helterline Attorney contract are all essential legal services that will be deferred to the Department of Justice if these contracts are cut or eliminated (see explanation below in the 100% elimination section), so cuts to these contracts in contracted adoption services would result in a cost shift to the DOJ budget. Of the remaining contracted adoption services, leave Oregon Adoption Resource Exchange and Northwest Adoption Resource Exchange intact.
- Permanency: 25% Reduction Post Adoption Services program, impacting supports for over 400 adoptive and guardianship families each year. (IV-B portion of budget). Reduce training, library purchases, and support group start-up for information and referral, advocacy and support, and crisis intervention.
- Permanency: additional 50% Reduction Post Adoption Services program, impacting supports for over 400 adoptive and guardianship families each year. (IV-B portion of budget) Eliminate training, library purchases, and support group start-up for information and referral, and crisis intervention only

Department of Human Services: Delivery and Design

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Laurie Price, Deputy Director Child Welfare



Program Overview

This program represents the structure that supports the safety of children across Oregon who are abused or neglected. As of January 1, 2016, there are 1,412 legislatively approved child welfare caseworker positions across Oregon. These caseworkers respond to over 32,000 reports of abuse and neglect, and serve approximately 11,200 abused children who experience foster care, each year. The program also finalizes approximately 800 adoptions each year, creating a permanent home for children that cannot safely return to their parents. This structure is administered in our central office in Salem and supports DHS field staff through supervision, technical support, establishing policies and standards, evaluation, analysis, and continuous quality improvement of program areas in Child Welfare.

The staffing investment in 2015-2017 brought the Child Welfare caseworkers to approximately 86 percent of the workload model, assuming all positions are filled.

These staff are critical to the integrity of the Oregon Safety Model, our child welfare practice model for safety assessment and safety management.

Program Funding Request

CHILD WELFARE - Design	GF	OF	FF	TF
LAB 15-17	$ 33,318,439	$506,520	$ 34,922,970	$ 68,747,929
GB 17-19	$ 22,670,588	$501,460	$ 43,173,653	$ 66,345,701
Difference	$ (10,647,851)	$ (5,060)	$ 8,250,683	$ (2,402,228)
Percent change	-32.0%	-1.0%	23.6%	-3.5%

CHILD WELFARE - Delivery	GF	OF	FF	TF
LAB 15-17	$232,417,091	$ 1,605,751	$182,401,180	$ 416,424,022
GB 17-19	$276,988,800	$ 1,754,699	$193,508,060	$ 472,251,559
Difference	$ 44,571,709	$ 148,948	$ 11,106,880	$ 55,827,537
Percent change	19.2%	9.3%	6.1%	13.4%

Program Description

This program provides the personnel necessary for the entire array of Child Welfare programs and services; which includes screening and evaluation of calls reporting abuse and neglect, assessment of families and determination of child safety, case management for all open child welfare cases, assessment , recruiting and retention of substitute care resources, visitation for children with their parents and family while experiencing out-of-home care, court preparation and review, transition planning for children over 14 years of age, permanency planning, and case management services through completion of a permanency plan. The program also provides clinical supervision of direct service staff, critical to building worker competencies including reinforcing professional social work ethics and values, self-reflection and critical thinking skills, casework practice through a trauma informed and culturally appropriate lens, mentoring and coaching to develop professional skills, and supporting the worker through casework decision-making and crises. This is partially achieved through lower staff-to-supervisor ratios as recommended by the Child Welfare League of America (CWLA). Oregon has adopted a specific model for evaluating and ensuring safety throughout the life of a case. This model, the Oregon Safety Model, is Oregon's child welfare practice model that requires safety assessment and safety management at all stages of case management, from screening through case closure.

Child Welfare design and delivery coordinates with Self Sufficiency design and delivery to support family stability and prevent entrance into the foster care system for their common clients. In addition, Child Welfare partners with other child and family serving systems including Oregon Housing Authorities, Oregon Health

Authority, Oregon Department of Education, Oregon Youth Authority, community and faith based organizations, etc. Child Welfare also contracts with numerous community service providers and individuals, to provide families and children the individualized services they need to be successful. This program continues to work to eliminate disparities and ensure equitable outcomes for families and children. Currently, Native American and African American children are disproportionately represented in the foster care system.

Major cost drivers for the personnel need are: Program mandates (Federal and State); the number of reports received alleging abuse; family stress factors which affect abuse risk and case complexity (substance abuse, unemployment, mental or physical health issues, criminal history, domestic violence, etc.); personnel turnover (training/travel costs); work effort required to provide services, and personnel packages (i.e., position cost, etc.). Additional drivers of cost include representation from the Department of Justice connected to dependency matters, court-ordered services and workload associated with Federal mandates such as the Indian Child Welfare Act (ICWA).

DHS has implemented Lean Daily Management Systems in all districts across the State and in central office. This active process of identifying ways to improve efficiencies allows DHS to reinvest staff resources to close the gap between positions earned and authorized positions as they are identified. Currently this effort is directed at decreasing the time spent on the processes used to deliver the work. There has also been a significant investment in ensuring each office has streamlined business systems.

Child Welfare continues with a primary focus of safely and equitably reducing the number of children who experience the foster care system. Critical elements of the program are thorough and comprehensive assessment of child safety, certification of adequate and appropriate substitute care providers and timely permanency outcomes. Oregon's Round 3 Federal Child and Family Services Review includes specific strategies to address these areas of needed improvement in Oregon's child welfare practice.

Program Justification and Link to Focus Areas

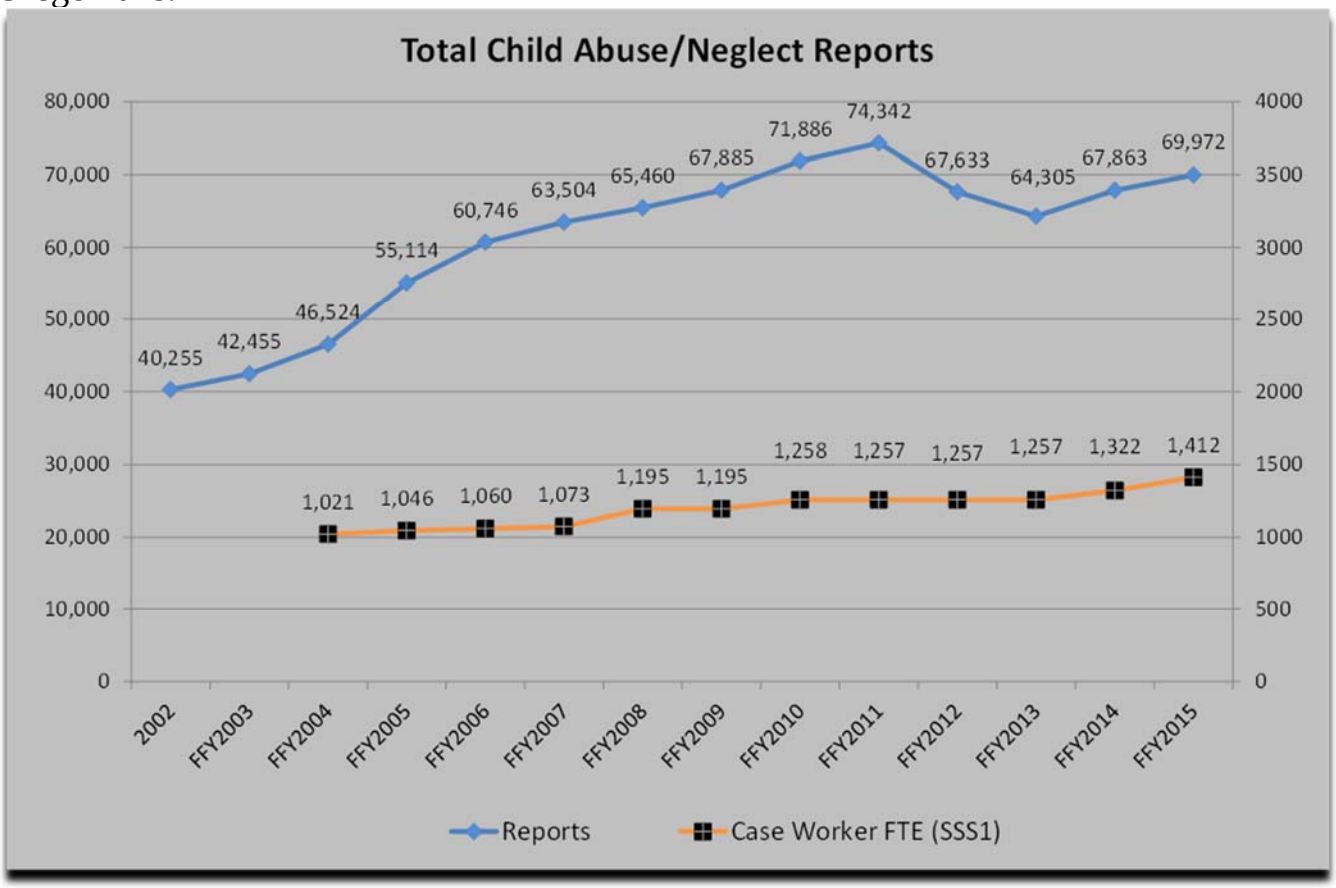
There is a direct link between the program design and delivery for Child Welfare and Safer, Healthier Communities. The Child Welfare Program supports increased family stability and child safety; prevents vulnerable youth from entering the foster care system; and implements social justice reinvestment practices. Through Child

Welfare interventions, safety for abused and neglected children is established. The program's work with families enhances their ability to safely parent their children and prevent foster placements.

Child Welfare Program delivery and design provides the personnel to administer, design and deliver child safety supports through abuse investigation, service identification and procurement, family development and reunification where possible, or alternative child safety planning when necessary, which all have a direct impact on Safe, Healthier Communities.

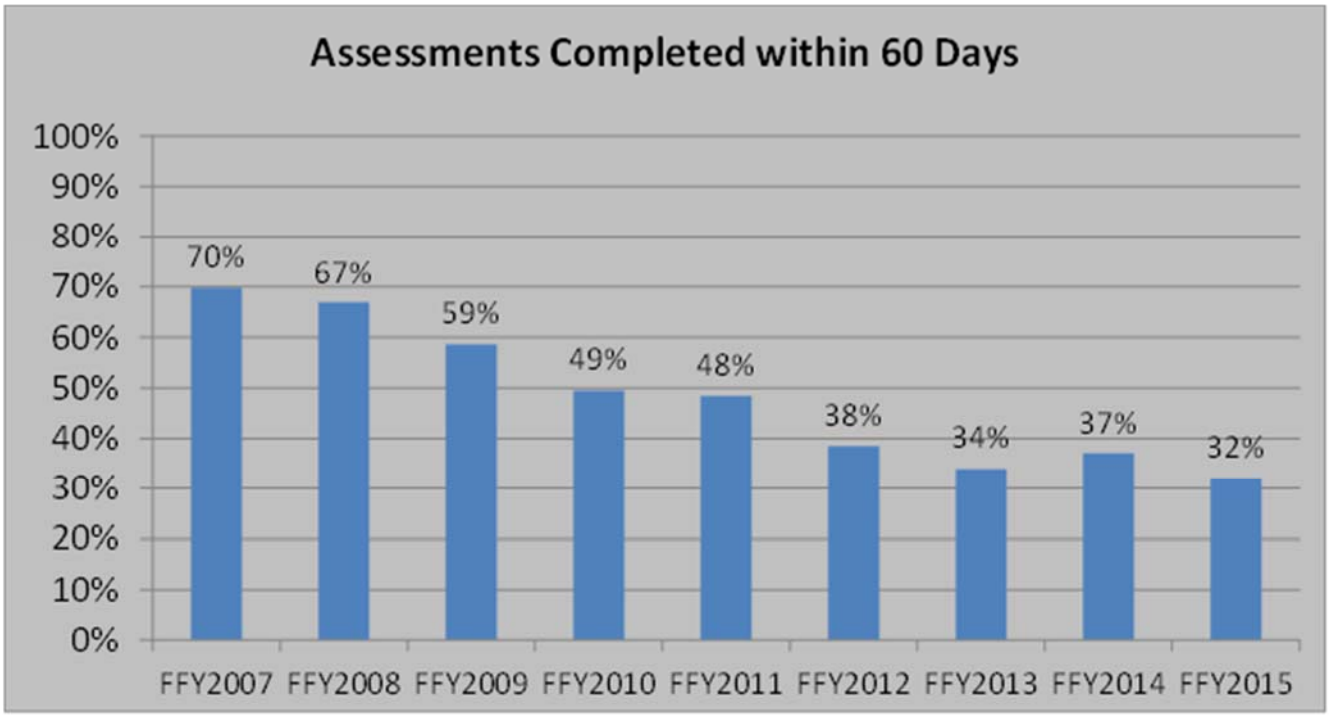
Program Performance

Personnel resources are necessary to provide performance in the delivery of programs within Child Welfare. At current staffing levels, the Child Welfare Program is performing below federal standards in most categories. The chart below provides a comparison of the caseload growth (74%) to the personnel growth (38%) over time which provides a display of how our resources directly impact the Department's ability to keep pace with the need of vulnerable Oregonians.



Safety for children is measured through the performance metrics of: timeliness of responding to reports of abuse and neglect, re-abuse rates, our ability to have regular and frequent face-to-face contact with children and families, and the timeliness of achieving a permanent plan for a child to minimize the duration of a stay in foster care. All of these performance measures are impacted by the staffing levels for the Child Welfare Program. Child safety is jeopardized when there is not adequate staff to respond, visit children and families, ensure family stability prior to return, or move children to a permanent home.

Having a staff that is representative of the children and families that we serve is essential to child safety. Additionally, staff must also be able to respond to the variety of cultural and language needs of our families. Although additional staff were added in the 2009-2011 legislative session, the hiring freezes of 2010 and 2011 eroded the gains made on completing assessments within 60 days. Adding additional staff in 2013-2015 was critical to reestablishing a positive trend in foster care reduction. While we were also able to see an initial bump in the number of assessments completed within 60 days, we are now at our lowest point in the last 9 years. Increasing caseloads and workload expectations, vacancies, and other factors have led to a steady turnover rate which impacts our ability to gain solid traction in all areas. Normally, it takes up to two years for new staff to become fully able to carry the workload effectively.



With the assistance of McKinsey & Company, a workload model was developed to record the work effort to provide program delivery. The workload model provides a basis for determining personnel needs to adequately support the work of Child Welfare. The Fall Forecast matrix below provides a comparison of the delivery positions authorized by the 2015-2017 Legislature and the need, based on work effort to meet the need. The Child Welfare central support was not included in the workload modeling by McKinsey. However, the work of Child Welfare central support is vital to the delivery of services in field offices. Central support provides the oversight of policy development, program design and changes required through legislation, Federal reporting compliance, and direct practice support to the field. In April of 2016, the worker surveys and field validation work was completed for re-calculation of the workload for delivery positions. This provides a current workload assessment to do the work.

CW | Workload Model 17-19 budget build calculations					17-19 w/updates SPRING 2016 FORECAST			
	2015-17 (post-LAB) w/Spring 2015 Forecast				2015-17 (post-LAB)			
POSITION TYPE:	Current Position Authority	Positions Earned Forecast (S15)	Percent of Earned	Difference Current to Workload Forecast	Current Position Authority	Positions Earned Forecast (S16)	Percent of Earned	Difference Current to Workload Forecast
Case Worker	1412.02	1,574.53	89.7%	(162.51)	1412.02	1588.93	88.9%	(176.91)
Social Service Assistant	201.40	231.55	87.0%	(30.15)	201.40	233.67	86.2%	(32.27)
Support Staff	427.81	524.84	81.5%	(97.03)	427.81	529.64	80.8%	(101.83)
FRS/IVE Specialists	43.30	52.55	82.4%	(9.25)	43.30	51.74	83.7%	(8.44)
Leadership Support	38.30	48.10	79.6%	(9.80)	38.30	48.45	79.1%	(10.15)
Field Management	203.00	258.00	78.7%	(55.00)	203.00	257.5	78.8%	(54.50)
Totals	**2325.83**	**2,689.57**	**86.5%**	**(363.74)**	**2325.83**	**2709.93**	**85.8%**	**(384.10)**

Enabling Legislation/Program Authorization

Child Welfare services are mandated by multiple Federal and State laws including PL96-272, Adoption Assistance and Child Welfare Act; PL95-608, Indian Child Welfare Act PL 105-89, Adoption and Safe Families Act; PL 110-351, Foster Connections to Success and Increasing Adoption Act; Social Security Act Title IV-E and Title IV-B; ORS Chapter 418, and ORS Chapter 419B.

Funding Streams

Personnel for program design and delivery is determined through Random Moment Sampling Surveys (RMSS) where field delivery staff are required at random intervals to indicate the time spent on various activities to determine the level of

Federal funding which directly supports our ability to provide critical child welfare services. Block grant funds include Social Services Block Grant (SSBG) and Temporary Assistance for Needy Families (TANF) funds. Leveraged funds include Medicaid, Title IV-E and IV-B funds. State-only General Funds also comprise a portion of the budget.

Funding Justification and Significant Changes to CSL

This does not include statewide reductions.

110 Legal Representation in Child Welfare

General Fund	Other Funds	Federal Funds	Total Funds
6,916,041	0	12,957,561	19,873,602

Historically, DOJ's billable hour model has been considered cost-prohibitive in juvenile dependency cases and has been a deterrent to DHS accessing and utilizing DOJ for full representation, including attendance at all hearings, regular case consultation, impromptu legal advice, and regular participation in case worker training, meetings, and staffing. A block grant model will allow DOJ to manage cases according to a workload method of case assignment with each DOJ attorney carrying a consistent number of weighted cases. In this model, each dependency case is assigned to an attorney who handles it from petition to permanency. This case assignment method will provide DHS caseworkers with continuous representation which, in turn, will promote attorney-caseworker collaboration, improve caseworker job satisfaction and retention, avoid the risk for unlawful practice of law by case workers, and improve the overall efficiency and cost-effectiveness of the system. This Policy Option Package assumes a total fund block grant funding model of $45 million total fund for full representation and assumes the exception to DHS representation in these cases is lifted. If the representation exception is continued DHS is still short $4.5 million GF in order to meet projected CW AG costs in 2017-19.

Reductions:

- Staffing Workload Reduction in GB: This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in Child Welfare to ensuring the safety of Oregon Children.

- Screening Positions in GB: This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in Child Welfare to ensuring the safety of Oregon Children.

Department of Human Services
Vocational Rehabilitation Program

Mission

Vocational Rehabilitation's (VR) mission is to assist Oregonians with disabilities to achieve and maintain employment and independence. VR partners with Oregonians with disabilities to gain employment through a variety of services designed to assist in identifying and mitigating the functional impediments created by disability.

Program

This is a state and federal program authorized by state law and the federal Rehabilitation Act of 1973, amended in 1998 and in 2014.

VR helps Oregonians with disabilities gain employment through a variety of services. This includes helping youth with disabilities transition to jobs as they become adults, helping employers realize the benefit of employing people with disabilities, and partnering with other state and local organizations that coordinate employment and workforce programs. A total of 350,586 working-age Oregonians experience a disability, but only 35 percent are employed. Employment helps people with disabilities progress towards self-sufficiency, become involved in their communities, and live more engaged and satisfying lives.

All working-age Oregonians who experience a disability and are legally entitled to work are potentially eligible for VR services. Individuals who experience a medical, cognitive or psychiatric diagnosis that results in a functional impediment to employment are typically eligible for services. Recipients of Social Security disability benefits are presumed eligible for services.

Approximately 99 percent of all eligible clients currently served by VR are people with significant disabilities. These individuals experience multiple functional impediments requiring several services provided over an extended period of time.

VR has counselors with expertise in the areas of intellectual and developmental disabilities (I/DD), deafness and hearing impairments, mental health, motivational intervention, spinal injury, and traumatic brain injury.

Individuals we serve
Vocational Rehabilitation employees provide direct services through a network of local offices across Oregon. For a list, see:
http://www.oregon.gov/dhs/vr/Pages/officelocation.aspx

Services are provided by rehabilitation counselors and support staff who deliver direct client services through 34 field offices and multiple single employee outstations in Work Source Oregon Centers and other human services agencies across the state. As the demographics in Oregon are changing, VR is adapting accordingly in order to provide culturally-specific services to Oregonians and to help diversify the State workforce.

VR Data**:**

- Helped 16,488 individuals and obtained 2,973 employment outcomes in federal fiscal year 2016.
- Contract with 39 school districts and consortia on behalf of 115 schools to provide serves for approximately 1,300 students each year.
- Assisted 620 individuals with intellectual and developmental disabilities (I/DD) and 67 individuals with psychiatric disabilities obtain jobs in federal fiscal year 2016. Of those 620 individuals with I/DD who obtained jobs, 403 are maintaining their job through supported employment services.

Services Provided
VR is designed under four primary areas: basic services, youth programs, supported employment, and independent living. In addition, VR is also engaged in Oregon's Employment First program in partnership with the Office of Developmental Disability Services and is actively engaged in improving workforce partnerships.

Basic Services: These are basic services provided to individuals whose disabilities present a potential barrier to employment. A rehabilitation counselor conducts a comprehensive assessment to evaluate vocational potential, including diagnostic and related services necessary for the determination of eligibility for services as well as the nature and scope of services to be provided. Vocational counseling and guidance builds on this assessment and helps the client identify a vocational goal. The counselor, in partnership with the client, develops an individualized plan for employment and authorizes appropriate services in support of the plan while maintaining a counseling relationship with the client.

Youth Transition Program (YTP): YTP operates as a partnership between (VR), the Oregon Department of Education (ODE), the University of Oregon's College of Education, and local Oregon school districts. At least 70 percent of students with disabilities in YTP complete high school and transition to a job or postsecondary education, a rate that exceeds the national average. This internationally and nationally-recognized school-to-work transition approach is a best practice for young people with disabilities. YTP bridges the gap between school and work by providing coordinated vocational rehabilitation services while the student is in school and ensuring a smooth transition to adult services and employment after completion of school. YTP currently serves about 1,880 students in 112 school districts.

Supported Employment Services: These services target individuals with the most significant disabilities for whom employment was not possible through traditional means, but who can obtain and maintain competitive employment in the community with the provision of job coaching and ongoing supports. Basic vocational rehabilitation services are provided on a time-limited basis for each client. Oregon Health Authority (OHA), the Office of Developmental Disability Services (ODDS), other community programs, families and private employers are responsible for the follow-along services once VR has completed placement and training services. Supported Employment Services combine traditional VR services and support services provided by job coaches, typically at job sites.

Independent Living: Services are available through seven Centers for Independent Living (CILs). The CILs are nonprofit organizations that provide information and referral, independent living skills training, peer counseling, both systems and individual advocacy and transition services for youth and those wanting to leave institutional living. CILs also provide a range of services based on local needs, many of which compliment services provided through other state and federally funded programs. Services are provided through a peer-mentoring model, with an emphasis on self-help, self-advocacy, and consumer responsibility.

CILs are a federal program established in the Rehabilitation Act of 1973. Oregon's State Independent Living Council was established by Governor's Executive Order 94-12 in 1994. VR has the responsibility to:

- Receive, account for, and disburse funds received by the state;
- Provide administrative support services to the CILs;

- Keep records and provide access to such records as required by the Administration on Community Living (the Federal authority for the Independent Living program); and
- Fund and support the State Independent Living Council's resource plan.

In addition, VR is working with the CILs and Disability Rights Oregon (a private nonprofit) to sustain the Work Incentive Network (WIN). WIN was developed as a pilot project through a Medicaid Infrastructure Grant and is an evidence-based practice, providing benefits and work incentives planning to individuals with significant disabilities who want to obtain, maintain, or increase their employment, but should not lose other benefits and medical coverage. This allows people on disability benefits to become employed, gain more levels of self-sufficiency, become engaged in their communities, and live a higher quality of life. They also begin paying taxes and reduce reliance on those publicly-funded services.

Employment First: Youth and adults with intellectual and developmental disabilities (I/DD) are significantly underrepresented in Oregon's workforce. With appropriate services and assistance, people with I/DD can work successfully in the community. The state is seeking to increase employment of people with I/DD in integrated workplaces through increased efforts around the Employment First policy and the Settlement Agreement (Lane v Brown) with targeted outcomes

The Governor's Executive Order 13-04 and subsequent EO 15-01 directs state agencies and programs, including VR, DHS' Office of Developmental Disability Services (ODDS) and the Oregon Department of Education (ODE), to increase community-based employment services for people with I/DD and to reduce state support of sheltered work. VR has specialized counselors around the state committed to working with people with I/DD to find employment in the community.

Workforce Partnerships: Historically, VR services have also been viewed as outside looking into the workforce system. With the passage and implementation of the Workforce Opportunity and Innovation Act (WIOA) of 2014, VR has been named a core partner in the workforce system. VR has been busy working closely with the core workforce partners to create a workforce system that is less siloes and more efficient.

VR, DHS-SSP, the Oregon Employment Department, local workforce development boards, and Adult Basic education programs around the state have been meeting to ensure all of our services are aligned, there is minimized duplication, and there are opportunities to expand services that meet the needs of our joint client needs. Moving towards this shared purpose has increased awareness of the needs of individuals with disabilities seeking employment while creating more opportunities for our clients in the local economies.

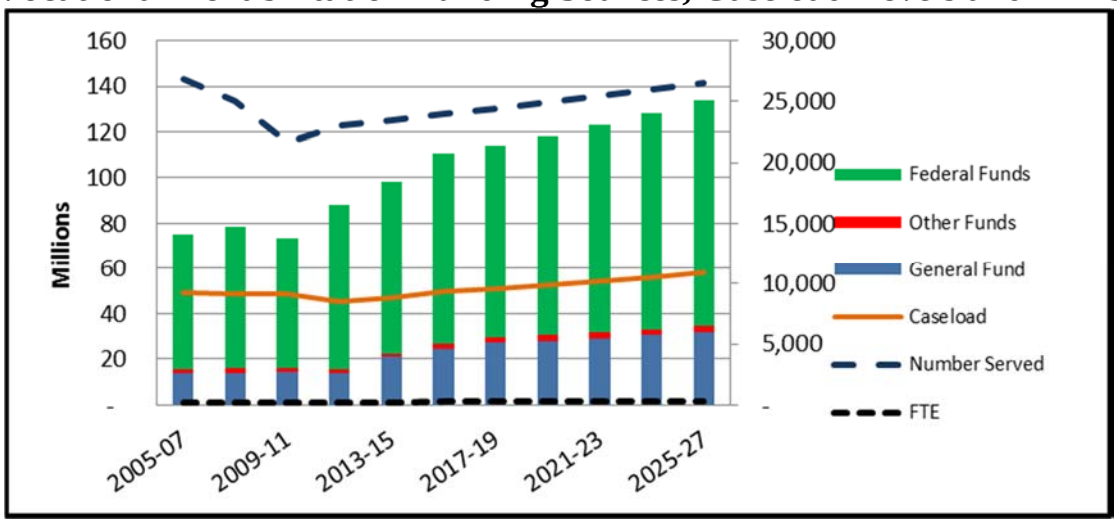
As part of our movement into the core of the workforce system, VR has joined all nine local workforce development boards in the state. We also have a larger role with in the statewide Workforce Investment Board. This last year, VR's state plan was submitted as part of the larger statewide combined plan that included the strategic vision of the OWIB.

VR continues to create opportunities for individuals with disabilities to access and benefit from various workforce strategies. Moving forward, VR will enhance employer outreach strategies to engage employers and conduct outreach and education to show that clients are reliable, dependable, and skilled workers who also happen to have disabilities. VR will also engage employers to provide work-based learning opportunities for all clients, including youth transitioning into post-secondary careers.

Department of Human Services: Vocational Rehabilitation

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: A Thriving Oregon Economy
Program Contact: Trina M. Lee

Vocational Rehabilitation Funding Sources, Caseload Levels and FTEs



Note: Cost per case increase is the result of a growing number of people with cognitive disorders requiring services that come with higher costs.

Program Overview

Vocational Rehabilitation (VR) helps Oregonians with disabilities obtain, maintain, regain and advance in employment through counseling, specialized training and job placement. This includes helping youth with disabilities transition from the educational system to the workforce as they become adults, helping employers overcome barriers to employing people with disabilities, and partnering with other state and local organizations that coordinate employment and workforce programs. The public workforce system in Oregon, ~~It~~ includes the following state agency partners: Oregon Employment Department (OED), Self Sufficiency Program (SSP), Vocational Rehabilitation (VR), and the Higher Education Coordinating Commission (HECC). Agencies work in conjunction with the governor's office and Local Workforce Development Boards. There is a Workforce System Executive Team tasked with communication among partners and assuring system alignment.

A total of 350,586 working-age Oregonians experience a disability, but only 35 percent are employed. Employment helps people with disabilities become more self-sufficient, involved in their communities, and live more engaged and satisfying lives.

All working-age Oregonians who experience a disability that creates a barrier to employment and are legally entitled to work are potentially eligible for VR services. Individuals who experience a medical, cognitive or psychiatric diagnosis that results in an impediment to employment typically are eligible for services. Recipients of Social Security disability benefits are presumed eligible for services. Approximately 95 percent of all eligible clients currently served by VR are people with significant disabilities. These individuals typically experience multiple functional limitations requiring several services provided over an extended period.

VR has counselors who specialize in the areas of intellectual and developmental disabilities (I/DD), deafness and hearing impairments, mental health, motivational intervention, spinal injury, and traumatic brain injury however the majority of VR counselors provide services to a wide array of Oregonians with disabilities.

Services are provided by rehabilitation counselors and support staff who deliver direct client services through 34 field offices and multiple single employee outstations in one-stop career centers and other human services agencies across the state.

Specialized services that help clients be as independent as possible are provided through seven Centers for Independent Living (CILs) located throughout the state.

VR staff work in partnership with community organizations and businesses to develop employment opportunities for people with disabilities. These activities range from live resume events and job fairs to presenting disability awareness workshops in local businesses. VR also offers business services that include consultations with employers about diversifying their workforces by hiring people with disabilities and pre-screening services to match employers with clients who are qualified, reliable job candidates.

Program Funding Request

OVRS	GF	OF	FF	TF
LAB 15-17	$ 24,308,416	$ 2,327,882	$ 84,146,036	$ 110,782,334
GB 17-19	$ 26,996,950	$ 2,340,616	$ 84,634,350	$ 113,971,916
Difference	$ 2,688,534	$ 12,734	$ 488,314	$ 3,189,582
Percent change	11.1%	0.5%	0.6%	2.9%

Program Description

VR is designed under four primary areas: basic services, youth programs, supported employment, and independent living. VR is also engaged in Oregon's Employment First initiative. VR is a core partner in the implementation of the Workforce Innovations and Opportunities act and is committed to improving access to the Workforce System for Oregonians with Disabilities. VR works with the Commission for the Blind and Oregon's Tribal VR (121) Programs.

Basic Services

These are basic services provided to individuals whose disabilities present an impediment to employment. The Vocational Rehabilitation Counselor (VRC) conducts a comprehensive assessment to evaluate vocational potential, including diagnostic and related services necessary for the determination of eligibility for services as well as the nature and scope of services to be provided. Vocational counseling and guidance builds on this assessment and helps the client identify a vocational goal. The counselor, in partnership with the client, develops an individualized plan for employment and authorizes services and training in support of the plan while maintaining a counseling relationship with the client.

Youth Transition Program (YTP)

YTP operates as a partnership between VR, the Oregon Department of Education (ODE), the University of Oregon's College of Education, and local Oregon school districts. At least 70 percent of students with disabilities in YTP complete high school and transition to a job or postsecondary education, a rate that exceeds the national average. This internationally and nationally-recognized school-to-work transition approach is a best practice for young people with disabilities. YTP bridges the gap between school and work by providing coordinated vocational rehabilitation services while the student is in school and ensuring a smooth

transition to adult services and employment after completion of school. YTP currently serves about 1,800 students in 112 school districts.

We will be reviewing the Youth Transition Program in the context of Pre-Employment Transition Services as required by the WIOA. It will require a 15% "set aside" of VR funds in order to meet this requirement. This will reduce funds available to meet the needs of other population groups we serve.

Supported Employment Services
These services enable Oregonians with the most significant disabilities, including youth with the most significant disabilities, to achieve and maintain competitive integrated employment. Vocational rehabilitation supported employment services (i.e., job coaching, training normally done at the job site) are time-limited; lasting from job placement until the individual is stable in their job and long term supports are in place. Addictions and Mental Health (AMH); Office of Developmental Disability Services (ODDS); community programs; families or private employers provide long term supports after the individual reaches job stabilization, which continue after the client has exited the VR program..

Independent Living
Services are available through seven Centers for Independent Living (CILs). The CILs are nonprofit organizations that provide information and referral, independent living skills training, peer counseling, and both systems and individual advocacy. CILs also provide a range of services based on local needs, many of which compliment services provided through other state and federally funded programs. Services are provided through a peer-mentoring model, with an emphasis on self-help, self-advocacy, and consumer responsibility. CILs, along with Oregon's Area Agencies on Aging (AAAs), provide leadership statewide and nationally in the formation of the "No Wrong Door" experience for seniors and people with disabilities accessing Long Term Care Supports & Services via the Aging & Disabilities Resource Connection (ADRC) network.

Program Justification and Link to Focus Areas

VR assists individuals with disabilities to establish a foundation by identifying a personal vision, goals and steps necessary to achieve success in education and employment, and become independent, productive citizens. The VR program and the services provided primarily link to the Governors initiative relating to Safer and Healthier Communities. It has been shown that higher rates of employment result in healthier and safer communities. This is especially true in regards to

Oregonians with Disabilities who are underrepresented in the workforce. Secondarily, by creating better access to the Workforce System, we are increasing the number of employable Oregonians, many of whom bring in skills and attributes necessary to today's economy, thereby contributing to a Thriving Oregon Economy.

Employment and Jobs

- The VR Program has developed a plan in partnership with the Workforce System as defined by the Workforce Innovations and Opportunities Act (WIOA) which includes goals regarding employment outcomes for clients, to increase skills upgrading and certification of Oregonians with Disabilities seeking employment
- As a result of the Settlement from Lane v Brown, The state is seeking to increase employment of people with intellectual and developmental disabilities (I/DD) in integrated workplaces through increased efforts around the Employment First initiative. The Governor's Executive Order 15-01 and the Settlement Agreement directs state agencies and programs, including VR, DHS' Office of Developmental Disability Services (ODDS) and the Oregon Department of Education (ODE), to increase community-based employment services for people with I/DD and to reduce state support of sheltered work. VR has specialized counselors around the state committed to working with people with I/DD to find employment in the community.
- VR assisted 620 people with I/DD and 624 individuals with psychiatric disabilities obtain jobs in federal fiscal year 2016.
- In federal fiscal year 2016, 2,975 individuals obtained and maintained work through the basic rehabilitation program. VR Employer Services provides training and technical assistance to employers for new hires and incumbent workers, and identifies and refers qualified candidates. A 2013 Portland State University study found that VR returned $4.03 in tax revenues to the state of Oregon for every $1 spent in the program.
- VR continues to contract and collaborate with the Latino Connection program in reaching out to and providing specialized job placements services to native Spanish-speaking individuals with disabilities. The focus of these services has been in Portland, Clackamas, Salem and Woodburn, which have large Latino communities. This program had a 73.6 percent rehabilitation rate in federal fiscal year 2016.
- VR is continuing to increase community engagement with communities of color, non- or limited English speaking communities and other communities

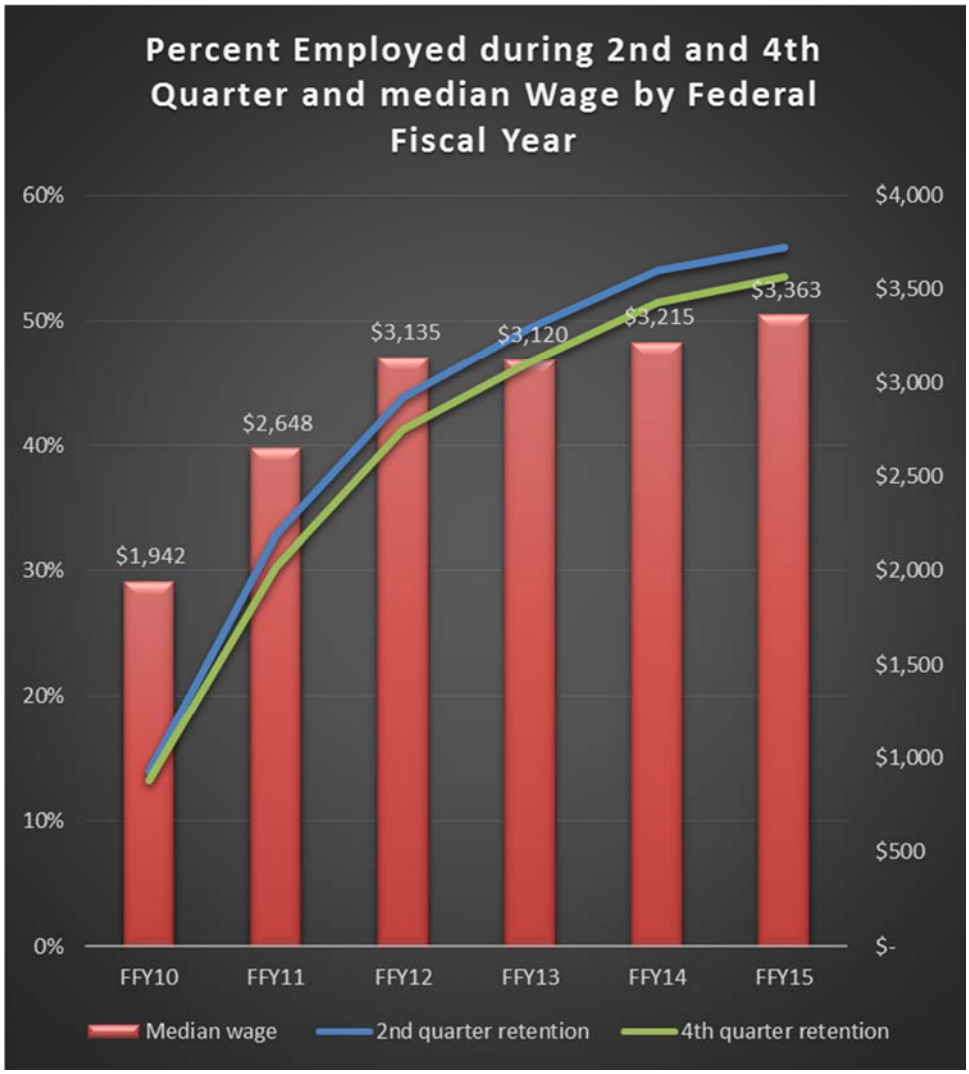
across the state. VR works with DHS to provide information in alternative formats and language to communities across the state.

Program Performance

Vocational Rehabilitation measures its performance primarily by employment outcomes. Employment outcomes are defined as the number of individuals who obtained and successfully maintained employment for a minimum of 90 days. The chart below shows employment outcomes for the program since FFY2012.

Vocational Rehabilitation						
Year		FFY16	FFY15	FFY14	FFY13	FFY12
# Served	Youth	4,215	3,887	3,449	2,051	1,886
	Adult	12,245	12,171	12,150	13,694	13,859
Employment Outcomes	VR Overall	2,973	2,723	2,376	2,314	2,032
	SE	660	414	254	290	228
	Youth	765	672	552	548	439
	SSI/SSDI	967	815	646	539	558
Percent Rehabilitated		61.8%	62.6%	62.0%	59.0%	58.0%
Avg. Hourly Wage		$ 13.09	$ 12.18	$ 12.07	$ 11.76	$ 11.63
Avg. Weekly Hours		26	27	27	27	27
Cost per Rehabilitation		$ 6,574.50	$ 6,471.00	$ 6,473.59	$ 3,132.00	$ 2,848.00

Under the new Workforce Innovation and Opportunities Act of 2015 there has been several added measures with emphasis on long term employment. The graph below displays some of the new measures the program will be expected to achieve.



Education

- The internationally-recognized Youth Transition Program has expanded to 112 school districts in Oregon. More than 70 percent of students with disabilities in YTP complete high school and transition to a job or postsecondary education, a rate that exceeds the national average. YTP bridges the gap between school and entry into the work by providing coordinated vocational rehabilitation services while the student is in school and ensuring a smooth transition to adult services and employment after completion of school. YTP currently serves about 1,800 students in 112 school districts.
- VR utilizes Supported Employment, an evidence-based model, which allows individuals with developmental and intellectual disabilities to work in competitive employment in the community with needed supports.

- The Independent Living program partners with schools and families to support the transition of students with disabilities to secondary education and/or work.
- Memorandums of Agreement with the Office of Developmental Disabilities Services and the Oregon Department of Education are designed to more effectively align transition services, identify opportunities to braid and leverage funding in order to increase the number of students with disabilities.
- Introduction of services in partnership with ODE to meet WIOA requirements to expend 15% of our Federal funds to meet Pre Employment Transition Services as required by the WIOA.

Safety

- CILs train seniors and people with disabilities to develop personal preparedness plans and on empowerment and safety as a preventative for crime and abuse often faced by these populations.
- CILs also provide training and mentoring to parents with disabilities, which enhances skills for management of their homes and families.

Oregon's seven Centers for Independent Living (CILs) continue to be innovative catalysts to independence for people with disabilities in Oregon. Leveraging community partnership funds and empowering people with disabilities with peer supports, CILs provide a Return on Investment (ROI) for Oregonians estimated at about a $6 return for every $1 invested. The ROI, conducted by the Association of Oregon Centers for Independent Living, is based on statistical studies of consumers served and cost savings achieved in 2008 with an updated 2014 analysis pending for winter 2015 publication. The chart below shows Independent Living Program outcomes since 2009.

Independent Living Program

YEAR	FY2014	FY2013	FY2012	FY2011	FY2010	FY2009
# Served	18,940	16,497	14,791	11,863	7,358	5,688
Consumer Goals	3,015	2,913	3,853	4,225	3,533	4,317
% Goals Achieved	56%	55%	61%	60%	60%	62%
Consumer Satisfaction	81%	74%	73%	87%	89%	92%

Enabling Legislation/Program Authorization

VR is a state and federal program authorized by Oregon state law (ORS 344.511et seq.) and the Workforce Innovation and Opportunity Act of 2014.

The Independent Living Program is a federal program established in Title VII of the Rehabilitation Act of 1973, as amended, and regulated by the Code of Federal Regulations, Title 34, and Parts 364-367. In conjunction, Oregon's State Independent Living Council was established in 1994 by Governor's Executive Order 94-12. VR is listed as the designated state unit for this program in the State Plan for Independent Living, per Section 704 of Title VII.

Funding Streams

VR is funded through the federal Department of Education. It receives a formula-based grant with Match and Maintenance of Effort requirements. The match rate for Vocational Rehabilitation is 21.3% General Fund; 78.7% Federal Fund. For Independent Living the match rate is 10% General Fund; 90% Federal Fund. Grant dollars cannot be utilized by other programs. Program income, which is reinvested back into VR, includes Social Security reimbursement and Youth Transition Program grants.

Funding Justification and significant Changes to 17-19 CSL

This does not include statewide reductions.
Reductions:

- Use one time ReAllotment revenues to backfill CSL GF in GB - OVRS has successfully been awarded one time ReAllotment funding allowing a partial one time backfill of GF. If possible this reduction should replace the program and position reduction so VR does not enter an order of selection. ($7,400,000 GF)

Department of Human Services
Aging and People with Disabilities Program

Mission

The Department of Human Services Aging and People with Disabilities (APD) program assists a diverse population of older adults and people with disabilities to achieve well-being through opportunities for community living, employment, family support and long term services and supports that promote independence, choice and dignity.

Goals

- Ensure the safety and protection of the population we serve with a focus on prevention.
- Facilitate broad awareness of, and easy access to, services.
- Invest in preventive services to keep people independent, safe and healthy for longer periods of time.
- Provide person centered services and supports.
- Serve people in an equitable and culturally sensitive manner.
- Promote high quality services by APD, its local partners and providers.
- Increase advocacy efforts to improve outcomes for APD consumers.
- Administer programs with the utmost integrity.

Individuals we serve

During the 2017-2019 biennium, we expect to serve:

- More than 5,000 people age 60 and older through Oregon Project Independence.
- More than 36,000 older adults and people with physical disabilities per month with long-term care services paid through Medicaid.
- More than 450,000 older individuals with Older Americans Act services.
- More than 150,000 Oregonians with direct financial support services.

Oregonians needing information and referral services about any of the aforementioned programs or services may contact the Aging and Disability Resource Connection (ADRC) of Oregon. The ADRC is a collaborative public-private partnership that streamlines consumer access to a complicated and confusing aging and disability service delivery system. ADRC services are free to

Oregonians and the service raises visibility and awareness of the full range of options available. The ADRC provides trusted information and assistance, and empowers people to make informed decisions. Through trained options counselors, Oregonians can develop action plans to address long-term services and supports needs that align with consumer preferences, their financial situation, strengths, values and needs. If a person is likely to be eligible for Medicaid long-term care services, they will be referred to APD local offices or Area Agencies on Aging (AAAs) for a full assessment. During the last biennium the ADRC took more than 18,000 calls and received 164,000 web hits. Employees from both APD local offices and AAAs throughout Oregon are responsible for providing direct client services. Employees also determine eligibility around the aging and people with disabilities population for medical programs provided through the Oregon Health Authority (OHA).

APD is impacted by demographic growth in the older adult population and is increasingly serving a more diverse population. APD strives to identify disparities in outcomes for diverse populations and identify strategies to serve all individuals in a culturally and linguistically appropriate manner.

Adult Protective Services

APD and AAA offices are responsible for investigating instances of adult abuse across the state. Elder abuse and other adult abuse is costly both from a human and financial perspective. A person who has experienced abuse is likely to have increased health and long-term care costs. In 2014, more than 18,000 allegations of abuse were received and the number of investigations of abuse conducted increased by 10 percent. More than 3,500 instances of abuse were substantiated. Financial exploitation and neglect remain the most common forms of abuse for people served by APD.

Medicaid Services

Approximately 33,000 older adults and physically disabled Oregonians use Medicaid long-term services each month, with more than 36,000 forecasted for the 2017-2019 biennium. By federal law, each state must develop criteria for access to nursing facility care paid by Medicaid. Criteria must include financial and asset tests as well as service eligibility criteria. The federal government, through Centers for Medicare and Medicaid Services (CMS), must approve any criteria established by the states.

DHS created service priority levels (SPLs) to establish eligibility for Medicaid long-term services. SPLs prioritize services for older adults and people with physical disabilities whose well-being and survival would be in jeopardy without services. Level 1 reflects the most impaired while Level 17 reflects the least impaired; levels are based on the ability of the person to perform activities of daily living (ADLs). Because of budget constraints, only levels 1-13 are funded. ADLs are personal activities required for continued well-being. These include eating, personal hygiene, cognition, toileting and mobility. Many individuals with disabilities need assistance from other people to perform daily activites. APD assists thousands of Oregonians who require ADL services in selecting competent providers and establishing effective working relationships with those service providers. Due to the increasingly diverse population served, the program requires supports that are equally diverse, linguistically and culturally appropriate.

Programs

APD's budget is sectioned into three key areas; program services, program design and program delivery.

Program Services

Program services focus on supporting fundamental ADLs such as bathing, dressing, mobility, cognition, eating and personal hygiene. Long-term services ensure that the person is living in a safe and healthy environment. All services promote choice, independence and dignity. Services can be provided in nursing facilities, or community settings such as residential care facilities, foster homes or in the person's own home.

Program services are provided through six programs:

- Older Americans Act
- Oregon Project Independence
- Direct financial support
- In-home services
- Community-based care facilities
- Nursing facilities

Older Americans Act

This is a federal program and is administered through APD. It provides federal funding for locally developed support programs for individuals ages 60 and older. APD distributes funds to local Area Agencies on Aging (AAAs) for service delivery through subcontractors. More than 230,000 Oregonians accessed these services in 2015. The AAAs develop services that meet the needs and preferences unique to individuals in their local area. Program mandates require services target those with the most significant economic and social need, to minorities and those residing in rural areas. There are no income or asset requirements to receive services except those related to the Senior Community Service Employment Program (SCSEP).

APD distributes federal funds to the AAAs using a federally approved intra-state funding formula based on the demographics and square mileage of each area. APD encourages and incentivizes culturally-specific and linguistically competent supports within all programs. Programs might include; family caregiver supports, medication management, nutrition via congregate and home-delivered meal programs, senior employment, legal services or elder abuse prevention services. They may also provide assistance to senior centers and sponsor and promote evidence-based wellness and chronic health condition management activities.

Oregon Project Independence (OPI)

This is a state-funded program offering in-home services and related supports to individuals 60 years of age and older or people who have been diagnosed with Alzheimer's or a related dementia disorder. Approximately 5,000 Oregonians are served in this program. It represents a critical element in Oregon's strategy to prevent or delay individuals from leaving their own homes to receive services in more expensive facility-based settings, or depleting their personal assets sooner than necessary and accessing more expensive Medicaid health and long-term service benefits. The program was expanded by the 2005 Oregon Legislature to include younger adults with disabilities. In 2014 and 2015 a pilot program was funded expanding the program to adults ages 19-59 with physical disabilities. Through this pilot more than 500 individuals have been served.

OPI is administered statewide by local Area Agencies on Aging (AAAs). Many areas have waiting lists due to high demand and limited program funding. Client eligibility is determined by an assessment of functional ability and natural supports

related to activities of daily living. Typical services include assistance with housekeeping, bathing, grooming, health care tasks, meal preparation, caregiver respite, chore services, adult day services and transportation.

The OPI program has no financial asset limitations for clients. A sliding fee scale is applied to clients with net monthly income between 100 and 200 percent of the federal poverty level (FPL) to pay toward the cost of service. A small group with income above 200 percent of FPL pays the full rate for services provided. Generally this is because they benefit from the case management; ongoing support and monitoring, in addition to the actual purchased services.

Direct financial support

Programs are designed to meet a variety of special circumstances for certain low-income populations.

Cash payments – special needs

APD is required to meet maintenance of effort (MOE) payment for low-income aged and disabled Oregonians who receive federal Supplemental Security Income (SSI) benefits. These benefits are focused on payments that allow clients to retain independence and mobility in a safe environment. Examples of special needs payments include help for non-medical transportation, repairs of broken appliances such as a furnace, or for such things as adapting a home's stairs into a ramp.

Employed Persons with Disabilities Program (EPD)

This program allows people with a disability to work to their full extent and not lose Medicaid coverage. To be eligible, a person must be deemed to have a disability by Social Security Administration criteria, be employed and have adjusted income of less than 250 percent of FPL. Eligible individuals pay a monthly participation fee and are eligible for the full range of Medicaid benefits and services.

Other benefits

The Centers for Medicare and Medicaid Services (CMS) requires DHS to coordinate with Medicare in many areas and clients need help accessing other programs for which they are eligible. The federal Medicare program is the most

common program clients need assistance with. APD determines client eligibility and submits client data to CMS for two Medicare-related programs: Medicare buy-in and Medicare Part D low-income subsidy. APD served more than 140,000 clients in these two programs over one year. These programs help low-income beneficiaries with their cost-sharing requirements. Securing this coverage also ensures Medicare remains in a "first payor" status, ultimately saving the state's Medicaid program significant money.

In-home services

In-home services are the cornerstone of Oregon's community-based care system. For older adults or people with physical disabilities, the ability to live in their own homes is compromised by the need for support in regular activities of daily living. For more than 25 years, Oregon has created options to meet people's needs in their own homes. All options are funded with support of the Medicaid program through home- and community-based waivers or state plan options. Oregon has been able to create cost-effective programs that meet people's needs in their homes and other community settings using these options and spared Oregonians from the unnecessary use of much higher cost services, primarily offered in nursing facilities.

Services to older adults and people with physical disabilities are designed to support assistance with fundamental activities of daily living (ADLs), such as mobility, cognition, eating, personal hygiene, dressing, toileting and bathing. In order to receive in-home services, an individual must be financially eligible for Medicaid. A case manager works with the client and together they identify needs and develop a plan for the in-home services.

Medicaid client-employed Home Care Workers

Home Care Workers (HCW) are hired directly by the client and provide many of the services Medicaid clients need to remain in their own homes. The client, or his or her selected representative, is responsible for performing the duties of an employer. These duties include selecting, hiring and providing on-site direction in the performance of the care provider duties authorized by a case manager to meet the client's individual needs and circumstances. The HCW must pass a criminal background check. In conjunction with the client, APD develops and authorizes a service plan, makes payment to the HCW on behalf of the client and provides ongoing contact with the client to ensure his or her service needs are met. More

than 18,000 clients are expected to receive services supplied by HCWs each month in 2015-17.

The Oregon Home Care Commission (HCC) was established in 2000 by an amendment to the Oregon Constitution. It is a public commission dedicated to ensuring high-quality home care services to APD clients using client-employed providers. Service Employees International Union Local 503, Oregon Public Employees Union, represents approximately 17,000 HCWs. For purposes of collective bargaining, HCC serves as the HCW employer of record. The Commission maintains a statewide, computerized registry of workers and provides an extensive training curriculum. The HCC also makes training available to clients to better understand their employer responsibilities and increase their skill in managing the use of HCWs.

In-home agency services

Many clients prefer to receive their in-home services through a home care agency. In-home agencies are licensed by the Oregon Health Authority. These agencies employ, assign and schedule caregivers to perform the tasks authorized by the client's case manager. APD contracts with licensed in-home care agencies throughout the state. Agencies work closely with DHS case managers and clients to ensure services are provided as authorized and to ensure the quality of the work performed.

Medicaid Independent Choices

This program offers a choice to clients in the way they receive in-home services and increases clients' self-direction and independence. Clients receive a cash benefit based on their assessed need. They purchase and directly pay for services. Clients are responsible for locating providers, paying their employees, and withholding and paying necessary taxes. Depending upon how they are able to manage their service benefit, many are able to purchase a few additional services or items otherwise not covered by Medicaid to increase their independence or well-being.

Medicaid adult day services

These services provide supervision and care for clients with functional or cognitive impairments. Service may be provided for half or full days in stand-alone centers, hospitals, senior centers and licensed care facilities.

Medicaid home-delivered meals

Home-delivered meals are provided for to those who are homebound and unable to go to sites, such as senior centers, for meals. These programs generally provide a hot midday meal and, often, frozen meals for days of the week beyond the provider's delivery schedule.

Medicaid personal care services

Services are limited to no more than 20 hours a month. Personal care can be used only for tasks related to the performance of activities of daily living, such as mobility, bathing, grooming, eating and personal health assistance.

Medicaid specialized living services

Services are provided to a special-need client base, such as those with traumatic brain injuries or other specific disabilities that require a live-in attendant or other 24-hour care. The services are provided through a contract with APD and targeted to a specific group of clients living in their own apartments, and assisted by a specialized program offering direct service and structured supports.

Community-based care

Community-based facilities

These include a variety of 24-hour care settings and services to provide an alternative to nursing facilities. Services include assistance with activities of daily living, medication oversight and social activities. Services can include nursing and behavioral supports to meet complex needs. State and federal guidelines related to health and safety of these facilities have to be met.

Adult foster homes

Services are provided in home-like settings licensed for five or fewer individuals who are not related to the foster home provider. Homes may specialize in certain services, such as serving ventilator-dependent residents.

Residential care facilities

Licensed 24-hour service settings serve six or more residents and facilities range in size from six to more than 100 beds. Different types of residential care include 24-hour residential care for adults and specialty memory care facilities. Registered nurse consultation services are required by regulation.

Enhanced care services

Specialized 24-hour programs in licensed care settings that provide intensive behavioral supports for seniors and people with physical disabilities who have needs that cannot be met in any other setting. These programs support clients with combined funding from APD and the Oregon Health Authority.

Assisted living facilities

These facilities are licensed 24-hour settings for six or more residents, including private apartments. Services are comparable to residential care facilities. Registered nurse consultation services are required by regulation.

Memory Care Community Endorsement

These facilities are licensed as an Assisted Living Facility or Residential Care Facility and serve individuals with Alzheimer's disease, other forms of dementia and other cognitive diseases. They are required to have enhanced training and a more secure setting for their residents. The endorsement is in addition to the underlying licensure.

Providence Elder Place

This is a capped Medicare/Medicaid Program of All-inclusive Care for the Elderly (PACE) providing an integrated program for medical and long-term services. Nearly 1,200 Oregonians age 55 and older are served in this program that generally allows them to attend adult day services and live in a variety of settings. The Elder

Place program is responsible for providing and coordinating their clients' full health and long-term service needs in all of these settings.

Nursing facilities
Institutional services for older adults and people with physical disabilities are provided 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.

Oregon has led the nation since 1981 in the development of lower cost alternatives to institutional (nursing facility) care. Home- and community-based alternatives to nursing facility services emphasize independence, dignity and choice and offer needed services and supports at lower costs than medical models.

Program Design

Staff and services support the administration of APD programs, including:

- Central leadership and administration
- Medicaid eligibility and federal waiver administration
- Development and maintenance of policy and administrative rules
- Support and leadership for various advisory councils.
- Administration of the Older Americans Act
- Home Care Commission

Program Delivery

Staff and services provide direct services to Oregonians, including:

- Direct service staff located in local offices throughout the state
- Presumptive Medicaid Disability Determination Team
- State Family/ Pre-SSI
- Disability Determination Services
- Administration of Medicare Modernization Act and Buy-in programs
- Provider payments and relations
- Adult Protective Services investigations
- Adult Foster Home licensing

Eligibility and case management services are delivered throughout the state by APD and AAA employees. ORS Chapter 410 allows AAAs to determine which

populations they wish to serve and which programs they wish to administer. Type B Transfer AAAs choose to provide Medicaid services in addition to Older Americans Act and OPI services. In areas where the AAAs (Type A AAAs) do not provide Medicaid services, APD has local offices to serve older adults and people with physical disabilities.

History

During the past 30 years there has been a profound shift in society's understanding of the importance of independence for aging and people with physical disabilities. Traditionally, states had provided services to these individuals in institutional settings such as nursing facilities. Oregon's first nursing facility opened in the 1940s. With the passage of the federal statute creating Medicaid, the state began to pay for nursing facility services for eligible individuals in the 1960s.

The Older Americans Act also passed in the 1960s, which over time, has expanded additional protections and services to vulnerable older adults, including access to home-delivered meals, senior centers, transportation, family caregiver support, legal services and the Office of the Long Term Care Ombudsman to uphold rights and resolve complaints.

Professional standards and public thinking about how to best serve people with disabilities began to change and community living became more accessible. Civil rights were strengthened and expanded by the Americans with Disabilities Act, in the areas of employment, public accommodations, transportation and housing. Community integration, a right, became more available to individuals with disabilities as accessibility increased and society began to accept people with disabilities as part of the community. Families had the ability to remain intact and to keep their loved ones — child, adult or senior — at home.

Federal dollars to fund Medicaid waivers first became available in 1981 for "Home and Community-Based Services." That same year, the Oregon Legislature updated its policies around disabilities and found that significant numbers of people with disabilities lived in institutions because adequate community services did not exist. The Legislature mandated that the state work to empower people with disabilities, keep them as independent as possible, and develop service settings that were alternatives to institutionalization. The 1981 Oregon Legislature also created the Senior Services Division and a strong statutory mandate to support seniors in their own homes and community settings outside of institutions. This action forged the

way for Oregon to lead the nation in the development of lower-cost alternatives to institutional care.

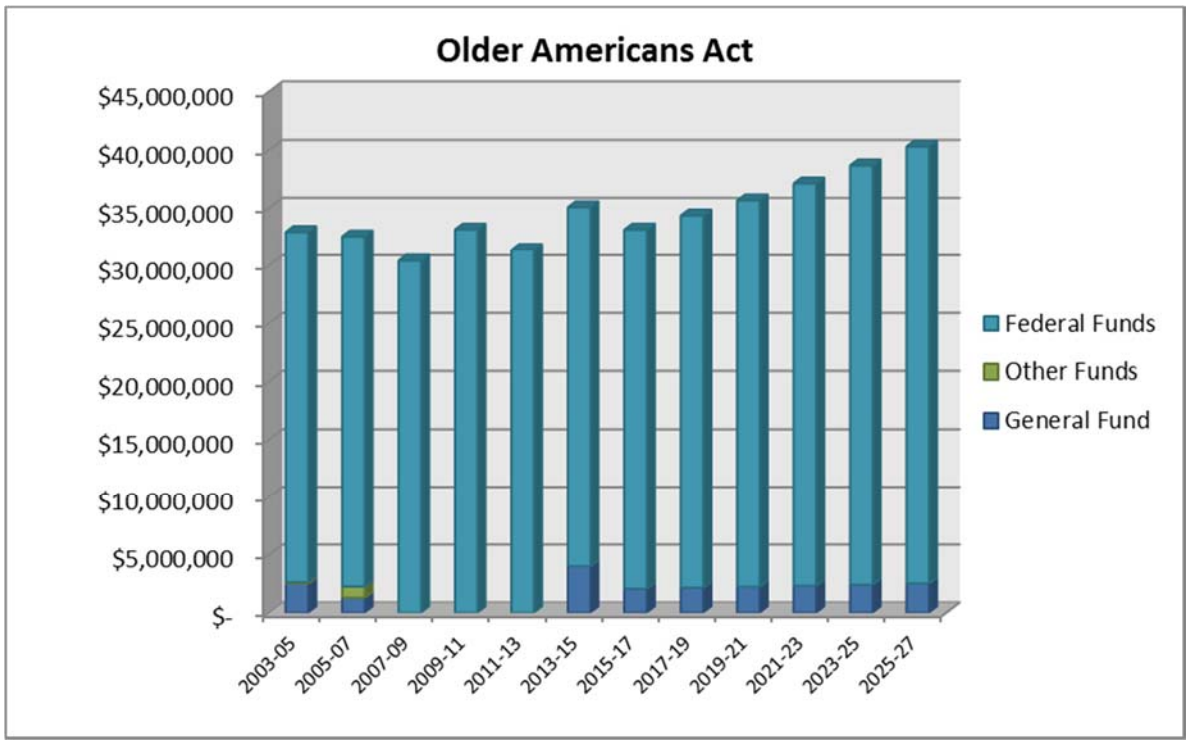
In response to that mandate, Oregon applied for, and received, the first home and community-based waiver that allowed Medicaid funds to provide long-term services outside an institution. Throughout the 1980s and 1990s, Oregon received waivers that allowed services for unique groups of people. For Medicaid-eligible older adults and people with disabilities in Oregon, this has meant that the provision of long-term care has, in large measure, shifted away from nursing facilities to in-home services, assisted living facilities, residential care facilities and adult foster homes.

Future populations

The aging population is growing rapidly. The number of people in the United States over age 65 is projected to nearly double from 40.2 million in 2010 to more than 71.4 million people by 2030. In 2010, approximately 13 percent of Oregon's population was 65 years or older. By 2030, the percentage is expected to increase to nearly 20 percent. In Oregon, people 85 years or older make up a small but rapidly growing group within the total population. By the end of 2010, approximately 76,000 Oregonians will have reached age 85. By 2030, the number is expected to reach nearly 120,000, an increase of almost 57 percent. Cultural diversity, including individuals of different races, ethnicities and sexual orientation will require new approaches to service delivery that ensure all individuals achieve desired outcomes.

Department of Human Services: Older Americans Act

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Outcome Area:
Program Contact: Ashley Carson Cottingham



Older Americans Act funding comes primarily from the federal government. In 2011, OAA funding helped serve nearly 380,000 Oregonians.

Program Overview

Services and supports provided to individuals under the Older Americans Act (OAA) provide vital assistance designed to prevent or delay entry into Medicaid-funded long-term care such as In-Home or 24-hour residential services. The OAA is a Federal law that set out a national aging network structure consisting of the U.S. Administration on Aging (AoA) now part of the Administration for Community Living, State Units on Aging (DHS/Aging and People with Disabilities program), and Area Agencies on Aging (AAAs). The OAA authorizes funding and services through this network to serve older individuals in their homes and communities, through local entities. All individuals, aged 60 or older,

regardless of income are eligible to receive services but the programs are targeted towards those in greatest social or economic need. A specific focus on how to better serve diverse populations of older adults across race/ethnicity, sexual orientation, gender, veteran status, and other intersecting categories are essential with the continually changing demographics of Oregon.

Program Funding Request

Older Americans Act				
	GF	OF	FF	TF
15-17 LAB	$ 2,077,127	$ -	$ 31,055,014	$ 33,132,141
17-19 GB	$ 2,153,981	$ -	$ 32,204,050	$ 34,358,031
Difference	$ 76,854	$ -	$ 1,149,036	$ 1,225,890
% Difference	4%	0%	4%	4%

Program Description

Older Americans Act services are administered entirely by local Area Agencies on Aging. To qualify for OAA supported services an individual must meet the following criteria:

- Be 60 years of age or older;
- Be a caregiver of someone 60 years of age or older (or younger if the person is diagnosed with Alzheimer's Disease or related dementia) or an older individual caring for a child 18 years of age or younger;
- Be 55 or older and have an adjusted income at or below 125 percent of Federal Poverty Level for the Senior Community Service Employment Program (Title V).

Please Note: There is no income or asset/resource criteria for eligibility, except for the Senior Community Service Employment Program (Title V).

The Older Americans Act authorizes services and funding by title

Title III
Supportive Services
Provides assistance to maintain independence through assisted transportation, information and referral/assistance, in-home care, adult day care, chore services, home modification and other housing help, legal assistance, mental health

outreach, and assistive devices. Title III also funds Oregon's Aging and Disability Resource Connection (ADRC), which provides unbiased information, referral, and options counseling for individuals (consumers, family members, caregivers) needing long-term services and supports.

Nutrition Services
In order to reduce hunger and food insecurity and promote socialization, health, and well-being the Act authorizes both home-delivered (commonly known as Meals on Wheels) and congregate (community setting, senior center, community center, etc.) meals programs. The Act also provides nutrition education and counseling.

Services Incentive Program (NSIP)
Supplements funding authorized under Title III for food used in meals served under the Older Americans Act. States receive an allocation based on the number of meals served under the OAA in the state in proportion to the total number of meals served by all states.

Preventive Health Services
Authorizes evidence-based programs that promote healthy lifestyles through physical activity, appropriate diet and nutrition, self-management of chronic health conditions and regular health screenings.

National Family Caregiver Support Program
Provides individual and group options counseling, training, and respite care for family members and friends who are primary caregivers to seniors. This program also provides support to grandparents raising grandchildren.

Title V
Senior Community Service Employment Program (SCSEP)
Authorizes a community service and work-based training program for older workers that provides subsidized, service-based training for low-income persons 55 or older who are unemployed and have poor employment prospects. Participants are paid minimum wage for approximately 20 hours per week while they develop valuable skills and connections to help them find and keep jobs in their communities. Title V funding is awarded to DHS/APD from the U.S. Department of Labor and is competitively sub-granted to a qualified job training organization.

Title VII

Elder Rights Services

Provides a focus on the physical, mental, emotional and financial well-being of older Americans. Services include pension counseling, legal assistance, and elder abuse prevention education.

Ombudsman Program

Establishes an Office of the State Long-Term Care Ombudsman program to identify, investigate, and resolve complaints made by or on behalf of residents of licensed care facilities (nursing homes, assisted living, and adult foster homes) and promote system changes that will improve the quality of life and care for residents. The allocation for this program is 100 percent passed through to the Office of the Long-Term Care Ombudsman, a separate state agency from APD.

OAA Funding

OAA funding is granted to each State Unit on Aging (DHS/APD) based on a population formula. The State Unit on Aging sub-grants Title III funds to Oregon's 17 designated Area Agencies on Aging (AAA) based on a state population formula. The AAAs work with their local communities to assess and develop a menu of services that meet the needs of older adults in their planning and service area. Subsequently, the AAA submits an Area Plan to the State describing the delivery of OAA services in their communities; this is basis for the funding agreement between the AAA and DHS/APD.

Program Justification and Link to Focus Areas

OAA program services contribute to the Safer, Healthier Communities goal. The OAA, in partnership with providers and clients, provides vital support for older adults who are at significant risk of losing their independence by providing food, job training/opportunities, social support, transportation, chronic disease self-management and fall prevention.

Annual State Program reports are submitted to the Administration on Community Living, consisting of service unit data and client demographics. Evidence-based programs supported by the preventive health services funding under Title III have provided an opportunity to demonstrate health care cost-saving based on the research supporting the programs. The Senior Community Service Employment Program tracks six performance measures each year including employment and retention. Performance standards and measures have recently been established for

the Aging and Disability Resource Connections Program and will be tracked appropriately.

Program Performance

- **Number of people served/items produced**
  OAA data reporting requires AAAs to capture identifiable unduplicated clients who receive "registered services" and an estimated number of clients receiving "non-registered services." Registered services include personal care, home care, chore, meals, day care, case management, assisted transportation, caregiver, and nutrition counseling. Non-registered services include but are not limited to information and assistance, health promotion programs, group education, etc. The estimated number of non-registered service clients is 5-6 times that of the registered services clients (e.g. in 2011 OAA served 50,649 registered clients and an estimated 338,234 non-registered participants).

- **Quality of the services provided**
  Program standards have been established for the major services and annual program monitoring is conducted.

- **Timeliness of services provided**
  The Family Caregiver Support Program of the OAA is the only service area that consistently encounters wait lists.

- **Cost per service unit**
  Varies depending on the level of community support, the OAA funding on average supports about one-third of the cost of service. Further funding comes from local governments, donations, and fundraising.

  The following are selected examples of program performance for the OAA:

Older Americans Act Nutrition Program

	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY14*
Total Registered Service Clients	58,311	66,942	61,652	54,049	50,649	54,149	52,809	48,730
Home-Delivered Meal Clients	12,826	17,605	14,152	13,891	13,441	13,630	12,636	12,652
Congregate Meal Clients	35,100	44,511	42,398	37,980	34,432	34,828	36,102	32,844
# of Home-Delivered Meals Served	1,747,541	1,699,180	1,705,901	1,675,082	1,667,493	1,601,457	1,734,292	1,620,727
# of Congregate Meals Served	1,023,497	1,029,856	981,866	1,006,814	977,815	949,202	941,152	924,300
# of High Nutritional Risk Persons	9,402	9,355	14,056	15,060	16,232	11,713	11,634	12,180

*Preliminary State Program Report data

Senior Community Service Employment Program (SCSEP)

Performance Measure	PY07	PY08	PY09	PY10	PY11	PY12	PY13
Participants Served	218	243	257	320	212	180	156
Community Service Level	61.3%	78.7%	75.5%	83.7%	97.0%	80.4%	83.9%
Entered Employment Level	42.2%	42.7%	50.7%	45.3%	47.5%	34.8%	39.7%
Employment Retention	73.0%	69.7%	51.6%	68.4%	72.1%	29.0%	75.0%
Average Earnings Per Participant	$9,076	$6,360	$4,453	$9,032	$7,906	$8,914	$7,482

Enabling Legislation/Program Authorization

Federal Law: 45 CFR, Part 1321.

Funding Streams

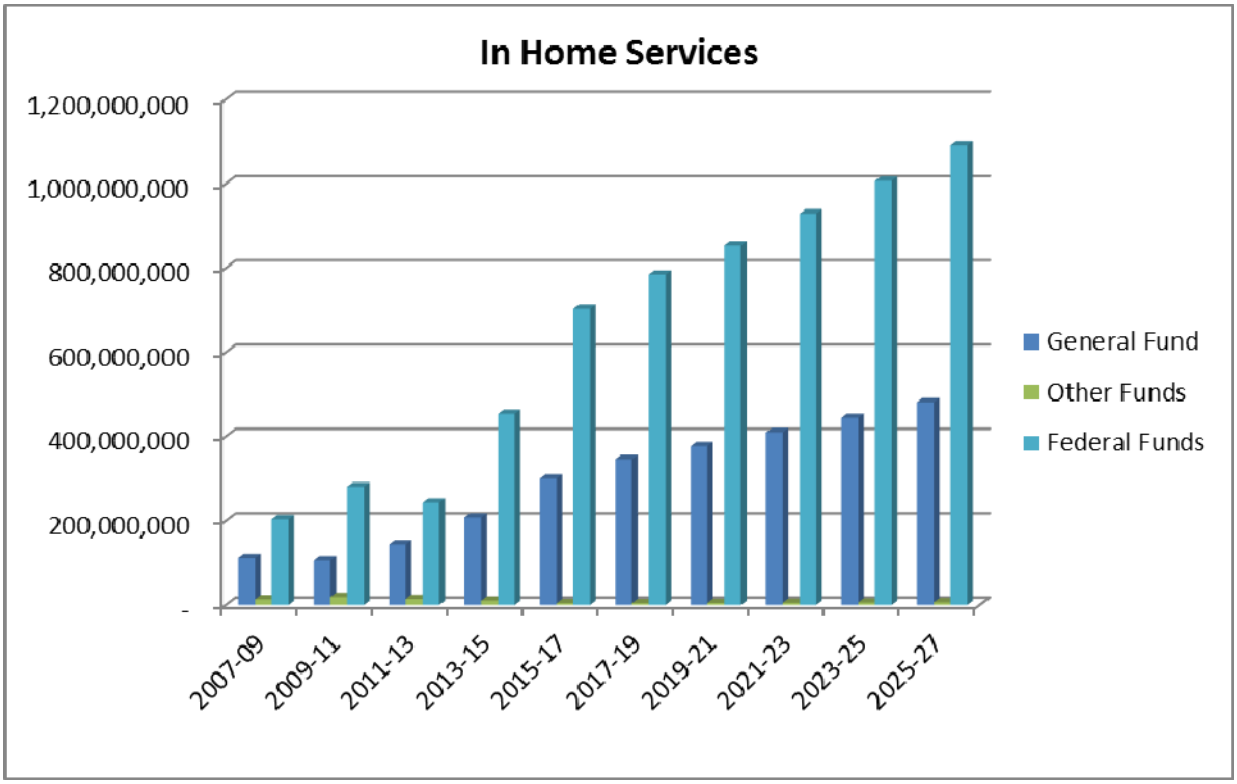
OAA funds are 100 percent federal. The law has a required Maintenance of Effort and state match of $5 million per biennium, which is met with state funding authorized for the Oregon Project Independence Program (ORS 410.410 to 410.480). OAA funding was never intended nor does it fully fund services. Each dollar of OAA funding is leveraged with $2 of state and local funds, participant donations, and community fundraising. Additionally, the services are enhanced with the in-kind support of volunteers, donated community space and equipment, etc.

Funding Justification and Significant Changes to CSL

This does not include statewide reductions. The agency's request is to continue at the current service level for 2017-2019.

Department of Human Services: Medicaid Long-Term Care In-Home Services

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Ashley Carson Cottingham



In the 13-15 biennium, in-home agency and personal care budgets were moved from 'other services' to In-Home care for reporting purposes.

Program Overview

In-home services are the least restrictive service offered in Oregon's long-term care continuum. This program funds Medicaid long-term care services to seniors and people with disabilities in their own homes for individuals who are eligible to receive the same services in a nursing facility. In 2013, Oregon added a new Medicaid, 1915(k) State Plan Option, or "K plan," that provides additional flexibility and funds. Approximately 52.5 percent of individuals served in Oregon's long term care system are served in their own homes. In-home services

offer an opportunity to provide differentiated care in a respectful, sensitive, and inclusive manner to Oregonians from a variety of diverse backgrounds.

Program Funding Request

APD In Home Care				
	GF	OF	FF	TF
15-17 LAB	$ 299,600,294	$ 4,385,313	$ 703,169,212	$ 1,007,154,819
17-19 GB	$ 346,018,375	$ 4,589,092	$ 784,422,127	$ 1,135,029,594
Difference	$ 46,418,081	$ 203,779	$ 81,252,915	$ 127,874,775
% Difference	15%	5%	12%	13%

Program Description

This cost-effective program enables eligible low-income seniors and people with disabilities to remain in their own homes and established communities. Individuals from culturally diverse backgrounds benefit from this program that provides enhanced independence, health, safety, and quality of life. Oregon's model of long-term care is referred to as a social model, distinctly different from a medical model of care. Social models of care focus on client autonomy, respect, choice, and individualized care planning. Individuals are viewed holistically, with provided supports that enhance independence, dignity, and respect.

Eligibility for services is based upon a combination of financial criteria and service needs. An individual's service needs are calculated as a "service priority level" which ranges from 1 (highest need) to 18 (lowest need). In the 2003 budget crisis, funding to serve individuals with service priority levels 14 through 18 was eliminated. These levels remain unfunded through Medicaid; however, some (not all) of the needs can be met for these individuals through Older Americans Act and Oregon Project Independence programs.

In-home supports include necessary assistance with activities of daily living (walking, transferring, eating, dressing, grooming, bathing, hygiene, toileting, and cognition) and instrumental activities of daily living (meal preparation, housekeeping, laundry, shopping, medication, and oxygen management). Assistance ranges from several hours per week to 24 hours per day. Without these supports, more than 17,000 individuals would likely receive services in a more costly nursing facility. Oregon provides a variety of in-home service options available to individuals based on preference, choice, and cost-effectiveness.

Consumer-Employed Provider Program

Individuals participating in this program receive services from hourly or live-in homecare workers. The in-home recipient is considered the employer and is empowered and responsible to hire, train, supervise, track hours worked, address performance deficiencies, and discharge providers. Homecare workers are paid a set rate established through collective bargaining, which the State pays on the individual's behalf. The Oregon Home Care Commission establishes homecare worker enrollment standards and training for homecare workers, both of which contribute to the quality of in-home services. APD is forecasted to serve more than 20,000 individuals in this program in the 2017-2019 biennium.

Independent Choices Program

This program is a 1915(j) State Plan Option and allows individuals to exercise more decision-making authority in identifying, accessing, managing, and purchasing goods and services that enhance independence, dignity, choice, and well-being. This option is popular among individuals who wish to take complete control over the planning and provision of services. In the Independent Choices Program, the cost of the established service plan is "cashed-out" and deposited into the eligible individual's dedicated Independent Choices Program checking account. The individual then pays providers directly based on a negotiated rate. Participants have the flexibility to use a portion of the funds to purchase goods that enhance their independence and are unavailable through the medical plan, such as a wheelchair lift for a vehicle or a wheelchair ramp for their home. The state performs periodic monitoring with an emphasis on safety and program integrity. APD is forecasted to serve 587 individuals in this program in the 2017-2019 biennium.

Specialized Living Services

These services are designed to serve a specific special-needs consumer base, such as those with traumatic brain injuries or other specific disabilities who would otherwise require a live-in attendant or other 24-hour care. The services are provided through contracts with qualified vendors who provide specialized, shared-attendant services to individuals living in their own homes or apartments. APD is forecasted to serve more than 200 individuals in this program in the 2017-2019 biennium.

Cost Drivers

The major cost drivers of the in-home services program are the current number of eligible individuals, their level of needed assistance, the length of time receiving services, and the growing population of those requiring services. The population served is much different than it was 30 years ago when Oregon first received a waiver. With the advancement of medical technology and treatment options, individuals are living longer with chronic disease and significant disabilities. Another major cost driver is the provision of wages and benefits for homecare workers tied to collective bargaining. This includes set wages, paid time off, workers' compensations premiums, unemployment insurance, and other benefits.

Program Justification and Link to Focus Areas

In-home services link to the Safer, Healthier Communities focus area. In the early 1980s, Oregon was the first state awarded a Medicaid 1915(c) Home and Community-Based Services waiver from the Centers for Medicare and Medicaid Services, which allowed Oregon to serve individuals in their homes and communities. In 2013, Oregon added a new, 1915(k) State Plan Option, or "K plan," that provides additional flexibility and funds. In an independent study conducted by AARP, Oregon received an overall ranking of 3rd out of 50 states in terms of choice of settings and providers, quality of life and quality of care, and effective transitions from nursing facilities back into the community. Across the nation, Oregon continues to be a leader for serving individuals in their own homes.

The program empowers individuals to direct their own services and make choices that enhance their quality of life, live with dignity, and remain as independent as possible. Health is maintained through the provision of necessary assistance with activities of daily living and instrumental activities of daily living. Consistent provision of services, including medication management and the preparation of nutritious meals, delays or diverts an individual's entry into more costly care settings.

Program Performance

A key goal of the Department of Human Services (DHS) is that people are safe and living as independently as possible. DHS currently measures this goal based on the percentage of individuals living in their own homes in lieu of a licensed care facility, as well as the percentage of individuals who move to a less restrictive service setting. Currently, DHS is serving 87.2 percent of all recipients in home- and community-based settings. In the 2017-2019 biennium, DHS is forecast to increase this level to 88.9 percent.

Enabling Legislation/Program Authorization

Medicaid is an entitlement program that was enacted in 1965 under Title XIX of the Social Security Act. Eligible individuals have the right to receive long-term care services in a nursing facility. While states are not required to participate in Medicaid, they must follow Medicaid rules to receive federal matching funds. Oregon's Long Term Care system operates under a variety of Medicaid options which allows long term care services to be provided in home and community based settings.

Funding Streams

In-home services are funded through the Medicaid program. Therefore, the federal government pays approximately 69 percent and the state pays 31 percent. There is a small amount of funding from the estates of former recipients. When a Medicaid recipient dies, DHS is required by federal law to recover money spent for the individual's care from the recipient's estate. These funds are reinvested in services for other individuals, offsetting the need for general funds.

Funding Justification and Significant Changes to CSL

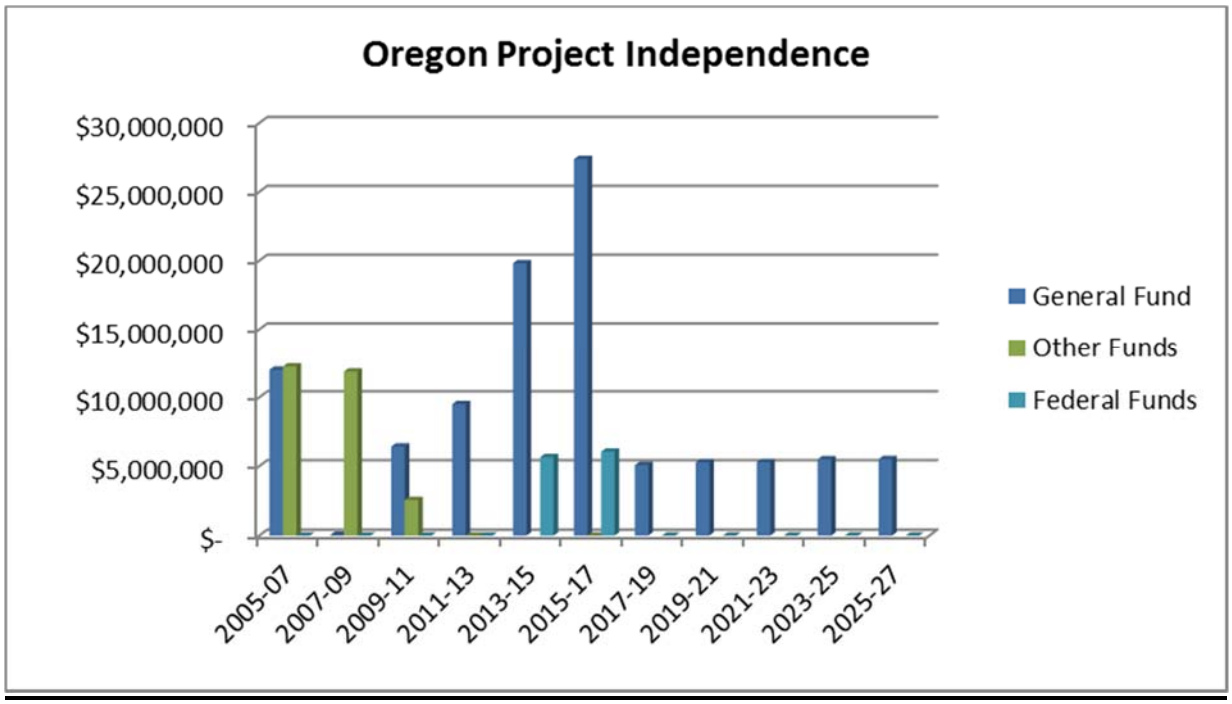
This does not include statewide reductions. The agency's request is to continue at the current service level for 2017-2019.

Reductions:

- Eliminate the Live-in Program as of July 1, 2017 – move consumers to Hourly program - At the time of this report, there are approximately 350 individuals remaining in the Live-in care program ($20,823,405 GF).

Department of Human Services: Oregon Project Independence

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Ashley Carson Cottingham



Program Overview

Oregon Project Independence (OPI) provides preventive and in-home services and supports to a diverse population of eligible individuals to reduce the risk of out-of-home placement and promote self-determination. This program optimizes eligible individuals' personal and community support resources to prevent or delay spend down to Medicaid-funded long-term care, which could consist of in-home or other 24-hour residential services.

Program Funding Request

Oregon Project Independence				
	GF	OF	FF	TF
15-17 LAB	$ 26,111,625	$ -	$ 12,630,938	$ 38,742,563
17-19 GB	$ 5,077,755	$ -	$ -	$ 5,077,755
Difference	$ (21,033,870)	$ -	$ (12,630,938)	$ (33,664,808)
% Difference	-81%	0%	-100%	-87%

Program Description

Oregon Project Independence (OPI) is a state-funded program offering in-home services and related supports to a diverse population of Oregonians. DHS/APD strives to deliver in-home services in a culturally and linguistically appropriate manner. OPI provides essential services such as personal care, homecare and chore assistance, adult day care, service coordination, registered nursing (teaching/delegation of nursing tasks to caregivers), and home-delivered meals. This program complements services provided under the Older Americans Act.

Traditionally, OPI has served individuals who are 60 years of age or older are assessed as needing assistance with activities of daily living (eating, dressing/grooming, bathing/personal hygiene, mobility, elimination, and cognition) and/or instrumental activities of daily living (housekeeping, shopping, transportation, medication management and meal preparation) and are not receiving Medicaid. Also, individuals under age 60 who have been diagnosed with Alzheimer's disease or a related disorder are also eligible. The program was expanded by the 2005 Oregon Legislature to include younger adults with disabilities and recently $6 million to continue funding for a pilot program has been made available to support this expansion.

There are neither income nor resource requirements for eligibility; however, these factors are taken into consideration when assessing the individual's risk of needing Medicaid long-term care. OPI clients do not pay a charge for the service coordination services they receive. Services other than service coordination are provided at no cost to families with net incomes at or below 150 percent of the federal poverty level (FPL). Families with net incomes from 150 percent to 400 percent FPL pay a fee toward services using a sliding scale based on income. Families with net incomes at or above 400 percent FPL pay the full cost of the services provided (other than service coordination).

In a 2012 study of selected comparable clients, OPI clients used 24 percent of the hours that Medicaid clients used. The hourly rates are the same for homecare worker services in the two programs. OPI clients used 24 percent of the billed hours compared to Medicaid. Due to budget restrictions, the OPI program has capped the number of hours available to each client. In addition to personal and home care hours, Medicaid eligibility also provides individuals with benefits for comprehensive healthcare under the Oregon Health Plan (OHP) and pays for these costs. OPI clients do not access OHP so the healthcare expenditures are $0.

Oregon Project Independence services are delivered statewide through the network of 17 designated Area Agencies on Aging (AAAs). Administrative cost efficiencies have been realized in one area of the state where neighboring AAAs collaborated to jointly secure contracted services of a single in-home care agency. Similar partnerships should be encouraged statewide.

Program Justification and Link to Focus Areas

OPI contributes to the Safer, Healthier Communities focus area and has a desired outcome to "decrease the number of older Oregonians that access Medicaid-funded long-term care." Data reported by the Area Agencies on Aging in 2009 revealed that 63.6 percent of OPI clients had income below the FPL (33.1 percent between 100 percent and 200 percent of FPL and 3.3 percent over 200 percent of FPL). This data also revealed that fewer than 10 percent of OPI clients transitioned to Medicaid-funded services, despite the high rate of OPI clients whose income was at or below the FPL. AAAs are currently maintaining waiting lists of individuals who are eligible to be served by OPI. Annually, the "unable to serve" lists of individuals will be evaluated to determine how many of these individuals accessed Medicaid-funded services while waiting to be served by OPI.

This program empowers individuals to direct their own services and make choices that enhance their quality of life, live with dignity, and remain as independent as possible. Health is maintained through the provision of necessary assistance with activities of daily living and instrumental activities of daily living.

Program Performance

- **Recent data on number of individuals accessing OPI:**

	15-Sep	15-Oct	15-Nov	15-Dec	16-Jan	16-Feb	16-Mar	16-Apr
60+ years	2,790	2,617	2,591	2,534	2,450	2,382	2,272	2,139
19-59 years	296	286	297	304	309	314	310	307
Total	3,086	2,903	2,888	2,838	2,759	2,696	2,582	2,446

- **Quality of the services provided**
  Personal and home care services are delivered via licensed in-home care agencies or registered home care workers. Quality of care standards for in-home care agencies are set forth in licensing rules found in OAR Chapter 333, Division 536; compliance with licensing standards is monitored by the Health Care Licensing and Certification unit of the Public Health Division. Home Care Workers who provide services to OPI clients are required to be registered with the Home Care Commission and receive background checks and ongoing training.

- **Cost per service unit**
  The average monthly cost of services to an OPI client is $332. This average is calculated using a combination of direct, administrative, and other costs.

Enabling Legislation/Program Authorization

OPI is authorized under Oregon law at ORS 410.410 to 410.480.

Funding Streams

OPI is comprised of majority State General Funds with a small amount of Federal match funding. Services are expanded through the utilization of program income generated from client cost sharing based on a sliding fee schedule.

OPI serves as the required Maintenance of Effort (45 CFR Sec. 1321.49) and state match (45 CFR Sec. 1321.47) to receive federal funding under the Older Americans Act. At least $5 million per biennium in state funds is needed to maintain the Maintenance of Effort and match requirements of the OAA.

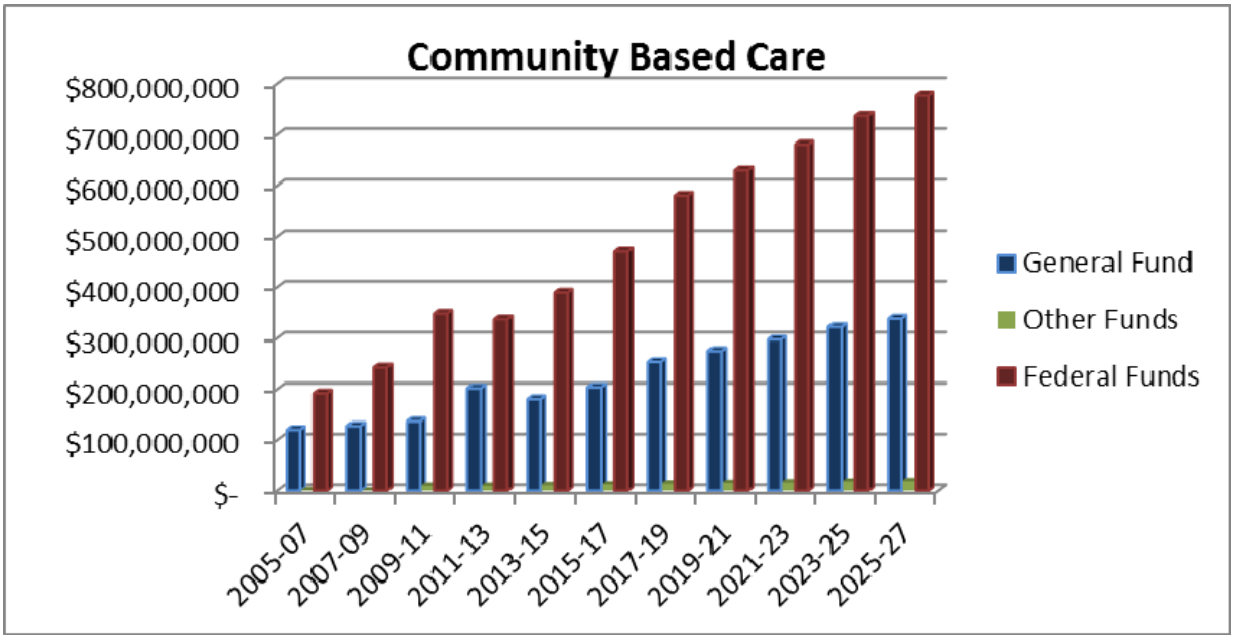
Funding Justification and Significant Changes to CSL

This does not include statewide reductions. The agency's request is to continue at the current service level for 2017-2019.
Reductions:

- Eliminate OPI for people with disabilities - Approximately 300 individuals per month will lose access to the OPI people with disabilities program if funding is eliminated ($6,000,000 GF).
- Reduce OPI by $10M - We estimate that approximately 1,000 of the over 2,100 individuals currently being served per month by the traditional OPI program will no longer have access to these services if OPI is reduced by this amount ($10,000,000 GF).
- Reduce OPI by another $6M - We estimate that approximately 1,000 of the over 2,100 individuals currently being served per month by the traditional OPI program will no longer have access to these services if OPI is reduced by this amount. This is an additional $6 M, leaving $5 M to cover the Maintenance of effort requirements for the OAA Federal Grants ($6,000,000 GF).

Department of Human Services: Medicaid Long-Term Care Community-Based Care

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Ashley Carson Cottingham



Access to care was challenging when a robust private-pay market existed in the mid-2000s. An investment by the Legislative Assembly in 2008 strengthened access considerably.

Program Overview

Community-based care is considered the middle layer of Oregon's long-term care continuum and includes a variety of 24-hour care settings and services for low-income seniors and people with physical disabilities who cannot meet their own activities of daily living. These services are part of Oregon's nationally recognized home and community- based care system, which provides a critical, cost-effective alternative to nursing facilities.

Program Funding Request

Community Based Care				
	GF	OF	FF	TF
15-17 LAB	$ 203,993,634	$ 12,401,777	$ 470,391,968	$ 686,787,379
17-19 GB	$ 253,611,174	$ 14,091,754	$ 580,559,997	$ 848,262,925
Difference	$ 49,617,540	$ 1,689,977	$ 110,168,029	$ 161,475,546
% Difference	24%	0%	23%	24%

Program Description

The State of Oregon strives to meet the needs and expectations of increasingly diverse populations, and community-based care provides a critical alternative to nursing facilities for seniors and people with disabilities who cannot meet their own daily needs.

Eligibility for long-term care services and supports is based upon a combination of financial criteria and service needs. Recipients contribute their own funds toward room and board directly to community-based care facilities, while the state pays for services consisting mostly of assistance with activities of daily living (walking, transferring, eating, dressing, grooming, bathing, hygiene, toileting, and cognition) and instrumental activities of daily living (meal preparation, housekeeping, laundry, shopping, medication, and oxygen management). Nursing facility care is a guaranteed Medicaid benefit to eligible individuals. If the state did not use alternatives to nursing facility level of care, more than 12,000 individuals would likely be receiving services in nursing facilities at more than 300 percent of the cost of community-based care services.

Community-based care includes:

- Adult foster homes, which serve five or fewer individuals in a home-like setting.

- Residential care facilities (RCF), which serve six or more individuals in a facility with private or shared rooms and common areas.

- Assisted living facilities (ALF), which serve individuals in their own apartments.

- Memory care facilities, dually licensed as either an ALF or RCF, specializes in serving individuals with dementia.

- Enhanced-care services, which serve individuals with significant limitations complicated by mental health needs. This program is jointly funded between DHS and the Oregon Health Authority - Addictions and Mental Health Division).

- Program of All-Inclusive Care for the Elderly (PACE) serves more than 1,000 individuals via a fully capitated premium. The program is jointly funded with Medicare and Medicaid dollars and provides an integrated program for medical and long-term services. Participants are 55 years of age or older, generally attend adult day services, and live in a variety of settings representative of Oregon's long-term care continuum. Oregon's only PACE provider, Providence Elderplace, is responsible for providing and coordinating the full health and long-term service needs of their clients in all of these setting types.

APD competes with the private pay market for access to most community-based care. Most facilities have a mix of private pay and Medicaid residents. As the society ages and the economy strengthens, APD may lose access due to competition for open beds with the private pay market.

Adult foster homes are represented by SEIU and have collective bargaining rights. Factors such as safety and quality cannot be negotiated; however, issues such as training and service rates are mandatory subjects of bargaining.

Each community-based care setting must meet federal and state laws and regulations related to health, safety and service delivery. Mandatory services include assistance with activities of daily living, medication oversight, and social activities. Some settings that serve individuals with more complex needs may include additional services, such as nursing and behavioral supports.

Program Justification and Link to Focus Areas

Community-based care is a direct link to the Safer, Healthier Communities focus area (Oregonians are healthy and have the best possible quality of life at all ages). The program maximizes federal resources while reducing unnecessary costs in higher levels of care. With one of the lowest levels of nursing facility utilization in the country, Oregon is at the forefront of using community-based care as a core

alternative to nursing facilities. With ongoing support, Oregon can meet the target of serving 90 percent of the publicly funded long-term care caseload in-home and community-based care in the next ten years (up from 86 percent).

Program Performance

A key goal of the Department of Human Services (DHS) is that people are safe and living as independently as possible. DHS currently measures this goal based on the percentage of individuals living in their own homes in lieu of a licensed care facility, as well as the percentage of individuals who move to a less restrictive service settings such as community- based care. As of May 2016, DHS served 11,750 individuals in community based care, compared to 4,297 in nursing facilities.

Community-based care service plans have been proven to be a cost-effective alternative to nursing facility care. Costs range by facility type and assessed need of the individual. The monthly average cost by setting is:

- AFHs $2,576
- RCFs $1,634
- ALFs $2,346

The cost of similar services provided in a nursing facility exceeds $8,400 per month.

Enabling Legislation/Program Authorization

Community-based care is operated under a variety of Medicaid home and community-based services. The newest mechanism is the 1915(k) State Plan Option or, “K plan.” The state provides services that substitute for nursing facility services, the mandated benefit for Medicaid eligible individuals under Title XIX of the Social Security Act. Additionally ORS 410 and ORS 443 provide statutory policy and structure to the services offered.

Funding Streams

Community-based care services are funded through the Medicaid program. Therefore, the federal government pays approximately 69 percent and the state pays 31 percent. There is a small amount of funding from the estates of former

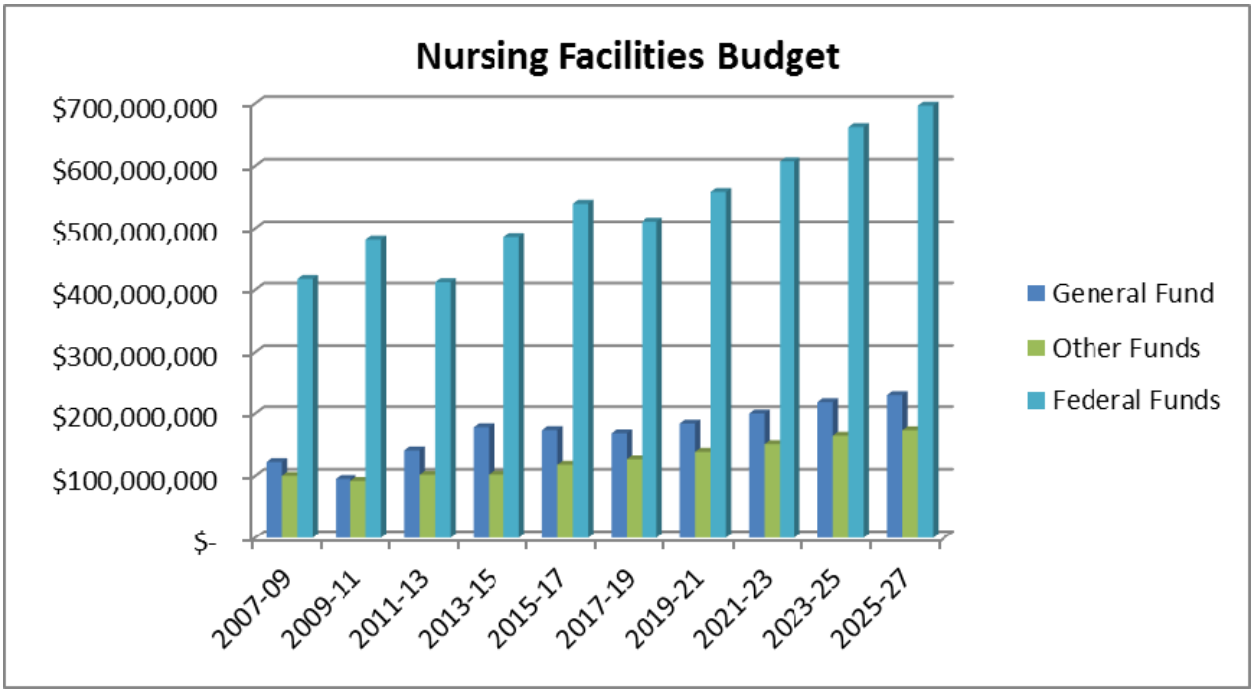
recipients. When a Medicaid recipient dies, the state is required by federal law to recover money spent for the individual's care from the recipient's estate. These funds are reinvested in services for other individuals, offsetting the need for general funds.

Funding Justification and Significant Changes to CSL

This does not include statewide reductions. The agency's request is to continue at the current service level for 2017-2019.

Department of Human Services: Medicaid Long-Term Care Nursing Facilities

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Ashley Carson Cottingham



State general fund investments decreased with the passage of the provider tax. Caseload has shifted toward an overall downward trend as more and more individuals choose to receive long-term care services in a home or community-based setting.

Program Overview

Nursing facility services are the institutional option available in Oregon's long-term care continuum, which also consists of in-home and community-based care. Nursing facilities are generally considered the most restrictive setting of the three options offered; however, this program is important for individuals with the highest levels of acuity and is a mandated federal benefit under the Medicaid program. Nursing facility level of care is the guaranteed benefit (entitlement) by federal law.

Program Funding Request

Nursing Facilities				
	GF	OF	FF	TF
15-17 LAB	$ 173,620,301	$ 118,315,172	$ 539,928,011	$ 831,863,484
17-19 GB	$ 168,445,175	$ 127,159,741	$ 511,149,918	$ 806,754,834
Difference	$ (5,175,126)	$ 8,844,569	$ (28,778,093)	$ (25,108,650)
% Difference	-3%	0%	-5%	-3%

Program Description

Nursing facilities are most appropriate for people with high acuity needs requiring 24-hour medical oversight and a protective/structured setting. They offer short-term care for individuals who need rehabilitation or 24-hour nursing. They may be appropriate for a limited number of individuals who need long-term care due to permanent health problems too complex or serious for in-home or community-based care settings.

Nursing facility rates cover basic, complex, pediatric, enhanced care, and post-hospital extended care. Services will vary in nursing care facilities, but generally consist of the following:

- Medical treatment prescribed by a doctor
- Physical, speech, and occupational therapy
- Assistance with personal care activities such as eating, walking, bathing, and using the toilet (custodial care)
- Social services.

Oregon currently has 137 licensed nursing facilities with 11,173 licensed beds, a decrease in both since the 2015 Legislative Session. These facilities have approximately 2.65 million annual resident days, of which approximately 59 percent are Medicaid clients. The annual resident days increased by approximately 12,000 in 2015, the first increase since we began measuring total days. The majority of residents were admitted directly from acute care hospitals with a very small percentage from home. In 2015, the average length of stay for nursing facility residents is 133 days with a median of 23. Approximately 82 percent of all nursing facility residents stayed less than 3 months. Over 80 percent of nursing facility residents are aged 65 and older.

Payer	Long-Term Care – Nursing Facility
Medicare	23%
Medicaid	59%
Private Pay	16%

The main cost drivers are low census in nursing facilities, the length of stay in a nursing facility, and the steady increase in the daily reimbursement rate. The nursing facility reimbursement rate is tied to the provider assessment statute. The current nursing facility reimbursement rate is $281.08 per resident per day, and the provider assessment rate is $22.99. In the 2017-2019 biennium, the provider assessment is expected to account for approximately $127.6 million of $2.1 billion in expenditures.

Program Justification and Link to Focus Areas

Nursing facility services link to the Safer, Healthier Communities focus area. Though nursing facility level of care is a guaranteed benefit, Oregon has been the national leader in creating cost-effective alternatives that meet people's needs in their homes and other community settings, such as assisted living facilities, in-home care, retirement communities, residential care, and adult foster homes. Oregon continues to work closely with individuals and their families to offer the full array of community-based services. The new State Plan Authority approved by the Centers for Medicare and Medicaid Services in July 2013 provides Medicaid-funded resources to assist individuals in transitioning from nursing facilities. Oregon strives to provide quality services in a linguistically and culturally competent manner.

Nursing facilities are an important service in our continuum, meeting the needs of some individuals with higher acuity levels; however, DHS still believes there are opportunities to decrease its usage. Oregon continues to highlight, strengthen, and encourage the use of community-based care facilities instead of nursing facilities. DHS has established a goal of decreasing the percentage of long-term care recipients utilizing nursing facility services to 10 percent by 2020. As of May 2016, the percentage of long term care recipients utilizing nursing facilities services is 12.7 percent.

Program Performance

Nursing facilities are heavily regulated by the federal government and are licensed and routinely monitored by the state. The state establishes requirements for nursing facilities that promote quality of care and maximization of personal choice and independence for residents.

DHS remains diligent in diverting and relocating people who receive Medicaid-funded long-term care services from nursing facilities into home or community settings. One way performance is measured in this program is by the occupancy percentage of nursing facilities. Oregon has the lowest occupancy in the nation at 64%, compared with the national average of 82 percent.

The 2013 Legislative Assembly approved legislation (HB 2216) that is intended to reduce this unnecessary nursing facility capacity and thereby reduce increasing cost per resident day. HB 2216 established a statewide bed reduction target to reduce licensed beds by 1,500 by December 31, 2015. The legislation provided incentives for providers to buy and close nursing facilities through an augmented rate of $9.75 per Medicaid resident day that lasts for four years. If the bed reduction target is not met, the statutorily set rate methodology will be reduced. As of June 2016, the nursing facility industry has reduced its capacity by 1,159 beds or 77 percent of the goal.

Enabling Legislation/Program Authorization

Medicaid is an entitlement program that was enacted in 1965 under Title XIX of the Social Security Act. While states are not required to participate in Medicaid, in order to receive federal matching funds states must follow the Medicaid rules. Oregon's long-term care system operates under Medicaid state plan authority. All clients qualify for nursing facility care have the choice of receiving care in other settings such as in-home or in community-based care settings.

Oregon's nursing facility reimbursement rate and accompanying provider assessment authorization in promulgated in ORS 409.736. The 2013 Legislative Assembly reauthorized the provider assessment through 2020.

Funding Streams

Nursing facility services are funded through the Medicaid program; therefore, the federal government pays approximately 64 percent with the remaining 36 percent being split between state general funds and provider taxes. In the 2017-2019 biennium, provider taxes from nursing facilities are expected to total $127.6 million. There is $27.2 million in biennial funding from the estates of former recipients. When a Medicaid recipient dies, the state is required by federal law to recover expenditures for the individual's care from the recipient's estate. These funds are reinvested in services for other individuals, offsetting the need for general funds.

Funding Justification and Significant Changes to CSL

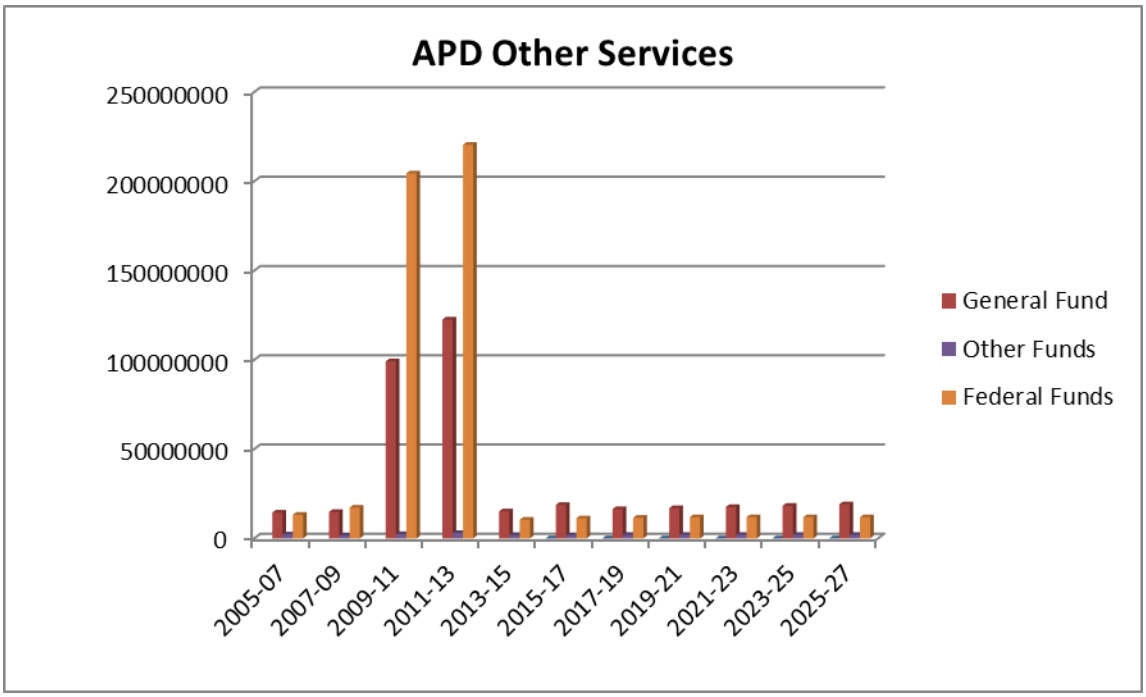
This does not include statewide reductions. The agency's request is to continue at the current service level for 2017-2019.

Reductions:

- Reduce the complex medical add-on for nursing facilities by 50%. This reduction would eliminate half of the 40% premium paid to nursing facilities that serve individuals with certain complex medical conditions. Taking this reduction will require a statutory change to implement ($6,590,581 GF).
- Hold nursing facility rates flat at the rate being reimbursed at 6/30/17. This would require a statutory change. No impact on consumers or access is anticipated with this reduction. Nursing facilities could likely absorb this without much consequence ($18,345,151 GF).

Department of Human Services: Other Services

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Ashley Carson Cottingham



Costs for 2009-2011 and 2011-2013 are higher due to the transfer of the funding for Medicare Part A and Medicare Part B buy-in programs from the Oregon Health Authority (OHA) to Aging and People with Disabilities (APD). These funding sources were transferred back to OHA in 2013-2015, but APD continues to administer the programs.

Program Overview

The other services category was previously dominated by federally mandated programs, such as the Medicare Buy-in and the Medicare Part D low-income subsidy programs, which help low-income Medicare beneficiaries meet their cost sharing requirements. This cost-effective investment ensures that Medicare remains in a first-payer position, thereby reducing or eliminating costs to the State's Medicaid health programs (Oregon Health Plan). Other services also includes programs that support individuals living as independently as possible in the community. For example, home-delivered meals provide a critical support to many individuals who otherwise may not be able to remain independent in their own home.

Program Funding Request

APD Other Services				
	GF	OF	FF	TF
15-17 LAB	$ 18,788,937	$ 1,845,606	$ 11,258,128	$ 31,892,670
17-19 GB	$ 16,462,345	$ 1,955,077	$ 11,554,645	$ 29,972,067
Difference	$ (2,326,592)	$ 109,471	$ 296,517	$ (1,920,603)
% Difference	-12%	6%	3%	-6%

Program Description

As stated above, the majority of funding in other services was previously dedicated to the Medicare Buy-in programs that support low-income individuals in accessing their federal Medicare benefits. Federal law requires states to provide payments for Medicare beneficiaries who meet specific income guidelines. APD helps consumers access this benefit. Medicare beneficiaries include individuals aged 65 or older and people with disabilities who have been receiving Social Security Disability payments for at least two years. The passage of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 expanded the asset allowance and eliminated the estate recovery component of Medicare Savings Programs. These changes eliminated many of the barriers to the Medicare buy-in programs for a significant number of Oregonians.

Oregon is expected to serve more than 150,000 seniors and people with disabilities in the following programs:

- **State Medicare buy-in:** By purchasing Medicare Part B (which has a federally required premium) for individuals eligible for both Medicare and Medicaid (dual-eligibles), the Medicaid program pays for medical services (such as physician, radiology and laboratory services) only after Medicare has paid as primary payer.

- **Medicare savings programs:** Clients in these programs receive federally mandated assistance with their Medicare Part B premiums. Specified low-income Medicare beneficiaries and qualified individuals are those individuals who have income between 100 and 135 percent of the federal poverty level.

- **Qualified Medicare Beneficiaries:** Beneficiaries receive state assistance for the costs associated with the Medicare hospital benefit, Part A, and physician services, Part B, that would otherwise be required of them, including premiums, deductibles and co-payments. These clients have income equal to or less than 100 percent of the federal poverty level.

- **Medicare Part D:** Medicare Part D is the Medicare pharmacy benefit. All clients in the Medicare buy-in programs receive assistance from CMS with their Medicare Part D premiums and co-insurance amounts. Oregon pays a per-person monthly premium to Medicare for eligible clients.

APD works to provide services that support individuals in their own home. These supports reduce reliance on nursing facilities and licensed community-based care while simultaneously improving quality of life and saving taxpayers' money. These programs provide supplemental services as needed to in-home clients and are not tracked as a separate caseload. These programs include:

- **Medicaid Adult Day Services:** Adult day services provide supervision for adults with functional or cognitive impairments who cannot be left alone for significant periods of times. Services may be provided for half or full days in stand-alone centers, hospitals, senior centers, and licensed care facilities.

- **Medicaid Home-Delivered Meals**: Home-delivered meals are provided for Medicaid eligible clients receiving in-home services who are homebound and unable to go to the congregate meal sites, such as senior centers, for meals. These programs generally provide a daily hot mid-day meal and often frozen meals for days of the week beyond the provider's delivery schedule.

- **Cash payments:** APD makes special-needs payments to reduce the need for more expensive long-term care payments and to allow a client to retain independence and mobility in a safe environment. Special needs payments may be used for such things as adapting a home's stairs into a ramp or repairing a broken furnace. Clients can also receive cash payments to help pay Medicare Part D prescription drug copays, payments for non-medical transportation, and a one-time emergency payment for an unexpected loss (such as stolen cash, a car repair or a broken appliance). The budget supporting these payments meets the federal requirement for APD's maintenance of effort (MOE).

Program Justification and Link to Focus Areas

Other services are targeted supports that help Oregonians remain in the least restrictive setting possible. The Department strives to provide services in a respectful, culturally and linguistically appropriate manner. These services tie to Strategy 1 on changing how health care is delivered in Oregon by supporting efforts to increase home- and community-based care to 90 percent of the total Medicaid long-term care caseload. The Safer, Healthier Communities focus area also envisions an integrated system that these community supports will help realize.

These services allow individuals to receive services at the right time and in the right place. They maximize expenditures by using the federal portion of Medicaid funding to provide person-centered services when the person needs them. It ties directly to the desired outcome of Ensuring Financial Stability for the Long-Term Care Service Systems and Supports.

Other Services complement and enhance in-home service plans, contributing to overall cost-effectiveness and the sustainability of the plan. Other services not only have a positive impact on consumers but also their natural support system (relatives/friends/neighbors), preventing burnout and the need for higher cost services.

Program Performance

In an independent study conducted by AARP, Oregon received an overall ranking of 3rd out of 50 states in terms of choice of settings and providers, quality of life, quality of care, and effective transitions from nursing facilities back into the community. With approximately 53 percent of the Medicaid caseload served in their own homes, Oregon continues to rank in the highest percentile.

Enabling Legislation/Program Authorization

Services in this category are operated under both the Medicaid state plan options, including the “K plan” and Oregon’s Home and Community Based Care 1915(c) waiver. The state provides services that “waive” against nursing facility services, the mandated entitlement for Medicaid eligible individuals under Title XIX of the

Social Security Act. Additionally, ORS 410 and ORS 443 provide statutory policy and structure to the services offered.

Funding Streams

Other services are mostly funded through the Medicaid program; therefore, the federal government pays approximately 69 percent and the state pays 31 percent. There is a small amount of funding that is state general fund only, which serves to meet the state's maintenance of effort requirements. Finally, there is a small amount of funding from the estates of former recipients. When a Medicaid recipient dies, the state is required by federal law to recover money spent for the individual's care from the recipient's estate. These funds are reinvested in services for other individuals, offsetting the need for general funds.

Funding Justification and Significant Changes to 17-19 CSL

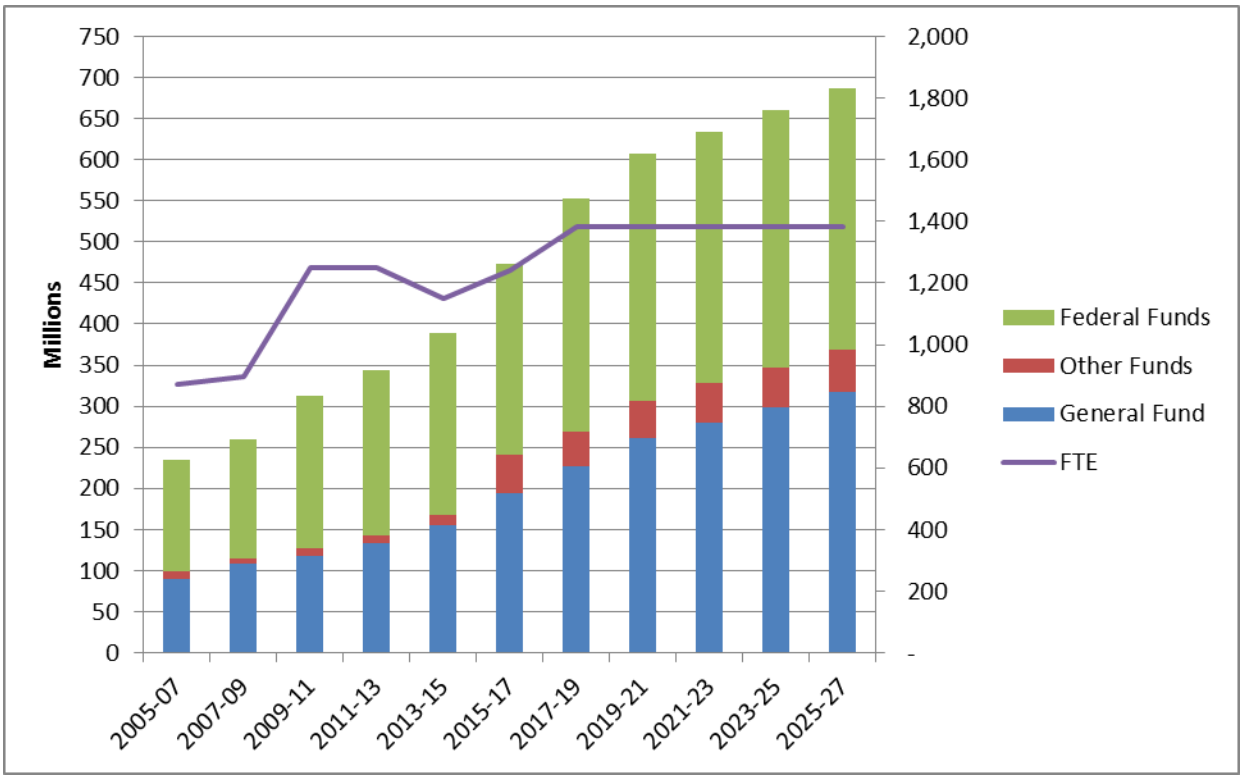
This does not include statewide reductions. The agency's request is to continue at the current service level for 2017-2019.

Reductions:

- Remove General Assistance - House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded ($1,597,705 GF).

Department of Human Services: Delivery and Design

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Ashley Carson Cottingham



APD is seeing tremendous growth in the individuals it serves with relatively flat staffing levels. The increase from 2015-2017 is driven by the reintegration of licensing staff into the APD program.

Program Overview

The Aging and People with Disabilities (APD) program delivery system provides services and supports to Oregonians over the age of 65 and to adults with physical disabilities. The population is a diverse cross-section of Oregonians that requires supports that take into account race, ethnicity and language; lesbian, gay, bisexual, and transgender (LGBT) older adults; homeless seniors; older adult immigrants; and many other populations that qualify for services. Design and Delivery includes staff who design and provide technical assistance for Oregon's long-term care system as well as the staff and partners who directly provide services in over 50 offices located throughout the state.

Program Funding Request

	General Fund	Other Fund	Federal Fund	Total Fund	Positions	FTE
15-17 LAB	193,650,643	47,732,570	232,269,289	473,652,502	1,253	1,242.28
17-19 GB	226,502,507	42,541,780	283,706,448	552,750,735	1,451	1,381.93
Difference	32,851,864	(5,190,790)	51,437,159	79,098,233	198	140
% Difference	15%	-12%	18%	14%	14%	10%

Program Description

The APD program delivery system provides respectful and inclusive services and eligibility determinations to over 170,000 Oregonians. Some of the services accessed by individuals include:

- Medical assistance (Oregon Health Plan and Medicare premium assistance)
- Disability determinations
- Supplemental nutrition assistance

This caseload is growing rapidly and is served by eligibility staff only; case management services are not provided to individuals accessing only the services above. Approximately 34,000 of the 170,000 individuals APD serves access long-term care services and supports. For these individuals, case management services are provided, which generally consists of assessment, choices counseling, service plan development, and monitoring. Additionally, local offices have memorandums of understanding (MOUs) with local Coordinated Care Organizations. These MOUs focus on joint accountability for coordinating care for individuals accessing long-term care services. State and Area Agency on Aging (AAA) case managers will be the front line in ensuring effective care coordination occurs for individuals served by APD's long-term care system.

Local staff also license adult foster homes, including those that do not participate in Medicaid. Local staff provide adult protective services, consisting of investigations of abuse and neglect against seniors and people with disabilities.

APD has historically earned local service delivery staff through a caseload ratio model (e.g. one eligibility worker for every 500 cases). For the 13-15 biennium, the Legislature authorized the transition to the workload model. This model differs

from the caseload ratio model in that it accurately measures time required to perform tasks and captures work performed for individuals who are never found eligible.

The delivery system is comprised of both state staff and AAA staff located in communities throughout Oregon. Under ORS 410.270, AAAs have the right to elect to deliver Medicaid services locally. Currently, four AAAs have elected this option. These four AAAs (Multnomah County, Northwest Senior and Disability Services, Oregon Cascades West Council of Government. and Lane Council of Governments) serve the most populous areas of Oregon. With the exception of Washington and Clackamas counties, state staff serves areas with lower population densities.

The Oregon Home Care Commission (HCC) is also included in the Design and Delivery Program Area. Under Oregon's constitution, the HCC is responsible for ensuring the quality of home care services for seniors and people with disabilities. The Commission maintains a web-site of home care workers that can be accessed by all Oregonians, including those not served by Medicaid. Training is provided to both consumers and home care workers in a variety of areas addressing safety and quality. The efforts of the HCC are critical to the successful delivery of long-term care services to Oregonians.

APD's Design and Delivery area also includes the staff that design and administer services centrally. Some of the major services provided include:

- Negotiating system design with federal partners
- Developing program policy and maintaining administrative rules
- Paying providers
- Executing contracts
- Negotiating and implementing collective bargaining agreements
- Maintaining provider rates

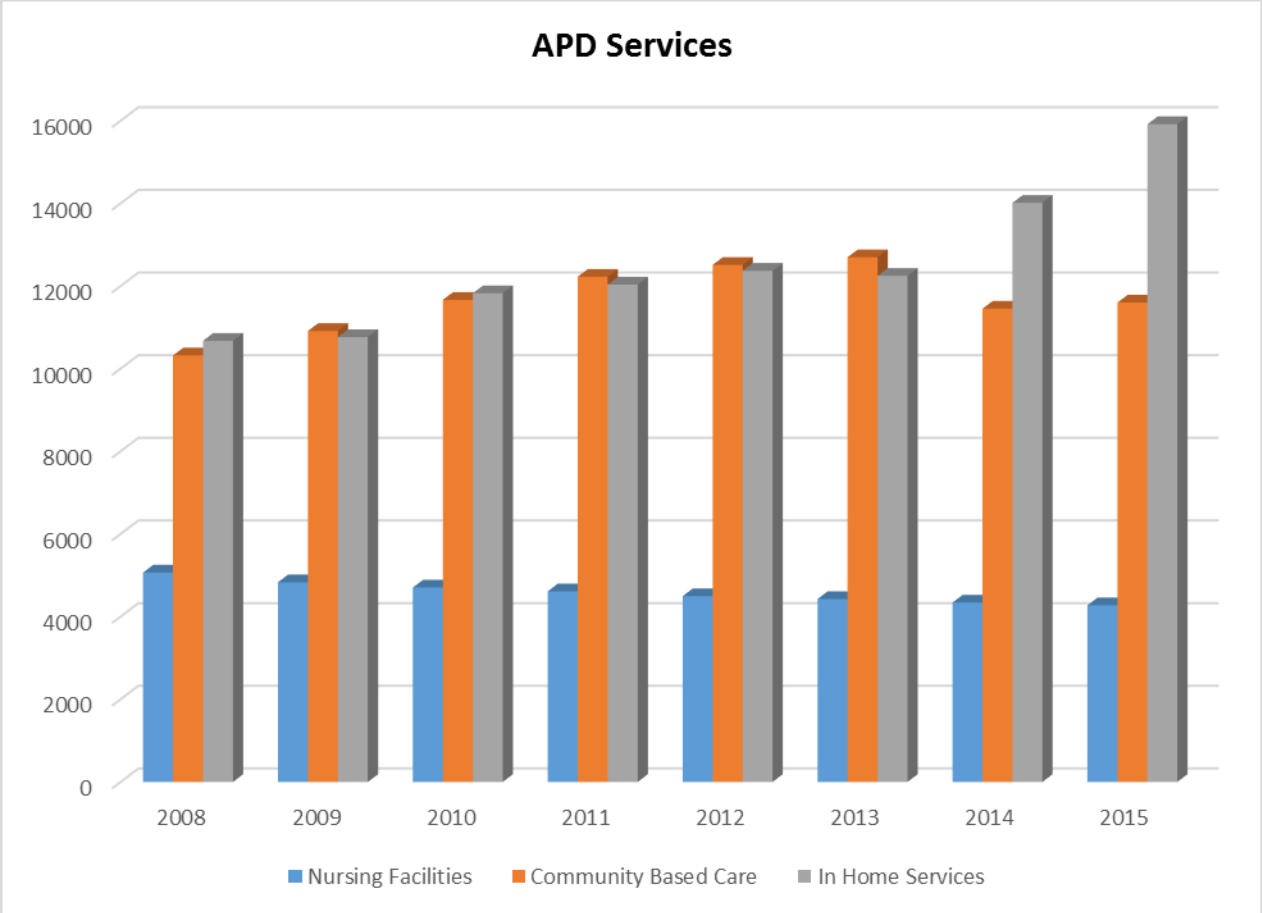
Program Justification and Link to Focus Areas

There is a direct link between this program and the goal of Safer, Healthier Communities. The APD Delivery system supports individuals living in their communities in settings of their choice, whether in their own home, a community-based care facility or a nursing facility. Partnerships between local law

enforcement, local court systems, and local advocates are critical to ensuring the senior and disability populations are protected from neglect and abuse.

Program Performance

A primary goal of the APD program is to ensure that older adults and people with disabilities are receiving appropriate services at a level that allows them to live independently and safely within their home and community. Local case managers work with a broad diversity of individuals and community partners to ensure appropriate supports are in place, including those that are culturally or linguistically needed. Each individual and family is unique in its strengths and needs. The following chart reflects the work of our nursing facility diversion and transition effort over the past five years. Not only are nursing facility placements the most expensive setting, they are generally viewed as the least desirable by consumers. Our local staff is critical in accomplishing this win-win outcome.



Enabling Legislation/Program Authorization

Oregon Revised Statutes 410.070 charges the agency with primary responsibility for the planning, coordination, development, and evaluation of policy, programs and services for older adults and people with disabilities in Oregon. Area Agencies on Aging have universal responsibilities as articulated in ORS 410.210. Additionally, ORS 410.270 authorizes Area Agencies on Aging to perform services locally that would otherwise be administered by state staff if they elect to do so.

Funding Justification and Significant Changes to CSL

This does not include statewide reductions. The agency's request is to continue at the current service level for 2017-2019. A mix of state general and federal dollars fund the majority of the services provided in APD Design and Delivery. Local partners also provide local matching funds to the Department, which the Department uses to leverage federal Medicaid dollars. This allows local entities to enhance services such as additional staffing and transportation.

102 Centralized Abuse Management System*

General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
1,694,922	2,050,000	147,945	3,892,867	2	1.50

House Bill 4151 requires the state of Oregon and DHS as its agent to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing, and investigating incidents of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations.

This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's

ability to achieve the capabilities and efficiencies of the proposed integrated solution. The Other Funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one time request for limitation. The General Fund is the best current estimate of costs of the ongoing operations and maintenance of the new system.

* This is the APD portion of this POP. Please see Shared Services and Program Design Services (ITBS) for remaining portions.

Reductions

- Additional 1% Vacancy Savings - This action reduces the funding for personal services in DHS by taking a 1% reduction in personal services funding. This action reduces personal services funding lowering the overall capacity of DHS to complete its mission ($1,015,971 GF). This is the APD Delivery and Design portion of this reduction. Please also see all other Program Areas for remaining portions.
- Remove inflation from S&S - This action reduces the funding for general inflation in most services and supply line items in DHS. This reduces service and supply funding lowering the overall capacity of DHS to complete its mission ($506,588 GF). This is the APD Delivery and Design portion of this reduction. Please also see all other Program Areas for remaining portions.
- Disallow Backfill for Federal Grants - This action assumes that there will be sufficient federal funding to cover assumed shortfall in capped grants. The agency will be reviewing its federal grant balances to determine the impact of this reduction closer to the close of the 15-17 budget when ending balances are more clear ($546,791 GF). This is the APD Delivery and Design portion of this reduction. Please also see all other Program Areas for remaining portions.
- Statewide Reductions to S&S - This action reduces the funding for services and supplies in DHS by taking a 3% reduction in services and supplies funding. This reduces service and supply funding lowering the overall capacity of DHS to complete its mission ($351,488 GF). This is the APD Delivery and Design portion of this reduction. Please also see all other Program Areas for remaining portions.
- State Staffing Workload Reduction - This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in APD to ensuring the safety of Oregon's aging and people with disabilities ($5,480,377 GF).
- Equity Model Reduction - This reduction is to CSL-earned positions for AAA's at 24 months. Positions were "earned" that are then priced for the

contract amount to the providers. This reduced the number of earned positions back to 12 months in this reduction. Staffing levels are critical in Aging and People with Disabilities to ensuring the safety of Oregon Seniors ($9,680,044 GF).

- Remove General Assistance (HB4042) - House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded. ($225,590 GF) NOTE: This is the APD Delivery portion of this reduction. Please also see APD Program, Shared Services and SAEC for remaining portions.

Department of Human Services
Intellectual and Developmental Disabilities Services Program

Mission

The Department of Human Services Intellectual and Developmental Disabilities Services program (I/DD) provides support across the lifespan to Oregonians. Our mission is to help individuals be fully engaged in life and, at the same time, address critical health and safety needs.

Vision

Oregon's system of supports is simple to use and responsive to the strengths, needs and direction of the people and families who live as valued members of their community.

Program

The I/DD program strives to support individuals with intellectual and developmental disabilities and their families within communities by promoting and providing services that are person-centered, self-directed, flexible, community inclusive, culturally appropriate, and supportive of the discovery and development of each individual's unique gifts, talents and abilities.

We are committed to work toward service options to ensure people with intellectual and developmental disabilities have the opportunity to have fulfilling and meaningful lives allowing them to contribute to and enjoy their communities.

As a result of the state's adoption of the Community First Choice Option (or K Plan), an increased number of children and adults with I/DD are able to access Medicaid-funded, community-based services to meet their needs, instead of having to meet crisis eligibility in order to access the appropriate level of support.

We seek to achieve the following outcomes and goals**:**

- Provide an array of options that are properly distributed to ensure access through equitable and culturally competent services
- Be responsive to emerging consumer demands for individualized, self-directed services and provide sufficient service choices

- Ensure the health and safety of individuals served
- Promote maximum independence and engagement in homes and communities
- Leverage use of available federal funding options
- Address improvements in business practices such as payment and information systems to achieve overall operational efficiencies
- Maintain sustainability of the program

Individuals We Serve

Individuals eligible for services must have an intellectual or developmental disability that significantly impedes their ability to function independently. Intellectual and developmental disabilities include intellectual disability, cerebal palsy, down syndrome, autism and other neurological conditions originating in the brain that occur during childhood. These disabilities must be expected to be lifelong in their effect and have a signficant impact on the person's ability to function independently. Some people with I/DD may also have significant medical or mental health needs. Most individuals with I/DD meet Medicaid financial eligibility requirements. The majority of I/DD program services are now administered under the Medicaid State Plan Community First Choice Option (CFCO). Case management and employment services are available through traditional, home- and community-based service waivers.

Community First Choice Option Services

Historically, the I/DD service system was comprised of three basic components. There were two separate program service areas — Support Services and Comprehensive Services. The third major component was program design and delivery. While program design and delivery remains the same, Support and Comprehensive Services are now primarily offered through the Community First Choice Option (CFCO).

With CFCO, eligible individuals receive a functional needs assessment that informs the amount and/or rate for services that are available to the individual. The assessment also informs the Individual Support Plan (ISP) which documents the person's needs and their goals for the next year. It also documents the services the person will access in order to meet those goals. The amount of service a person receives is based on the functional assessment, not whether they are in the Support Services or Comprehensive Services programs.

Program Services

I/DD offers a broad array of services in order to optimize consumer choice and offer an array of cost effective services based on functional need. Importantly, implementation of CFCO has expanded access to children with I/DD and has eliminated the hard cap that had been in place with the Support Services program. Since implementation of CFCO, Oregon has increased the number of children with I/DD that receive services and adults no longer have be in crisis to receive 24-hour supports in an out-of-home setting.

The shift to CFCO required that most I/DD services be categorized as attendant care. This has been challenging for the system because people with I/DD, their families, providers and advocates are more familiar with Oregon's important history of self-directed and strengths-based support system. It was critical that we refocus on the new vision for the I/DD system and affirm our commitment to person-driven supports. This process resulted in a firm understanding that the person, their family and the goals they want to achieve remain at the core of our system and the move to CFCO can be achieved in a manner consistent with Oregon's strong history of person-centeredness and self-direction.

Attendant Care

Attendant Care provides support for people to perform activities of daily living and instrumental activities of daily living (ADL/IADL). With CFCO, this is the primary service available to people with I/DD. Most Support and Comprehensive Services are considered attendant care services and are generally categorized based on the setting in which the person lives.

Services that now fall under attendant care include:

- In-home supports for children and adults
- Children's intensive in-home services
- 24-hour services:
    - Group home for children and adults
    - Adult and child foster care
    - Supported living (adults only)
- Day supports
- Stabilization and Crisis Unit (SACU)

In-home supports for children and adults

These services are designed to provide ADL/IADL supports in the home or in the community. Children that receive these supports live with family, and adults live either with family or in their own home. In-home services are provided to a majority of individuals served by the I/DD program. As a result of the expanded accessibility to these services, I/DD anticipates an increase in the utilization of this service over the 2017–19 biennium.

When families are supported to provide the core care, even individuals with the most significant needs have active and engaged lives in their community. Without in-home services, many individuals would require much more expensive out-of-home services such as group or foster homes.

Individuals who remain in their own home or with their family and have changes in support needs can access interim or short-term services. Interim services may include increased attendant care, behavior consultation or technical assistance to determine if an intervention will assist in maintaining the current placement. Depending on the change in support needs, environmental modifications may also increase the individual's likelihood of remaining at home.

For both children and adults, in-home services are provided by Personal Support Workers (PSWs) or certified provider agency Direct Support Professionals (DSPs). Personal Support Workers are directly hired by the individual or their employer representative. Direct Support Professionals are employees of private organizations that contract with the state to provide services.

Children's Intensive In-Home Services (CIIS)

These services consist of three model waiver programs which provide intensive supports in the family home. One of these programs is for children with intensive behavioral issues who, without supports, would require specialized out-of-home services. The second program is for children with medical conditions who, without supports, would require nursing home services. The third program is for children with intense medical needs. These are children that are dependent on life support technology such as ventilators that, without these in-home services, would require services in a hospital setting. With the implementation of the Community First Choice Option, children who do not have the intensive needs described above may now be able to access in-home support services through their local Community

Developmental Disability Programs (CDDP) upon completion of a needs assessment and an Individualized Support Plan (ISP).

24-Hour Services

These services are for children and adults who can no longer remain at home or adults who choose to receive services in a 24-hour setting. Under CFCO, these services are also categorized as attendant care. These services are primarily 24-hour supports, usually provided in settings outside the family home through group home, supported living or foster care providers.

These important services provide an alternative to institutional care. Community-based, as opposed to institutional care, remains a more cost-effective program as well as being the most desirable by individuals receiving services and supports from the department. Group home and supported living services are provided by private organizations that contract with the state. Adult foster care providers are represented by the State Employees International Union (SEIU). Child foster care providers are private providers licensed through either Child Welfare or the local Developmental Disability office.

Individuals usually receive 24-hour services when they are unable to stay at home on their own or with their family. This may be due to an individual's needs or the caregiver's ability to continue providing services. Under CFCO, adults can choose 24-hour services without meeting a threshold of need or crisis criteria.

For children with disabilities, they enter 24-hour comprehensive services as a voluntary placement because the intensive needs of the child cannot be met in the family home, or may be involuntary through child welfare action. Child Welfare programs maintain responsibility for the court relationship but I/DD provides the specific disability related care.

Day Services

Day services are available for people that are over 18 and out of school. Many adults receiving 24-hour services also receive day services ancillary to their residential services. These services are available for about 20–25 hours a week for out-of-home activities, including employment-related activities. Adults receiving in-home supports are also able to receive day services as part of their attendant care. Day support activities that fall under the category of attendant care are

provided through CFCO and provide supports needed to promote integration, independence, and participation in the individual's community.

Transportation

Non-medical transportation is also provided to help individuals with I/DD in in-home and 24-hour services when public transportation is not available, or not feasible, to help individuals participate in employment or other services.

Stabilization and Crisis Unit (SACU)

SACU is a 24-hour service now provided under the CFCO. SACU provides a safety net for Oregon's most vulnerable, intensive, medically and behaviorally challenged individuals with intellectual and/or developmental disabilities. SACU provides services when no other community-based option is available for an individual. This includes people with I/DD coming out of the Oregon State Hospital, corrections systems, and from crisis situations where counties and private providers cannot meet the needs of the individual to ensure their health and safety. SACU focuses on supporting people in community-based settings and enabling them to return to less intensive service levels as quickly as possible.

SACU provides 24-hour residential and day supports to individuals with I/DD from all across the state who have significant medical or behavioral needs. The services are provided in licensed five-bed group homes. The SACU cannot refuse to serve anyone because their needs are too high.

SACU started in 1987 when Oregon moved all individuals with developmental disabilities living at the state institution (Fairview Training Center and Eastern Oregon Training Center) to private providers. There were a small number of individuals with complex medical or behavioral needs who could not yet be supported by private providers.

From the first homes that were opened by SACU to today, the profile of the individuals served has changed. As private agencies increase their skills to meet challenging needs and agree to provide services, the person who needs a safety net has changed. In 2000, SACU had six homes serving 30 people that were considered "medical," which means they serve people with high medical needs. In the past, the numbers of people with intensive behaviors often had a diagnosis of autism. Today, intensive behaviors are more related to co-occurring mental health diagnosis and/or criminal convictions.

Ancillary Services

In addition, people with I/DD served through I/DD are able to access vital ancillary services. Examples of these services include:

- Behavioral consultation
- Assistive devices
- Assistive technology
- Long-term care community nursing
- Home-delivered meals
- Environmental modifications
- Specialized nursing

Case Management - Service Coordination and Personal Agent Services

These services are provided through certified entities called Support Service Brokerages or through Community Developmental Disability Programs (CDDPs). CDDPs support children and adults while Brokerages support adults.

The individual receives case management services from the Brokerage or CDDP. Additionally, the CDDPs are responsible for eligibility determination and redeterminations, crisis response and protective service investigations. After eligibility is established through the CDDP, adults can choose to be served by the CDDP or a Brokerage.

A functional needs assessment is administered to determine the person's level of need and the amount or rate of services that will be available. The Service Coordination (SC) or Personal Agent (PA) then works with the individual, family and others important in the person's life to complete an individual support plan (ISP) and career development plan (CDP). They then work with the individual to identify necessary supports required to meet the needs identified through the assessment and the goals identified in the ISP/CDP.

Employment Services

These services have been strengthened and improved as part of the important Employment First initiative. I/DD has restructured employment services to encourage integrated, competitively paid employment for people with I/DD. Employment services are no longer bundled with attendant care services, they have been broken out into discrete services to support individuals as they learn about,

find and maintain employment. Employment services are not offered through the CFCO, they remain available through the Medicaid waiver.

Employment services include:

- Job discovery
- Small-group supported employment
- Job coaching

Employment First Policy

This policy states that employment in fully integrated work settings will be the first and priority option explored in service planning for all working-age and transition-age individuals with I/DD. This policy is based on the general philosophy that individuals with developmental disabilities have the ability, with the right supports, to be productive and contributing members of their communities through work. This philosophy also recognizes intrinsic and financial benefits of paid work to the individuals with disabilities and their families. To support the policy and philosophy of fully integrated work settings, as of July 1, 2015 the department no longer fund services for new people to enter sheltered workshops. Employment services are also provided consistent with the provisions and expectations of Executive Order 15–01, "Providing Employment Services to Individuals with Intellectual and Developmental Disabilities," reissued in January 2015.

Family Support Services

These services are available to any family with a child under the age of 18 not eligible for Medicaid. The program offers minimal support services with the most common request being for relief-care services.

All children in this program have case managers through their county CDDP and state-funded services are allocated based on need. Most children are also in school programs and the case manager coordinates between school and home. Family support services can be more cost effective by allowing the family to support the child with a small amount of funding, without accessing Medicaid.

Family-to-Family Networks

These family-driven networks provide training, information, referral, and general support with families providing support among one another. Just having another

family to connect with or problem solve with is often what it takes to be supported in the family home.

Program Design and Delivery

Staff and services support the administration of I/DD programs through a central office providing strategic planning, program funding, policy development, general oversight, and technical support to community services and support and leadership for various advisory councils.

The structure for service delivery and design includes a central program administration office within DHS and contracted services with Community Developmental Disabilities Programs (CDDP) and Support Service Brokerages. Contracted CDDPs, usually operated by county government, are responsible for service eligibility determination, program enrollment, case management, abuse investigation, provider development, quality assurance, and crisis response. CDDPs are also responsible for local planning and resource development, and documentation of service delivery to comply with state and federal requirements. Brokerages provide case management services, including assessment and service planning for adults.

Brokerages and Community Developmental Disability Programs (CDDP) field reviews

The I/DD Quality Assurance unit conducts field reviews on a two-year cycle in each CDDP and Brokerage. The reviews are focused on ensuring Centers for Medicare and Medicaid Services (CMS) Assurances are met through performance measures approved by CMS. Areas of review include accuracy and reporting of level of care, case management functions performed and reported timely and accurately; individuals are made aware of their rights, including, abuse reporting, fair hearing and complaints; providers are qualified; individuals' health and safety needs are met; service plans are developed in accordance with needs identified through assessments and are person-centered focused. The reviews assist I/DD in identifying program specific strengths and areas requiring improvement allowing for focused training and technical assistance. The reviews assist with identifying individual issues needing to be corrected as well as allow for analyzing common trends across the state that may suggest a need for system changes, improvements, best practices and training.

ODDS Office of Licensure and Regulatory Oversight

The Intellectual/Developmental Disabilities (I/DD) Licensing Unit oversees a statewide program responsible for licensing and the quality of care in programs serving individuals with intellectual/developmental disabilities, including the licensing of adult foster homes and 24-hour residential facilities. It oversees, and is responsible for, the Medicaid-agency certification of agencies and the endorsement of 24-hour residential programs, supported living programs, and employment programs. It also certifies Support Service Brokerages and Child Foster Homes throughout the state. Through licensing and certification the DD licensing team ensures that providers of services comply with requirements for federal and state reimbursement. The I/DD Licensing team conducts complaint investigations and determines necessary corrective action up to and including civil penalties or revocation of a license or certificate.

History — Future Trends

The state of Oregon is recognized nationally as an innovative leader in developing community-based services for individuals with developmental disabilities. Oregon is one of the few states that have no state or privately operated institutional level services specifically for people with developmental disabilities. In fact, the majority of individuals with developmental disabilities in Oregon are served in their own home or their family's home.

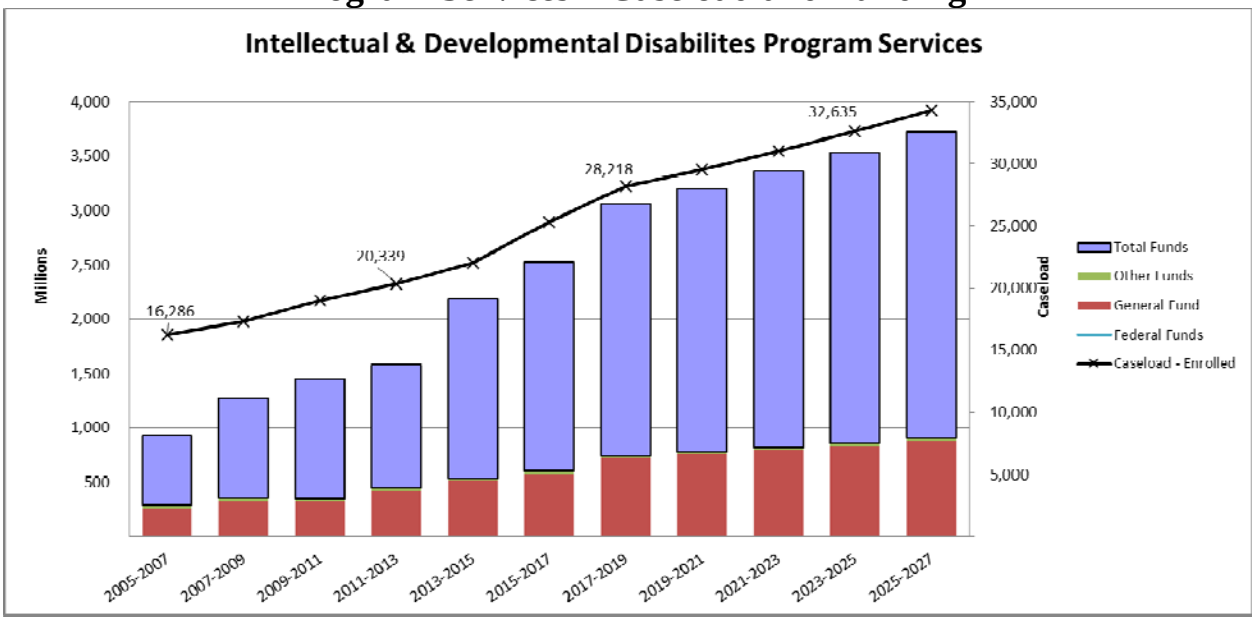
That is the result of two decades of work to aggressively "re-balance" the developmental disabilities system by moving from an institutional model with expensive, one-size-fits-all approach to a self-directed, family involved, individually focused, culturally appropriate, and less expensive approach to service. Individuals and families report a high level of satisfaction through increased control over services, the ability to more fully integrate in their home communities and the benefits of home community life.

Nationally, and in Oregon, the number of people with developmental disability-related needs is growing. There also is an increase in the number of people who need services that have co-occurring mental health needs or are coming to us from the corrections system. However, to maintain high levels of satisfaction, to further advance the inclusion of people with intellectual and other developmental disabilities in their communities of choice, and to serve the increasing number of people with I/DD accessing services, the system has an urgent need to continue its evolution in a fiscally sustainable manner.

Department of Human Services: Program Services

Primary Long Term Focus Area: Safer and Healthier Communities
Secondary Long Term Focus Area:
Program Contact: Lilia Teninty

Program Services – Caseload and Funding



Note: Effective 2013-2015, K Plan increased enrollment as well as lifted spending caps.

Program Overview

Oregon home- and community-based services for people with intellectual and developmental disabilities are provided under several Medicaid authorities including Community First Choice Option (CFCO), also known as K Plan; and five 1915(c) waiver programs. ODDS also operates a small Family Support Services program funded by state general funds providing limited flexible supports for individuals and families.

Currently, ODDS home- and community-based services support more than 25,300 adults and children with intellectual and developmental disabilities to live their lives in their communities. About 12,000 of them receive services in their own of family homes.

Program Funding Request

I/DD Program Services	GF	OF	FF	TF
LAB 15-17	$595,283,135	$23,144,442	$1,356,929,622	$1,975,357,199
GB 17-19	$725,483,426	$19,456,930	$1,567,001,258	$2,311,941,614
Difference	$130,200,291	-$3,687,512	$210,071,636	$336,584,415
Percent change	22%	-16%	15%	17%

Program Description

Oregon home- and community-based services for people with intellectual and developmental disabilities are provided under several Medicaid authorities including Community First Choice Option (CFCO), also known as K Plan; and five 1915(c) waiver programs. Supports provided under K Plan are services such as attendant services that support individuals in accomplishing activities of daily living and instrumental activities of daily living (ADL/IADL), relief care, behavioral support services, transportation, environmental modifications, and assistive technology and devices.

Support Services Waiver and Comprehensive Waiver provide services such as case management, employment services, and other ancillary services (direct nursing services, specialized medical supplies, environmental safety and vehicle modifications, and family training). Services through the Comprehensive Waiver are provided to children and adults in all settings, including family homes, group homes, foster care, and supported living (adults only) through County Developmental Disabilities Programs (CDDPs). Services through Support Services waiver are provided to adults, age 18 and older, who reside in their own or family home though Support Services Brokerages. Individuals receiving services through either waiver are able to access all K Plan services. Under CFCO, an individual can elect to live in any setting of their choice, but it may impact whether they receive case management support through CDDP or Brokerage.

Of the 25,300 individuals enrolled in services, 2,790 live in 24-hour group homes, 3,150 in foster homes, 700 in supported living. 12,230 individuals reside in their own or family homes. 7,680 of the adults served at home receive case management support through Support Services Brokerages; 4,800 children and adults living in-home receive case management through CDDP system. In-home support services average approximately $2,590 per month per individual while out-of-home services average approximately $6,850 per month.

For both children and adults, the direct care services are provided through Personal Support Workers (PSWs), provider agencies, behavior consultants, and respite providers. Personal Support Workers were provided collective bargaining rights in 2010 through HB 3618.

Employment services

ODDS currently offers supported employment services, such as job development, job coaching, supported small-group employment, discovery, and Employment Path. Discovery and Employment Path help individuals explore and learn skills to help them gain competitive integrated employment. These services are currently provided though the Comprehensive and Support Services Waivers.

People who are employed in the community have the highest level of integration and have stronger social networks. The more people with developmental disabilities are able to achieve paid employment, the less dependence there is on public resources and the greater the state's flexibility in designing future services that respond to the need of this population.

Oregon has been very successful in developing community-based care to move away from institutions as a model of care. Individuals with developmental disabilities fully engaging with their communities brings positive outcomes while being fiscally beneficial. Based on new federal requirements, community employment services will be the only employment services to receive federal funding as of March 2019.

Model Waivers

ODDS administers three Model Waivers through the Children's Intensive In-Home Services (CIIS) unit: Medically Involved Children's Waiver, Medically Fragile Model Waiver, and Behavioral Model Waiver for children. Currently, these waivers serve about 398 kids. Children receiving service through Model Waivers are also able to access K Plan services. These services are substantially the same as individuals served through the Comprehensive and Support Services Waivers, including attendant services, relief care, behavioral support services, environmental modifications, and assistive technology and devices.

Family Support Program

Limited supports for children are offered by ODDS through the Family Support Program and are available to any family of a child under age 18. The program is funded by general fund and offers flexible supports with the most common request being for attendant care and respite services. On average, during 2015-17 biennium, the program served 90 families per month at an average monthly cost of about $200. Surveys tell us this support is of great value to families. All children in these programs have case managers through their county Community Developmental Disabilities Program (CDDP).

Family-to-Family Networks

ODDS also provides $1.24 million in funding to the Oregon Consortium of Family Networks (OCFN) with support and technical assistance through Oregon Council on Developmental Disabilities (OCDD). OCFN collaborates with community partners and others to help families have an empowered vision of a full life for themselves and their children. They facilitate opportunities for families to support each other in accessing the information they need, navigating the many systems they encounter, and helping local community resources increase capacity to include and welcome families experiencing disability. OCFN believes that supporting families in this way will improve their quality of life and support greater sustainability of the formal support system over the long term.

Program Justification and Link to Focus Areas

ODDS services and supports for people with intellectual and developmental disabilities link to the Safer, Healthier Communities area through its focus on individuals with intellectual/developmental disabilities (I/DD) to ensure they are healthy and have the best possible quality of life in their communities among families and friends, and are working or attending school in order to achieve their greatest potential. Additionally, ODDS continuously works to ensure that services are provided in a linguistically and culturally competent manner.

When compared to the entire Medicaid population, adults in the Medicaid-funded home- and community-based services with I/DD are uniquely more reliant on the service system to make lifestyle changes and to adequately access health care. Funding I/DD programs to support the necessary lifestyle choices that reliably and consistently follow through with medical recommendations will result in

significant cost savings to the state's medical programs. Families and case managers are critical to help with health care coordination in the communication and implementation of treatment.

I/DD services are critical to the financial stability of a family and to the person with intellectual/developmental disabilities. With supports, families are not forced to decide between working and supporting their family member. It is also important that working-age adults with developmental disabilities are supported to work. Oregon has implemented an Employment First policy. This prioritizes individuals in actively engaging in developing work skills and defining work interests, pursuing job development or being employed in the community, and receiving support to maintain employment.

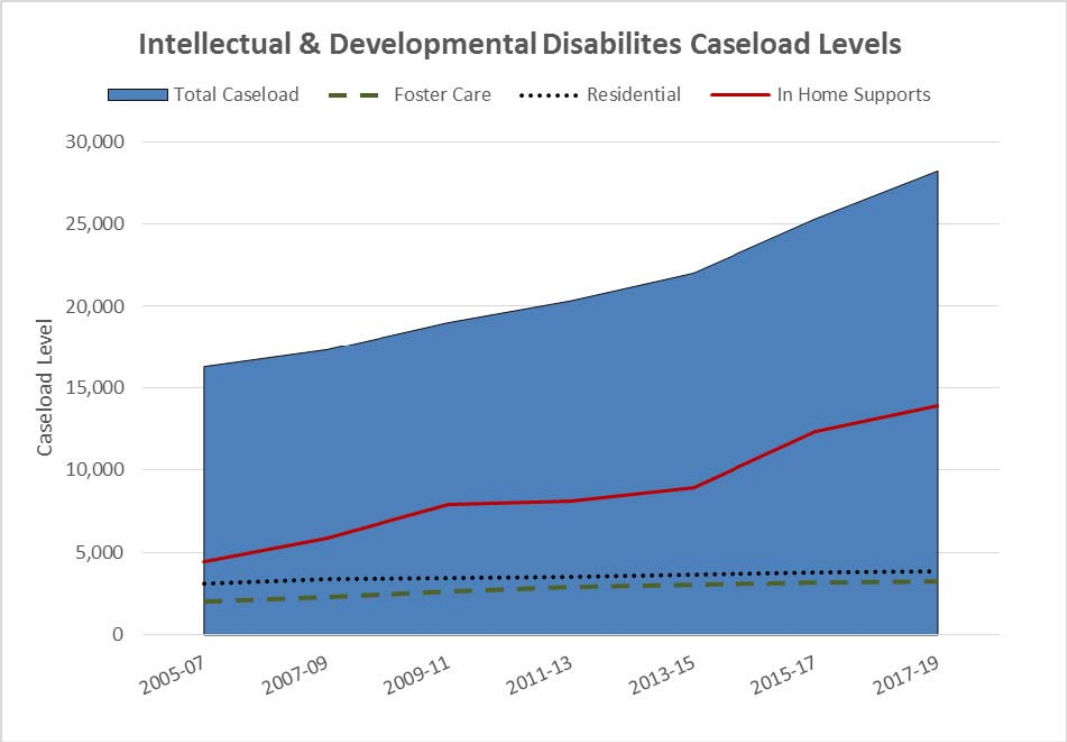
Executive Order 15-01 (which supersedes and replaces Executive Order 13-04 (issued in April 2013)) directs state agencies to take numerous steps that will advance the State's Employment First policy in Oregon. The goal of this Order is to further improve Oregon's system of designing and delivering employment services to those with intellectual and developmental disabilities in achieving integrated employment, including a significant reduction over time of state support of sheltered work and an increase in investment in employment services. The Order covers the time period of July 1, 2014 through July 1, 2022 and specifies certain benchmarks and metrics to be achieved each year.

Individuals with intellectual/developmental disabilities who are employed may provide additional resources for their family unit. In addition to being happier and healthier, individuals with I/DD who are employed broaden their network of supports, contributing to the Thriving Oregon Economy focus area.

The success of having people live with families for as long as they can is dependent on the families themselves being supported. In the 2015-2017 budget, funding was provided to the Office Developmental Disabilities Services for a total of eight Family-to-Family Networks. These are family-directed organizations that provide education, resource connections, and personal outreach and support to families experiencing similar needs.

Program Performance

Supporting individuals to live at home or live on their own is the most desirable outcome for people with I/DD and is most cost effective for the state. The number of people supported at home has been the largest area of growth in the I/DD system.



Graph has been updated with Fall 2016 Forecast

Enabling Legislation/Program Authorization

Oregon Revised Statutes 427.005, 427.007, and 430.610 through 430.695 enable the provision of family support for children with developmental disabilities. Oregon Revised Statutes 427.410 enables the provision of Support Services for adults through Support Services Brokerages.

At the federal level, in addition to all applicable Medicaid statutes and regulations, services must comply with the Title II of the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973. Compliance with these federal laws is subject to the U.S. Supreme Court's Olmstead Decision of 1999 and the U.S. Department of Justice's interpretation of that decision as it relates to the ADA and Rehabilitation Act. The Olmstead ruling applies.

Funding Streams

The services are designed and approved using a Medicaid 1915c Home and Community-Based Waivers, and primarily, the Community First Choice Option in the Medicaid State Plan. The program funding match rate is 63 percent Federal funds and 37 percent State General Funds for waiver services and 69 percent Federal funds and 31 percent State General Funds for State Plan services.

Funding Justification and Significant Changes to CSL

105 Stable and competent workforce for I/DD

General Fund	$22,094,082		
Other Funds	$0		
Federal Funds	$49,038,894	Positions	0
Total Funds	$71,132,976	FTE	0

Additional funding included in Design & Delivery Bid Form.

Perpetually low wages from an outdated rate model for the I/DD provider workforce has created a record level of turnover and a critical shortage of direct support professionals (DSPs). DSPs provide support for people with I/DD to live and work in a safe and healthy manner as members of their communities. DHS and stakeholders created the existing rate structure based on 2007 fiscal data. This model needs to be updated to align with current economic realities, new minimum wage requirements, new DOL Overtime Rule, and expectations around service quality, safety, and competency/training requirements. A stable and well-trained workforce is critical to the ability of I/DD provider network to providing high quality of services to individuals and assuring their health and safety. The provider rate structure needs to reflect these requirements and provide adequate compensation to ensure that individuals with I/DD are served by competent workers. This POP will ensure adequate DSP wages that are above minimum wage to reflect DHS' longstanding policy that DSP work is not minimum wage work; address compression effect of minimum wage increases on wages of house managers and supervisors; address cost impact of new DOL requirements around overtime pay for workers earning less than $913 a week ($47,476 a year); provide financial incentives for providers to ensure their staff achieves highest level of training and competency and by making available College of Direct Support training to Oregon DSPs and provide one FTE for ODDS to coordinate provider training requirements and programs.

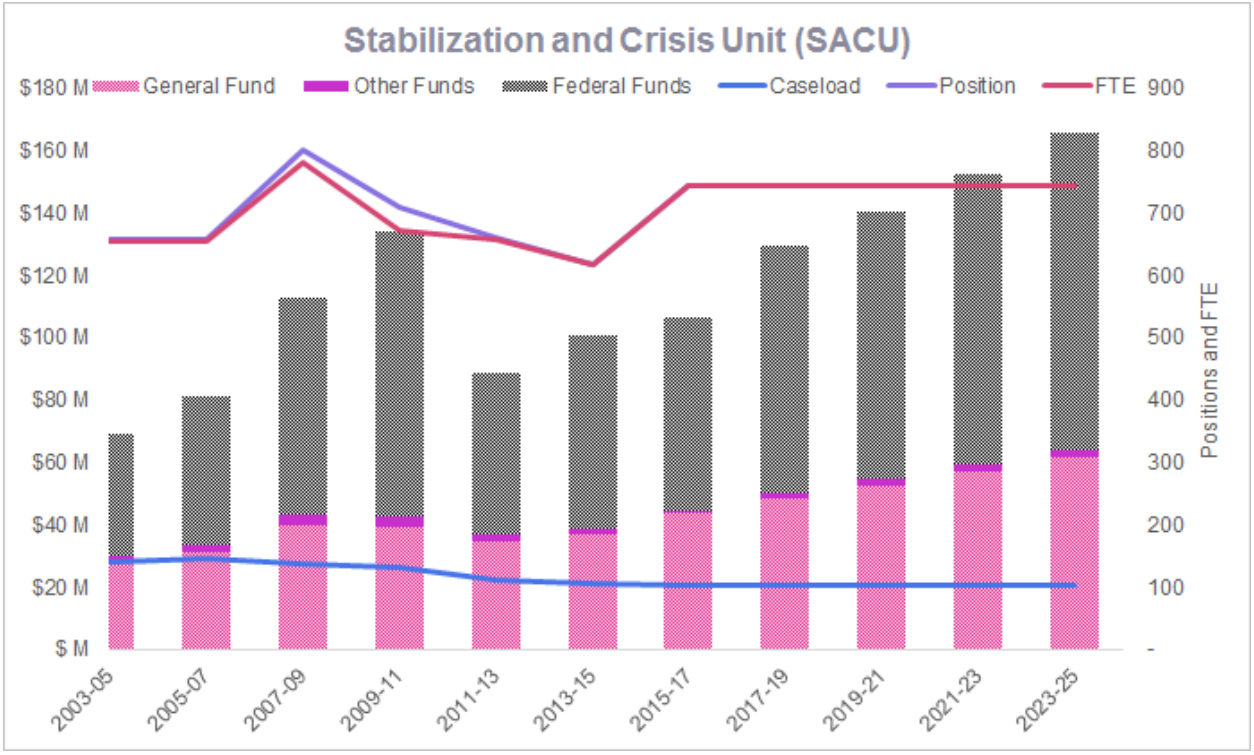
Reductions taken for 2017-2019 GB:

- Effective 7/1/17, eliminate funding to Family to Family Networks. This program began in 2012 after 2011 made significant reductions in the Family Support Program. The funding ($1.3M) supports up to eight networks. The work already accomplished by these groups includes family training, identification of local resources, and general support from one family to another. The networks leverage parent time and local resources in an effort to provide support at no cost to DHS/DD.

- Effective 7/1/17, eliminates options to help families and individuals with I/DD remove housing barriers by funding things such as ramps, accessible bathing options, and other housing modifications. Requires a statute change.

Department of Human Services: Stabilization and Crisis Unit (SACU)

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: N/A
Program Contact: Jana Mclellan



**A 7 percent overall budget reduction occurred in 2011.*

Program Overview

The Stabilization and Crisis Unit (SACU) provides a safety net for Oregon's most vulnerable, intensive, behaviorally and medically challenged individuals with developmental disabilities. This includes people with developmental disabilities coming out of crisis situations, including mental hospitals, correctional systems, and private providers who cannot meet the needs of the individual to ensure their health and safety. Almost all individuals present with dual diagnosis of mental health and I/DD issues. This program is an integral part of the overall intellectual/developmental disabilities continuum of services. SACU focuses on supporting people in community-based settings and preparing them to return to less intensive service levels once stabilized.

Program Funding Request

INTELLECTUAL & DEVELOPMENTAL DISABILITIES *SACU*	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
2015 - 17 LAB	46,415,229	918,040	76,771,116	124,104,385	745	745.00
2017 - 19 GB	48,089,579	827,741	76,395,730	125,313,050	745	745.00
Difference	1,674,350	(90,299)	(375,386)	1,208,665	0	0.00
Percent change	3.61	(9.84)	(0.49)	0.97	0.00	0.00

Program Description

SACU provides 24-hour residential services to individuals with intellectual/developmental disabilities who have significant medical or behavioral care needs. The services are provided in 5-bed group homes located across seven counties from the Portland metropolitan area south to Eugene.

As individuals enter into SACU, staff work with each person to modify behaviors and increase individual skills. Many of the people have frequent and intense behaviors and staff must provide physical interventions as trained through the Oregon Intervention System (OIS). All individuals have focused behavioral protocols that require frequent staff training and a high level of data collection and review.

There is an active referral list of adults and children waiting to enter SACU. Before entry into SACU, individuals are first referred by the CDDP and region to private community-based providers across the state but when they are denied or terminated from a current provider program, they move to a SACU placement. Nearly all individuals served have co-morbid (co-occurring) disorders of intellectual/developmental disability and mental illness. The acuity level of challenging behavior requires intensive 24-hour supervision and behavioral support services to ensure the safety to themselves and the community. Challenging behaviors range from aggression toward people or property inclusive of self-injurious behaviors. SACU also supports up to 10 individuals with medically fragile conditions that require 24-hour nursing care and support services.

More than 50 percent of these individuals have a history of criminal charges and/or current or pending legal sanctions. The convictions range from such crimes as assault, criminal mischief, theft, harassment, public indecency, possession, rape, sex abuse, and murder. A number have legal sanctions as a result such as parole,

probation, Psychiatric Security Review Board (PRSB), or are registered sex offenders. Some are civilly committed as they have been found to be a danger to themselves or others. The majority of individuals referred to SACU have an identified need for a secured facility due to their risk of flight and/or offensive behavior. In addition, a large percentage of individuals require "hardened" facilities where walls, windows, and fixtures are non-breakable to avoid injury to self and others.

SACU serves 79 adults who are in need of acute stabilization and crisis services. These individuals have been identified due to extreme behavioral and psychiatric needs that have not been successfully provided in the community.

SACU has 10 beds for children (up to 18 years old) who are in acute crisis and require stabilization. These children come from a variety of settings including the family home, foster care, 24-hour group home care, and institutional care.

SACU serves up to 10 individuals in specialized medical facilities due to their fragile medical conditions.

In all of the homes, SACU staff provides services that ensure health and safety needs are met and that the individual has the ability to participate in the community. As the goal of the program is to have the individual live in the most independent, least restrictive community setting, it is important to ensure the individual can be supported in the same type of setting.

All of the individuals in SACU qualify for Medicaid, currently use the Oregon Health Plan and are served by Coordinated Care Organizations, to meet their medical needs. Since there is high medical, behavioral and mental health needs, the program treatment plans are critical for individual stabilization and coordination of health services.

From the initial homes in 1987 to today, the profile of the individuals served by SACU has dramatically changed. As private agencies increase their skills to meet challenging needs and are able to provide services, the person who needs safety net services has changed. In 2000, SACU had six homes serving 30 people with high medical needs. Today these medical homes serve only up to 10 individuals. These individuals now receive care in community and nursing facilities.

In the past, the numbers of people with intensive behaviors were people who had a diagnosis of autism. Today, intensive behaviors are related to co-occurring mental health diagnosis and/or criminal convictions.

To respond to an individual in crisis, the program has always developed exit plans with providers and counties for people ready to leave at the same time new individuals are admitted; however, in 2011, the Legislature reduced the SACU budget. This prompted a comprehensive review of individuals in state care to determine if any could be moved out of SACU to reduce the overall number of individuals. Several individuals were identified and recommended for private care. They are still individuals who are assessed at the highest levels of acuity but have behavioral or medical needs that are predictable and can be supported by a private agency.

The 2011-13 budget reduction resulted in six homes being closed over the course of that biennium. This reduced overall individual capacity by 22 percent. With 104 funded beds in the 2015-2017 budget, the individuals that remain in SACU or will be entering as a new individual continue requiring the highest level of staffing and support.

With the 2015-2017 budget, SACU completely transformed the organizational structure in order to increase efficiencies and lower injuries and overtime. The agency formed seven island structures within the existing three regions and created a staffing float pool, which allows for more flexibility in direct care staffing. SACU also created the Crisis Outreach Assessment Team (COAT), a rapid-response team that responds to an individual's crisis as it is occurring. COAT also completes mental health assessments allowing SACU to better support the individuals served. In addition, SACU contracted with a national consultant, Benchmark, to review SACU as a whole and make recommendations for improved services as well as individual and staff safety. Lastly, the 2015 Senate Bill 226 called for a governor-appointed taskforce focusing on individual and staff safety. It is currently convening and will publish its recommendations.

Program Justification and Link to Focus Areas

SACU links to the Safer, Healthier Communities focus area. SACU helps individuals with intellectual/developmental disabilities be healthy and have the best possible quality of life by helping them live in their communities and to work or attend school to achieve their potential. Stabilization and training are provided

for adults and children who have entered the program in crisis. SACU helps individuals transition back into community settings with support from their families, caregivers, or private providers.

Individuals enrolled generally have no other alternatives for a residential placement. They are in crisis due to a family breakdown; discharge from a hospital, psychiatric or correctional setting, or discharge from a private provider who can no longer support them due to the intensity of their behavioral or medical needs. SACU provides a critical alternative to assist the person to return to a healthy and productive life through a high quality residential program, including community-based housing, appropriate nutritional and medical care, and interventions.

In addition, the safety net provided by SACU allows for targeted, community-based support to individuals in crisis or with otherwise unmet intensive needs, individuals receive the services they need for the time they need them, and are then assisted to transition back to families or private providers.

Program Performance

Staff ratios are quite high; at minimum all require a 1:1 staffing level. Many require a greater staffing level while in the community. The goal is to stabilize behaviors or health issues in a residential setting so that transition to a private provider is successful. Average length of stay for SACU adults overall (in both medical and behavioral beds) is 6.9 years which is down slightly from previous years. The average stay for SACU adults in behavioral beds only is down to 5.9 years.

SACU is focusing on placement of these long-term individuals in private care. These types of individuals, who can now be served by private providers due to improvements in community service skills and capacity, are no longer prioritized for this program.

SACU continues to build strong data tracking, including clinical data (individuals' incidents, medication errors, safety records, restraints, and a number of other elements), staffing data (ratios, overtime), and programmatic data (admissions, transfers, exits, length of stay). SACU uses this data to make programmatic changes.

Enabling Legislation/Program Authorization

Virtually all individuals served by SACU are funded through Medicaid Home and Community-Based Waivers and the 1915(k) Medicaid State Plan. The individuals served by SACU would be entitled to nursing home or intermediate care facilities for persons with Mental Retardation (ICF/MR) institutional services. Oregon no longer uses institutional care but the service would be required if we could not meet the need in the community.

Other federal laws or rulings that impact services delivered through SACU are the Americans with Disabilities Act and the Supreme Court Ruling on Olmstead, which generally require individuals to be served in least restrictive, non-institutional settings. Oregon commitment statutes in ORS 427 also require the State to provide care and custody to a person who presents harm to themselves or others, and SACU's status as the safety net is integral to accomplishing this.

Additional statutes that guide the delivery and program are found in ORS 412, 430, 409 and 410. The Oregon Administrative Rules (OARs) that govern the operations of SACU require that individuals be supported in the community and in pursuit of educational and vocational activities.

At the Federal level, in addition to all applicable Medicaid statutes and regulations, services must comply with the Title II of the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973. Compliance with these Federal laws is subject to the U.S. Supreme Court's Olmstead Decision of 1999 and the U.S. Department of Justice's interpretation of that decision as it relates to the ADA and Rehabilitation Act. The Olmstead ruling is relevant to SACU in that it requires all services allowed in the waiver, including SACU, are ones that create inclusion in the community equitably across the state.

Funding Streams

The services are designed and approved using a Medicaid 1915(c) Home and Community-Based Waiver and a 1915(k) Medicaid State Plan which provides a Federal match to the program's General Funds. The program funding match rate is 63 percent Federal Funds and 37 percent State General Funds for waiver services and 69 percent Federal Funds and 31 percent State General Funds for 1915(k) State Plan services. Based on their income level, some individuals also pay an Other Funds contribution toward their room and board costs.

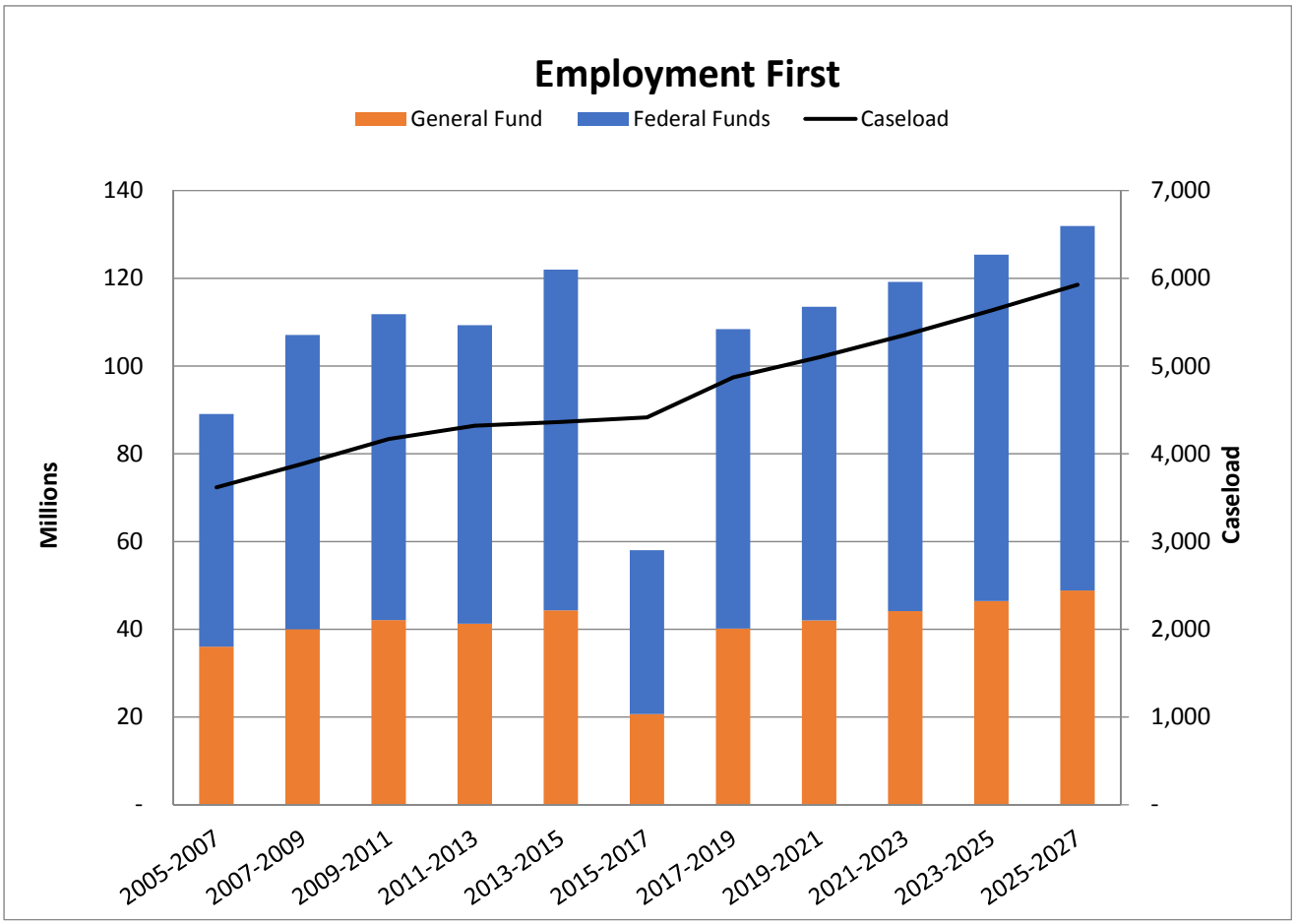
Funding Justification and Significant Changes to CSL

The 2017-19 funding proposal for SACU maintains the program at Current Service Level in 2017-19.

Department of Human Services: Employment First

Primary Outcome Area: Thriving Oregon Economy
Secondary Outcome Area: Safer Healthier Communities
Program Contact: Acacia McGuire Anderson, 503-947-5099

Employment First – Caseload and Funding



Graph represents employment caseloads provided through Employment waiver services compared to the funding. As of 2015-2017, funding for Daily Support Activities is reported under K Plan Program services. As of 2017-2019 GB, the Employment First budget will capture employment services reported under the brokerages.

Program Overview

Employment First is a nationwide initiative which helps individuals with I/DD reach and maintain competitive integrated employment by ensuring that employment is the first and priority option in each state. Research has shown that

people who are employed in the community have the highest level of integration and have stronger social networks. The more people with developmental disabilities that achieve paid employment, the less dependence there is on public resources and the greater the State's flexibility in designing future services that respond to the need of this population. For these reasons and many more, in 2008 Oregon was an early adopter of the Employment First initiative. Employment First is both a national initiative and a state policy. In Oregon, Employment First includes the Office of Developmental Disabilities Services (ODDS), Vocational Rehabilitation (VR), and the Oregon Department of Education (ODE). Employment First is working to increase employment opportunities for individuals with intellectual and developmental disabilities (I/DD). New federal regulations, as well as the Lane v. Brown settlement agreement, place even greater emphasis on the state's need to provide community-based employment services to people with I/DD. The state is also working to help providers that current provide facility-based services (also known as sheltered workshops) to transform their services to community-based.

Program Funding Request

Employment First	GF	OF	FF	TF
LAB 15-17	$20,640,257	$0	$37,357,132	$57,997,389
GB 17-19*	$40,501,628	$0	$69,670,644	$110,172,272
Difference	$19,861,371	$0	$32,313,512	$52,174,883
Percent change	96%		86%	90%

**Brokerage Employment First Services were moved from Support budget to Employment Budget.*
Employment First Funding Request does not include funding for Daily Support Activities.

Program Description

Employment First is based on the general philosophy that individuals with intellectual and developmental disabilities have the ability to be productive and contributing members of their communities through work. This philosophy also recognizes intrinsic and financial benefits of paid work to the individuals with disabilities and their families. This improved economic self-sufficiency has shown to also reduce reliance on government services. Oregon has been very successful in developing community-based care to move away from institutions as a model of care. Having individuals with developmental disabilities fully engaged in their communities is highly desirable as an outcome and fiscally efficient. The Employment First initiative is designed to ensure that employment supports are provided in the community.

All people with developmental disabilities who are eligible to receive services

through either the Comprehensive or Support Services waiver and the Community First Choice (K Plan) may choose to receive residential support through in-home services, foster care, group homes, or supported living services, as well as employment and/or day services. Employment supports include:

- Employment Path services — individuals learn employment skills
- Supported Small Group services —supports for individuals to work in the community with up to seven other individuals who have disabilities and make minimum wage or better
- Job coaching —support to work independently in a community-based job making minimum wage or better
- Discovery — a time-limited service designed to help an individual learn more about their employment strengths and potential job interests
- Day services— intended to help the person be integrated in the community and be engaged in meaningful activities, including both activates of daily living and skills training

The Employment First policy states that work in integrated jobs is the first and priority option in planning employment services for working-age adults and youth. Services should be planned using person-centered practices that identify an individual's talents, skills, and interests. This information can then help inform employment options and career opportunities.

In 2014, CMS issued additional guidance regarding their Home and Community Based Services (HCBS) regulation requiring that employment supports be community-based by March 2019 in order to receive any federal match. Further, DHS reached a settlement in the Lane v. Brown case in January 2016 which requires that ODDS, VR, and ODE work together to ensure that individuals who are currently in a sheltered workshop (or who have been in a sheltered workshop as of 2012) or transitioning out of high school with I/DD receive supported employment services to help them obtain competitive integrated employment. Additionally, the Rehabilitation Act was amended formally as of June 30, 2016 via the Workforce Innovation and Opportunity Act, which requires competitive integrated employment as the outcome to be considered a successful placement through VR.

All of these federal and state changes, as well as implementing Employment First policies, require some fundamental systems transformation. Many providers need support to change business practices to support individuals in jobs throughout

their communities. It is also critical for business partners to embrace the benefits of hiring people with developmental disabilities. Employment First partners with the Oregon Council on Developmental Disabilities and other stakeholder and advocacy organizations to develop policies and communications that strengthen employment outcomes.

As part of the department's strategic planning to integrate those with developmental disabilities into their communities, as well as new federal regulations which require that all employment supports be community-based, efforts are being made to move away from the sheltered workshop model in favor of jobs in the community. For people with developmental disabilities, the goal is that their time in career exploration and hours working in the community will increase and time spent in sheltered workshops decreases. This goal aligns with federal regulations, as well as the Lane v. Brown settlement agreement.

Program Justification and Link to Focus Areas

Employment First links to the Thriving Oregon Economy focus area. Individuals with developmental disabilities are healthier, safer, and happiest when they are engaged in meaningful work. Individuals are more likely to be able to live with their family longer when they have their own daily schedule that is similar to working parents. As with all other citizens, for individuals with I/DD, employment has many positive impacts. These impacts include increasing self-worth, building relationships, and access to community resources. Employment improves economic well-being as well as physical and mental health. Employment supports are key in moving people with developmental disabilities away from 24-hour support services, which results in less public funds being spent.

Employment First also links to other economic development strategies to increase workforce diversity while meeting business needs in ways that result in jobs and prosperity for all Oregonians.

Program Performance

Employment trends have been tracked since 2007. Since Employment First began in 2008, there has been growth in community employment. Additionally, according to the March 2016 Employment Outcomes System (EOS), 841 people received individual supported employment services. This is an increase of 264 people working in individual supported employment services from March 2015. From July 2015 to July 2016 (SFY 2016), Vocational Rehabilitation (VR) had 563 closures

that led to competitive integrated employment for those people also receiving ODDS services. The average number of VR case closures that led to competitive integrated employment has more than doubled, from 22 closures per month in 2011 to 48 per month in 2015. Based on a March 2016EOS count, there were 1,452 people in ODDS services working in a sheltered setting, a decrease of 485 individuals from the March 2015 count.

Employment First and its partners have reached the goals outlined in the 2015-2017 Bid ensuring that by 2016, no transition age youth may enter a sheltered workshop when leaving school as there were no new entry into a sheltered workshop setting allowed by Oregon Administrative Rule as of 7-1-2015. As stated above, the census and hours of individuals in a sheltered workshop setting have been reduced while the census of individuals in supported employment has increased.

For more details regarding process, please visit our bi-annual data reports: http://www.oregon.gov/DHS/EMPLOYMENT/EMPLOYMENT-FIRST/Pages/data-reports.aspx

Employment First Goals:

By June 30, 2019, based on the Lane v. Brown Settlement, Employment First (through ODDS and Vocational Rehabilitation) must place 1,115 individuals currently or recently in a sheltered workshop in competitive integrated employment; and

By June 30, 2019, based on the Lane v. Brown Settlement and Executive Order 15-01, Employment First must provide supported employment services to 4,600 transition age youth or individuals currently or recently in a sheltered workshop. This is required by the Lane v. Brown Settlement Agreement and DHS along with ODE is progressing toward system change in order to ensure these outcomes are reached.

Enabling Legislation/Program Authorization

The provisions of employment-related services for individuals with developmental disabilities are in ORS 430.610, .650 and .670.The enabling statutes are in ORS 409.050 and ORS 410.070.

At the federal level, in addition to all applicable Medicaid statutes and regulations such as the Home and Community Based Services regulation and Workforce

Innovation and Opportunity Act mentioned above, services must comply with the Title II of the Americans with Disabilities Act (ADA) of 1990. Compliance with these federal laws are subject to the U.S. Supreme Court's Olmstead Decision of 1999 and the U.S. Department of Justice's interpretation of that decision as it relates to the ADA and Rehabilitation Act. ADA and Olmstead are relevant to Employment First since the program must assure statewide access in the least restrictive environment.

As of January 2016, the Lane vs. Brown case has been formally settled and Oregon via DHS and ODE are mandated to effectively implement policies to achieve the required outcomes of the Settlement Agreement, which is mandated under federal jurisdiction.

Funding Streams

All funding for Employment First through ODDS is matched through the Medicaid 1915(c) Home and Community-Based Waiver. When a person is getting job development from Vocational Rehabilitation (VR), OVRS Title 1 case service funding is used.

Department of Human Services: Delivery and Design

Primary Long Term Focus Area: Safer, Healthier Communities
Secondary Long Term Focus Area: N/A
Program Contact: Anna Lansky

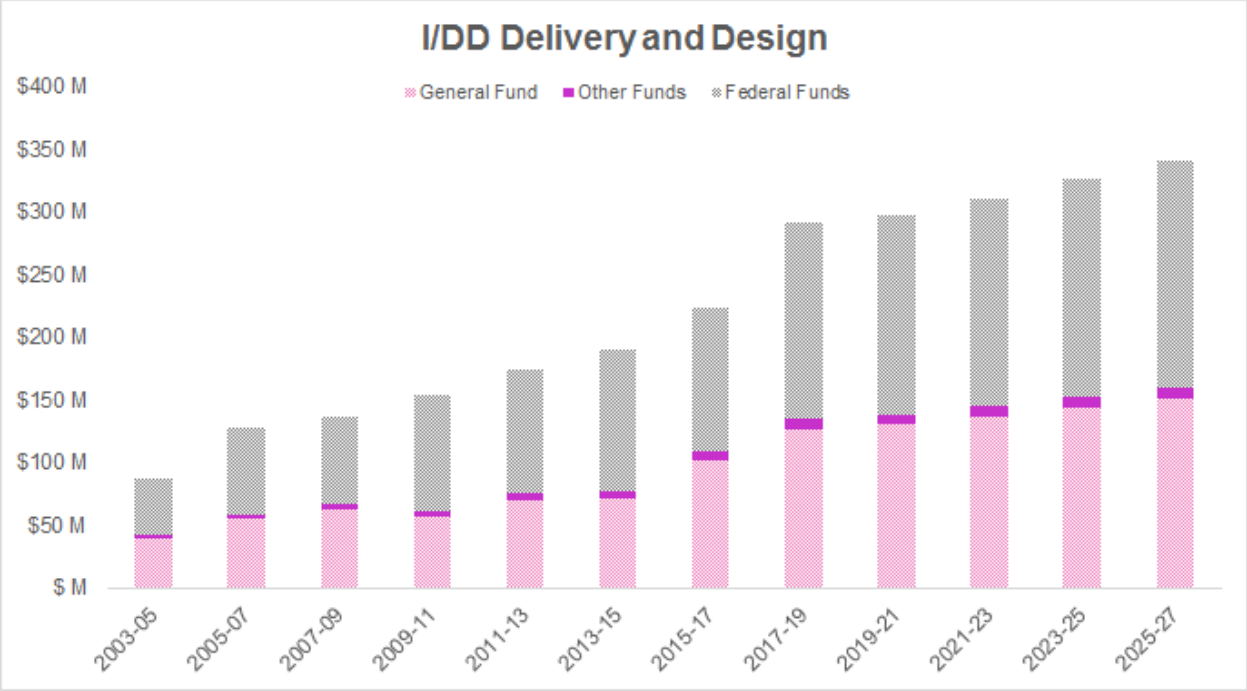


Figure I: Funding of I/DD Delivery and Design (not reflective of funding for the Stabilization and Crisis Unit (SACU)).

Program Overview

The Office of Developmental Disabilities Services (ODDS) manages a lifespan program that provides support and funding to children and adults with intellectual and developmental disabilities (I/DD) to live fully engaged lives in their communities. Oregon has stopped using institutional models to care for people with intellectual and developmental disabilities and has focused all efforts on people living in their community. Programs are provided in the community in the person's own home, family home or in a foster care, group home or in supported living programs. Design and Delivery provides administrative and operational support to these programs.

Program Funding Request

INTELLECTUAL & DEVELOPMENTAL DISABILITIES *DELIVERY & DESIGN*	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
2015 - 17 Leg. Approved	105,808,912	6,221,617	120,654,254	232,684,783	100	98.88
2017 - 19 Governor's Budget	120,334,063	8,700,139	146,409,828	275,444,030	98	98.22
Difference	14,525,151	2,478,522	25,755,574	42,759,247	(2)	(0.66)
Percent change	13.73	39.84	21.35	18.38	(2.00)	(0.67)

Program Description

There are over 26,000 Oregonians with I/DD receiving case management and other supports through the ODDS program. Since implementation of Community First Choice Option (CFCO), also known as K Plan, in July 2013, the Oregon I/DD service delivery system has undergone significant changes. Due to CFCO implementation, ODDS now can provide services to all eligible children, while in the past families with children with I/DD had to reach crisis before being able to access services and supports. Additionally, K Plan has expanded in-home services for adults as well, lifting budget caps previously imposed on amount of services adults with I/DD were able to access in their own or family homes. Under CFCO, the amount of in-home services is determined based on functional needs assessment. As a result of these changes, the number of individuals served within I/DD system has significantly increased. During this biennium, since July 2015, over 2,300 new individuals enrolled into the I/DD service delivery system increasing total population by 9.7 percent. The trend is expected to continue into the 2017-19 biennium.

The structure for service delivery and design includes a central program administration office, Children Intensive In-Home Services (CIIS) unit, and contracted services with Community Developmental Disabilities Programs (CDDP) and Support Service Brokerages (Brokerages). Additionally, the ODDS central office provides strategic planning, program funding, policy development, provider licensure and certification, general oversight, and technical support to community services. Contracted county Community Developmental Disability Programs (CDDPs) are responsible for eligibility determination, program enrollment, case management, abuse investigation, and quality assurance. Adults receiving in-home services can also choose to get case management through contracted Brokerages.

Services are offered on a continuum-of-care model and are provided as the first option of supports for a person with developmental disabilities. With CFCO, people can chose the setting in which they live, which increases the importance of supporting and strengthening the ability of families and communities to include and provide natural supports to those with I/DD.

ODDS delegates the responsibility for administration to local county government, Community Developmental Disabilities Programs (CDDPs), in accordance with state statutes (ORS 407). DHS has Intergovernmental Agreements with all but six counties. In those counties, the state contracts with a private agency. Local oversight responsibilities include determining eligibility for developmental disabilities, planning and resource development, developing and monitoring Individual Support Plans, documentation of service delivery to comply with state and federal requirements. Counties also are responsible for case management services, evaluation and coordination of services, abuse investigations of adults and quality assurance services. ODDS provides funding for the equivalent of nearly 865 full time employees of CDDPs through contracts. CDDPs provide case management for all individuals, except adults choosing to be served by a Support Service Brokerage. Adults living in their own or family home have a choice of case management providers, between the local CDDP and a Brokerage. Children are all served by the CDDPs, except those case managed by ODDS staff through the Children's Intensive In-Home Services or Children's Residential Services programs.

There are 14 Support Service Brokerages statewide. Brokerages vary in size and support from 251 to 720 people. People with I/DD are enrolled in Brokerages from the county when they select Brokerage case management services. Once in a Brokerage, the Brokerage Personal Agent (PA) completes a needs assessment, develops the Individual Support Plan, and assists the person in determining services needed, amount of service and possible workers or agencies. PA's help the individual to design plans that meet their needs as determined by the needs assessment. ODDS provides funding for 307 full-time employees to the Brokerages[1]. In order to not duplicate services, once a person is in a Brokerage, they do not also get case management from the CDDP.

The majority of individuals receiving services are eligible for Medicaid. Oregon no longer uses institutional models of care for people with I/DD. Instead, the State

[1] **Spring 2016 Forecasted caseload for 2017-2019 CSL**

uses Medicaid Home and Community-Based Services (HCBS) that allow for shared funding from the Federal government. Through the CFCO State Plan Option, the states receives FMAP plus an additional 6 percent in federal match.

ODDS staff provide policy and program design, technical support, provider licensure and certification, quality assurance, and field support of CDDPs, Brokerages, and direct service providers. There are more than 250 private service provider agencies, approximately 1,120 foster care providers and over 11,900 Personal Support Workers. Regulatory oversight for licensed settings is provided by the ODDS Office of Licensing and Regulatory Oversight.

Central office staff provides programmatic and budget analysis support to Department of Administrative Services Labor Management, collective bargaining, for the Adult Foster Homes, Home Care Workers, and Personal Support Workers.

The Delivery system also includes the Children's Intensive In-Home Services (CIIS) and the Children's Residential Services comprised of state staff under ODDS' umbrella. These units operate and provide case management services to the three Model Waivers for children and provide case management support to children in residential services.

Program Justification and Link to Focus Areas

This program links to the Safer, Healthier Communities focus area. The program delivery system, designed and monitored by central staff and implemented through either the CDDP or Brokerage, is designed to assure supports are provided so the individual is healthy and safe, and fully engaged in their community. The goal is to help them have the best possible quality of life at any age. Person-centered strategies are used to maximize the person's outcomes and use of natural supports. The CDDP and Brokerage report on critical incidents and the data are used to track trends and determine strategies to improve healthy living outcomes.

Program Performance

Adequate personnel resources are necessary to ensure delivery of programs and provision of services within Developmental Disabilities in a linguistically and culturally competent manner. The chart below provides a comparison of the caseload growth to the equivalent contracted CDDP and Brokerage personnel: CDDP Service Coordinators and the Brokerage Personal Agents.

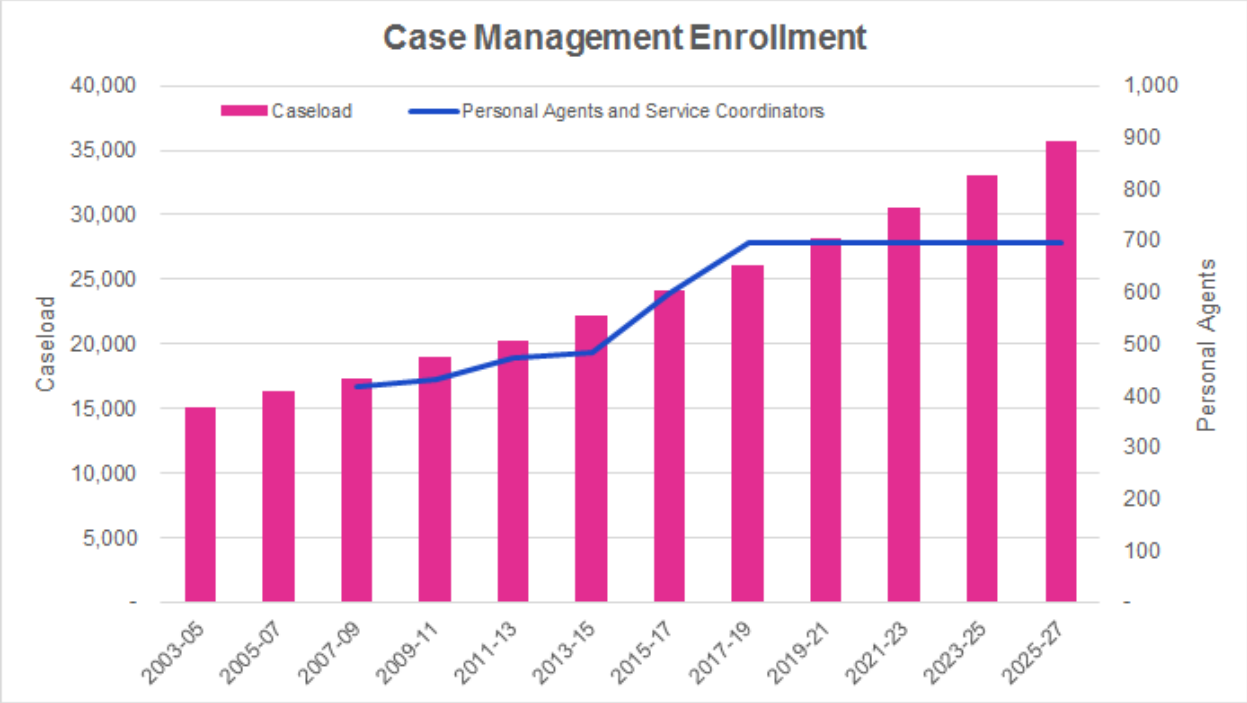


Figure II: Growth of I/DD Caseload and CDDP Service Coordinators and Brokerage Personal Agents.

Enabling Legislation/Program Authorization

The services are designed and approved using Medicaid 1915c Home and Community-Based Waivers and the CFCO Medicaid State Plan. Without the waivers and state plan, individuals would be entitled to Institutional Care for Individuals with Intellectual and Developmental Disabilities (ICF/IDD). Individuals can also be court committed to the state care and custody under ORS 427. Case Management is authorized under the Medicaid State Plan. Federal authorization for all services is at 42 C.F.R. 441 and Section 1915(c) of the Social Security Act. Authorization to provide the services in Oregon is in ORS 410.070, 409.050.

At the federal level, in addition to all applicable Medicaid statutes and regulations, services must comply with the Title II of the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973. Compliance with these federal laws are subject to the U.S. Supreme Court's Olmstead Decision of 1999 and the U.S. Department of Justice's interpretation of that decision as it relates to the ADA and Rehabilitation Act. The Olmstead Decision requires states to provide services and supports in non-segregated settings.

Funding Streams

The services are designed and approved using the Community First Choice Option in the Medicaid State Plan and Home and Community-Based Waivers, which provide a Federal match to the program's General Funds. The program funding match rate for waivered services is 63 percent Federal Funds and 37 percent State General Funds and for CFCO services is 70 percent Federal Funds and 30 percent State General Fund.

The administration of CDDP, Brokerage, and Central Office staff are funded at the Medicaid administrative match of 50/50. Authorization to provide the services in Oregon is in ORS 410.070, 409.050.

105 Stable and competent workforce for I/DD

General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
200,160	0	18,687	218,847	1	1.00

Perpetually low wages from an outdated rate model for the I/DD provider workforce has created a record level of turnover and a critical shortage of direct support professionals (DSPs). DSPs provide support for people with I/DD to live and work in a safe and healthy manner as members of their communities. DHS and stakeholders created the existing rate structure based on 2007 fiscal data. This model needs to be updated to align with current economic realities; new minimum wage requirements; new DOL Overtime Rule, and expectations around service quality, safety and competency/training requirements. A stable and well-trained workforce is critical to the ability of I/DD provider network to providing high quality of services to individuals and assuring their health and safety. Provider rate structure needs to reflect these requirements and provide adequate compensation to assure that individuals with I/DD are served by competent workers. This POP will: Ensure adequate DSP wages that are above minimum wage to reflect DHS' longstanding policy that DSP work is not minimum wage work; address compression effect of minimum wage increases on wages of house managers and supervisors; address cost impact of new DOL requirements around overtime pay for workers earning less than $913 a week ($47,476 a year); provide financial incentives for providers to ensure their staff achieves highest level of training and competency and by making available College of Direct Support training to Oregon DSPs, and provide one FTE for ODDS to coordinate provider training requirements and programs.

Reductions

- Eliminate Regional Staff – Effective July 1, 2017, this reduction eliminates the regional staff that support the CDDPs with crisis situations.

- Reduce Brokerage and CDDP equity by four percent from 95 percent to 91 percent – Effective October 1, 2017, this reduction reduces the operating funding to CDDPs and Brokerages by four percent.

DHS Program Eligibility Requirements 2017

	Child Welfare (CW)	Intellectual and/or Developmental Disabilities (I/DD)*	Aging and People with Disabilities - Medicare Savings Programs (APD)	Long-Term Care (LTC - within APD)	Adult Protective Services (APS)	Vocational Rehab Services (VR)	Employment Related Day Care (ERDC)	Temporary Assistance for Needy Families (TANF)	Supplemental Nutrition Assistance Program (SNAP)
Age	0-18, 18 - 21st birthday if in Foster Care prior to age 18.	All Ages	Any age with Medicare	65 or older or disabled N/A- (ACA Expansion Population)	65 or older or disabled	16 and older (can be down to age 14 if appropriate)	Children 0 - 12 years. Children with documented special needs are served through the age of 17.	Serves families with children up to age 17 and through age 18 if the child is in secondary school or an equivalent program full time.	All ages. Certain groups must apply together if in same household including: those who purchase and prepare together, spouses, adults who have children in common, children under the age of 22 living with parents, and children under 18 who are under parental control within household.
Disability	N/A	Age 0-7: 1) standardized testing verifying significant impairment; or 2) medical stmt w/diagnosis of neurological condition that will likely cause significant impairment in two or more areas of adaptive behavior. School-age children and adults: Significant impairment in adaptive behavior caused by: 1) intellectual disability present prior to age 18 (IQ 75 or below); or a neurological condition, prior to age 22 and expected to last indefinitely, that originates in and directly affects the brain. All age groups: impairment cannot be primarily related to an excluded condition, including, but not limited to, a mental or emotional disorder, sensory impairment, substance abuse, personality disorder, learning disability or attention deficit hyperactivity disorder.	N/A	SSA determination of blindness or disability	SSA determination of blindness or disability	Must have a physical or mental impairment that constitutes a substantial impediment to work that requires vocational rehabilitation services to obtain, maintain, regain and advance in employment. The presumption is that employment is the applicants objective.	Higher child care reimbursement rates may be available for children with documented special needs.	N/A	SSA determination of blindness or disability. Disability exempts ABAWDs from having to meet work requirements, makes students of higher education SNAP eligible, qualifies household for medical deductions and removes shelter cap on cases.
Citizenship	N/A	Must be a citizen or meet non-citizen requirements.	Must be a citizen or meet non-citizen status requirements.	Must be a citizen or meet non-citizen status requirements.	N/A	Must meet I-9 Federal Requirements to work in the United States.	Must be a citizen or meet non-citizen requirements.	Must be a citizen, qualified non-citizen, or other specific unqualified non-citizen.	Must be a citizen or meet non-citizen requirements.
Residency	N/A	Must be a resident of Oregon. For applicants under 18, legal guardian must be resident of Oregon.	Must be resident of Oregon	Must be a resident of Oregon	N/A	Must meet I-9 Federal Requirements to work in the United States.	Must be a resident of Oregon.	N/A	Must be resident of Oregon
Income	N/A	In-home waiver services: Oregon Supplemental Income Program – Medical (OSIPM) income limits; generally, the countable income limit is 300% of the full SSI standard for a single individual. In-home k-plan services: OHP MAGI-based income methodologies are used; up to 133% FPL. Case mgmt only: N/A.	$981 - $1325	$733 - $2,199	N/A	N/A	Current income must be no more than185% of the federal poverty level	Income must meet income and payment standards. Income limits vary by family size, but in general current income must be no more than 37% of the federal poverty level for initial certifications for a family of three. To meet ongoing, the same family must be no more than 60% of the federal poverty level.	Most households must have gross income below 185% of the federal poverty level to be eligible for SNAP. Services are based upon income received in past 30 days.

	Child Welfare (CW)	Intellectual and/or Developmental Disabilities (I/DD)*	Aging and People with Disabilities - Medicare Savings Programs (APD)	Long-Term Care (LTC - within APD)	Adult Protective Services (APS)	Vocational Rehab Services (VR)	Employment Related Day Care (ERDC)	Temporary Assistance for Needy Families (TANF)	Supplemental Nutrition Assistance Program (SNAP)
Asset/Resource Limits	N/A	OSIPM: $2000 (1-person need group) - $3,000 (2-person need group).	N/A	$2,000 - $3,000 (categorical) N/A- (ACA Expansion Population)	N/A	N/A	Cannot exceed $1,000,000.	Applicant resource limit $2,500. Recipient's resource limit $10,000. Allows a motor vehicle exclusion up to $10,000.	There is a $25,000 liquid asset test for households to meet categorical eligibility. All households that do not meet categorical eligibility must meet a $2250 resource limit unless an elderly or disabled member is in the household—then the resource limit is $3250.
Other	N/A	Needs assessment and authorized individual support plan.	N/A	Must meet service priority levels from 1 - 13: Individuals with the most impairments are assessed at a higher priority level. For example, individuals at level 1 have a higher level of need than an individual at level 13.	N/A	Youth age 14 can be eligible for VR services while participating in Transition activities coordinated by school districts.	N/A	Family must include one child or pregnant individual. Child only case must be under the age of 18 or under the age of 19 and in secondary school or equivalent program full time.	Able-Bodied Adults Without Dependents (ABAWDs) are adults ages 18-49 who don't have children in the home and must meet work requirements to be eligible for SNAP in non-waived counties, unless they meet an exemption. Qualified non-citizens are only eligible when additional criteria is met or when a special status such as Refugee or Trafficking is applicable.

***Intellectual/Developmental Disabilities**

In order to access DHS I/DD Services, individuals must meet *one* of the assessment/diagnosis requirements. For all other programs, *all* requirements must be met.

Department of Human Services
2017-19 Policy Option Packages

Program Area	Official Title (45 Character Limit)	Detailed description of ask.	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE	LC #	POP Number
APD	Centralized Abuse Management System	House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from ten (10) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations. This POP requests state funds to complete implementation efforts started in the 2015-17 biennium, for an integrated solution which meets HB 4151 criteria and helps protect vulnerable Oregonians. Not funding this POP will limit Oregon's ability to achieve the capabilities and efficiencies of the proposed integrated solution. The Other funds in this request are carryover Q-Bonds sold in spring of 2017 and is a one time request for limitation. The General fund is the best current estimate of costs of the ongoing operations and maintenance of the new system.	1,920,186	2,207,072	215,911	4,343,169	4	2.83		**102**
IDD	Stable and competent workforce for I/DD	Perpetually low wages from an outdated rate model for the I/DD provider workforce has created a record level of turnover and a critical shortage of direct support professionals (DSPs). DSPs provide support for people with I/DD to live and work in a safe and healthy manner as members of their communities. DHS and stakeholders created the existing rate structure based on 2007 fiscal data. This model needs to be updated to align with current economic realities; new minimum wage requirements; new DOL Overtime Rule, and expectations around service quality, safety and competency/training requirements. A stable and well trained workforce is critical to the ability of I/DD provider network to providing high quality of services to individuals and assuring their health and safety. Provider rate structure needs to reflect these requirements and provide adequate compensation to assure that individuals with I/DD are served by competent workers. This POP will: Ensure adequate DSP wages that are above minimum wage to reflect DHS' longstanding policy that DSP work is not minimum wage work; address compression effect of minimum wage increases on wages of house managers and supervisors; address cost impact of new DOL requirements around overtime pay for workers earning less than $913 a week ($47,476 a year); provide financial incentives for providers to ensure their staff achieves highest level of training and competency and by making available College of Direct Support training to Oregon DSPs and provide one FTE for ODDS to coordinate provider training requirements and programs.	22,281,720	-	49,045,426	71,327,146	1	1.00		**105**
CW	Family Foster Care Rate Reimbursement	Reimbursement rates for Family Foster Care have not been adjusted to the cost of living for a decade. In 2009 rates were adjusted to 90% of the cost of care based on a 2007 rate methodology. In 2011, these rates were reduced by an additional 10% due to department budget cuts. Families coming forward to provide foster care has continued to diminish over the last 5 years in part due to the low reimbursement rates. The current daily rate is $18.90 per day for a child under age 5 years old or $24.36 per day for a teenager. This is intended to cover the costs of food, shelter, clothing, school supplies, extracurricular activities, etc.… Based on the methodology created in 2009 Oregon is currently providing only 40-46% of the actual cost of care. Other states have been sued due to the low rate of family foster care payments and Oregon continues to increase the risk of a class action lawsuit.	7,926,190		4,857,987	12,784,177	-	-		**108**
CW	BRS rates	Update the rate model for Behavioral Rehabilitation Services (BRS) program to pay contracted providers for costs increases above inflation. Rates directly impact state agencies access to these programs. The BRS rate model has not been kept current since first established in 1998. Simply adding inflation to the previous biennium rate has not kept pace with significantly increasing costs. Some of the most heavily used programs have closed over the past two biennia. More programs have signaled if they don't receive more financial support from the state they will have to close soon. This package is most importantly about child and youth safety as well as maintaining access to this essential part of the system serving Oregon's most needy children. Without increases to the rate state agencies will continue to have pressure on the BRS system as provider costs increase and the rate remains inadequate.	2,116,547		3,823,804	5,940,351	-	-		**109**
CW	Legal Representation in Child Welfare	Historically, DOJ's billable hour model has been considered cost-prohibitive in juvenile dependency cases and has been a deterrent to DHS accessing and utilizing DOJ for full representation—including attendance at all hearings, regular case consultation, impromptu legal advice, and regular participation in case worker training, meetings, and staffing. A block grant model will allow DOJ to manage cases according to a workload method of case assignment with each DOJ attorney carrying a consistent number of weighted cases. In this model, each dependency case is assigned to an attorney who handles it from petition to permanency. This case assignment method will provide DHS caseworkers with continuous representation which, in turn, will promote attorney-caseworker collaboration, improve caseworker job satisfaction and retention, avoid the risk for unlawful practice of law by case workers, and improve the overall efficiency and cost-effectiveness of the system. This POP assumes a total fund block grant funding model of $45 million TF for full representation and assumes the exception to DHS representation in these cases is lifted. If the representation exception is continued DHS is still short $4.5 million GF in order to meet projected CW AG costs in 2017-19.	6,916,041		12,957,561	19,873,602				**110**
ITBSU DHS/OHA	Integrated Eligibility Project	DHS is seeking legislative approval for a project that would transfer human service eligibility determination functionality from Kentucky to add to the new integrated OregONEligibility system. This will impact eligibility for Non-MAGI Medicaid, ERDC, SNAP and TANF programs.	11,959,788	18,275,000	101,794,707	132,029,495	38	28.29		**201**

Department of Human Services
2017-19 Policy Option Packages

Program Area	Official Title (45 Character Limit)	Detailed description of ask.	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE	LC #	POP Number
HR DHS/OHA	Background Check Unit Workload	Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines for background checks. Groups for whom BCU completes checks include but are not limited to home care workers, personal support workers, subsidized child care providers, child caring agencies, System of Care and SPRF providers, and staff and volunteers from residential care, nursing, and adult foster home facilities. The staff requested in this policy option package would meet currently required needs to maintain timely background checks for all regulated groups handled by BCU, and meet projected needs due to program growth and new federal and state statutes implementing during the 2017-2019 biennium. The result would be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for vulnerable Oregonians through quality background checks. In addition, Department of Human Services (DHS) has identified a variety of expansion options to current background check criteria for DHS and OHA providers whose fitness determination is completed by the Background Check Unit (BCU). These options would provide more intensive background checks by accessing a variety of DHS, state and federal information regarding health, safety, abuse and fraud not currently utilized. The result would be increased health, safety and financial wellness for vulnerable Oregonians. The BCU has authority to charge fees but does not currently do so. A fee for service model is an option to cover some or all costs of the BCU.	6,118,266	7,251,800	1,221,826	14,591,892	22	11.00		**205**
						-				
TOTAL			**59,238,738**	**27,733,872**	**173,917,222**	**260,889,832**	**65**	**43.12**		

Department of Human Services
2017-19 Policy Option Package

Agency Name:	**Department of Human Services**
Program Area Name:	**DHS Shared Services**
Program Name:	**Oregon Adult Abuse Prevention and Investigations (OAPPI)**
Policy Option Package Initiative:	**N/A**
Policy Option Package Title:	**Implementing Centralized Abuse Management (CAM) System**
Policy Option Package Number:	**POP 102**
Related Legislation:	**N/A**
Program Funding Team:	**Safer, Healthier Communities**

Summary Statement:

House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults.

Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from nine distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations.

This POP requests state funds and requests carryover of Q bond funds to implement additional enhancements that will build upon the capabilities of a base system implemented in the 2015-17 biennium, for an integrated solution, which meets HB 4151 criteria and helps protect vulnerable Oregonians. Additional enhancements, anticipated to be complete by 12/31/2017, will fulfill the scope of the CAM project. Not funding this

POP will limit Oregon's ability to achieve the capabilities and efficiencies of the proposed integrated solution.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$1,920,186**	**$2,207,072**	**$215,911**	**$4,343,169**

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

This POP supports multiple DHS programs by funding the full implementation of an integrated solution for tracking, reporting and supporting investigations of adult abuse. Program areas include: Aging and People with Disabilities, Developmental Disabilities and Child Welfare.

Funding will support the second release of the system, which will realize efficiencies by enhancing capabilities to include reporting functionality, provide document management capability, enable notifications, interface with other Oregon systems and provide ongoing risk management while leveraging the base functionality planned for implementation in the 2015-17 biennium.

Activities this POP will fund include:

- Implementation costs for enhancements in order to fully realize the capabilities of the CAM system including state staff costs, professional services and quality assurance.
- Licensing costs for the full 2017-2019 biennium
- Operations and maintenance costs for the full 2017-2019 biennium

2. WHY DOES DHS/OHA PROPOSE THIS POP?

This POP provides the funding necessary to complete full implementation of a centralized abuse management system and funds software licensing through the full 2017-19 biennium and ongoing maintenance and support post-implementation.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

In 2014, almost 750,000 Oregonians belonged to one of the nine Oregon populations supported by OAAPI and its program partners that receive and process reports of abuse. During that same year OAAPI and its program partners received more than 38,000[1] allegations of abuse of these individuals, resulting in 18,185[1] investigations.

According to the 2014 OAAPI Annual Report dated July 2015, "In 2014, there was a 10% overall increase in the number of investigations conducted (compared to 2013)." During the next 10 years the number of allegations received and screened by OAAPI and its program partners is expected to increase nearly 60%. This assessment increases the projected 50,414 allegations in 2015 to more than 78,500 allegations in 2024, based on current and predicted growth of vulnerable populations. OAAPI is projecting 30,800 investigations by 2024, a nearly 63% increase from the 2015 level of 19,000 investigations. This growth in the number of abuse referrals and investigations, typical of previous years, is one of the reasons that OAAPI was formed, to ensure a coordinated and consistent response to an increasing number of abuse referrals across all vulnerable populations. Abuse can't be undone. Abuse carries with it lifelong impacts to a person's life in regard to health, emotional well-being and a person's ability to benefit from available services.

The need for a stable Centralized Abuse Management System becomes ever more critical as Oregon faces an aging population, a significant annual increase in abuse referrals and an increased need for services across all demographics.

An improved system for abuse data collection, from the time of screening through investigation, case closure and referral, is essential to better protect vulnerable Oregonians and to more accurately and efficiently produce

[1] OAAPI Annual Report 2014 – Published July 2015.

meaningful abuse data and outcomes to the Legislature, DHS leadership and the public. This system must be focused on abuse across programs, not simply added on to the various existing, disconnected program databases.

The full implementation of such a system would directly contribute to the DHS Policy Outcome of "Improving our Human Services Systems" by addressing a long standing gap in data collection and analysis and leading to a more efficient and effective state response to the reported abuse of vulnerable Oregonians.

Additionally, the implementation of a Centralized Abuse Management System is in alignment with the DHS/OHA Strategic Technology Plan (STP) including progress in pursuit of automating business workflows, decision-making, and business rules while reducing manual, paper-based processes. A Centralized Management System moves the state closer to providing a comprehensive view of a client and makes progress towards the goal of a "360 degree view of a person." The project will provide workers connectivity to a real-time system to perform their work anytime and anywhere. Through the reduction of data duplications and entry into multiple systems, CAM will make advancements in providing a trusted source for abuse and investigation data. The implementation of a SaaS (software as a service) solution will allow responsiveness to quickly evolving business needs.

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

Yes, this POP is directly tied to the following process measures and outcome measures outlined on the DHS Fundamentals Map:

"Protection and Intervention" (OP1) Process Measures:

- % of completed investigations coded "unable to determine" or "inconclusive"
- % of calls assigned for field contact that meet policy timelines
- % of investigation reports completed within policy timelines

"Safety" (O1) Outcome Measures:

- Re-abuse rate
- Abuse rate

As of the fourth quarter of 2015, DHS and OHA were not meeting most of the Adult Abuse Quarterly Business Review (QBR) – Key Performance Metrics (KPMs) for Adult Abuse.

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, this POP supports HB 4151.

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

Oregon considered three alternatives:

1. Maintain the status quo

   Under this alternative there would be no additional investment in abuse tracking system automation. Improvements to current processes would be limited to those that arise naturally through the Department's continuous improvement program.

   - The department would continue with ineffective, disconnected automated and manual systems that are difficult to oversee and analyze.
   - The requirements and recommendations made by HB 4151, SB 1515, and various reports and audits would not be met in the foreseeable future.

2. Implement a Custom Build Solution
   - Under this alternative the department would design, develop, test and deploy a custom solution built from the ground up for APS, HS, DD, CW and OSH Centralized Abuse Management needs. This alternative would allow a tailor-made solution that would meet all the functional, technical and organization requirements.

- The costs to develop a custom system are substantially higher than procuring the Salesforce CRM, with commensurate risks and a timeline that is more than a year longer to implement compared to implementing a Salesforce solution.

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

- Continued risk of not identifying cases of cross-population abuse or victims
- Inability to fully achieve the efficiencies of the base SaaS solution being implemented in 2015-17. The planned second release to expand on the base solution to include reporting, interfaces with other Oregon systems, notifications, document management (attachment of documents in the system), ongoing risk management (for Adult Protective Services clients) would not be completed, leaving workers with an incomplete and inefficient tool to support their abuse investigations.
- OAAPI frequently encounters the need for manual data mining and collection to respond to public or media inquiries, to perform effective oversight of local offices and investigators and also to provide basic quality assurance or monitor statutory compliance. In the current state, the department loses productivity when workers run semi-automated processes to link data between different databases in order to produce metrics. Many hours are lost during the process of exchanging, checking and interpreting data from the various systems. Unfortunately, this is valuable staff time that could be put to better use performing quality assurance and data analysis to identify the causes of abuse in community and facility settings and then to work to mitigate those causes.

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

Other agencies affected by this POP include OAAPI's Program Partners and those with a business needs for abuse data or investigation reports, such as:

- Background Check Unit (BCU)
- DHS Case Management (APD & DD)
- Child Welfare (CW)

- The Office of Licensing & Regulatory Oversight (OLRO)
- The Oregon Health Authority / Addictions and Mental Health Licensing

These agencies would experience a change in how they receive abuse data and reports from OAAPI and from community programs. Agencies access to abuse data would be based on business need and established using a role-based security protocol.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Oregon Adult Abuse Prevention and Investigations (OAAPI), on behalf of the Department of Human Services, Aging and People with Disabilities, Developmental Disabilities, and Child Welfare and multiple county partners including Multnomah County, champion this POP. All of these entities are stakeholders in protecting vulnerable Oregonians and will benefit from full implementation of an integrated tracking and reporting solution for adult abuse.

10. WHAT IS YOUR EQUITY ANALYSIS?

Abuse data systems currently in use do not capture the racial and ethnic identifiers needed for an analysis of service equity in the abuse investigation process. As a result, it is currently impossible to analyze the service equity in the provision of abuse response and investigation. The fully-implemented CAM system will incorporate such identifiers and allow for in-depth analysis of service equity in the delivery of abuse investigations and protective services.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s):

Release 1.0 will be complete by June 30, 2017 and will implement the base functionality using a software as a service solution. Release 2.0 will be complete by December 31, 2017 providing the remaining key functionality necessary to support notifications, reporting and fully-developed investigations across populations.

End Date (if applicable):
The transition to maintenance and operations is expected to start January 1, 2018 and be fully realized by March 2018. Licensing fees for the full biennium, estimated at roughly $600,000 a year as well as operation and maintenance fees for the full biennium, estimated at $100,000 a year are included in the pricing of this POP.

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

☒ Interface data from existing disparate systems into the CAM system will require engagement and support of program and policy resources for DHS as well as OIS resources supporting the back-end systems.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
None identified at this time.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No changes anticipated.

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.
Resources supporting the current project through the 2015-17 biennium will be needed to support this effort into the 2017-19 biennium. This includes subject matter experts from various program areas

who will need to provide input to refine requirements and test the usability of the solution for accuracy before implementation.

The level of continued core project staffing is modest because the majority of the integration work is expected to be supported by the Systems Integrator. No new staffing will be needed, the project anticipates utilizing current state staff to be allocated to the project as needed.

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

For 2017-19, the primary costs are to support the implementation of the remaining capabilities and are estimated at approximately $3.4 million total cost with a state general fund cost of $1.4 million. Training of staff and other end users will be necessary and communications, including new materials, will be needed to support adoption and business process changes to fully leverage the new solutions.

f. What are the ongoing costs?

Ongoing costs include licensing fees estimated at approximately $600,000 a year and operation and maintenance fees estimated at $100,000 a year.

g. What are the potential savings?

DHS will have the potential to sunset several systems or portions of systems. This will ultimately yield savings and enable utilization of the technical staff who support those systems to be leveraged in support of the new systems.

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

Yes.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	172,245	125,960	172,253	470,458	4	2.83
Services & Supplies	1,602,358	2,081,112	34,336	3,717,806		
Special Payments	145,583		9,322	154,905		
Total	**$1,920,186**	**$2,207,072**	**$215,911**	**$4,343,169**	**4**	**2.83**

DHS - Fiscal Impact Summary by Program Area:

	OAAPI	DHS SAEC	ITBS	APD Design	Total
General Fund	**$0**	**$157,072**	**$68,192**	**$1,694,922**	**$1,920,186**
Other Fund	**$157,072**	**$0**	**$0**	**$2,050,000**	**$2,207,072**
Federal Funds- Ltd	**$0**	**$0**	**$67,966**	**$147,945**	**$215,911**
Total Funds	**$157,072**	**$157,072**	**$135,628**	**$3,892,867**	**$4,343,169**
Positions	**1**	**0**	**1**	**2**	**4**
FTE	**0.75**	**0.00**	**0.58**	**1.50**	**2.83**

What are the sources of funding and the funding split for each one?
The Federal Funds are Medicaid. The Other Funds are non-add Other Fund limitation needed for Shared Services.

Department of Human Services
2017-19 Policy Option Package

Agency Name:	**Department of Human Services**
Program Area Name:	**Office of Developmental Disability Services**
Program Name:	**Office of Developmental Disability Services**
Policy Option Package Initiative:	**Stable and competent workforce for I/DD services**
Policy Option Package Title:	**Stable and competent workforce for I/DD services**
Policy Option Package Number:	**105**
Related Legislation:	**N/A**
Program Funding Team:	**N/A**

Summary Statement:

Perpetually low wages from an outdated rate model for the Intellectual/Developmental Disabilities (I/DD) provider workforce has created a record level of turnover and a critical shortage of direct support professionals (DSPs). DSPs provide support for people with I/DD to live and work in a safe and healthy manner as members of their communities. The Department of Human Services (DHS) and stakeholders created the existing rate structure based on 2007 fiscal data. This model needs to be updated to align with current economic realities; new minimum wage requirements, and expectations around service quality, safety and competency and training requirements. A stable and well-trained workforce is critical to the ability of the I/DD provider network to provide high quality services to individuals to ensure their health and safety. Provider rate structure needs to reflect these requirements and provide adequate compensation to ensure that individuals with I/DD are served by competent workers.

This POP will provide a percentage provider rate increase to:

1. Start addressing low DSP wages and maintain them above minimum wage to reflect DHS' longstanding policy that DSP work is not a minimum wage work.
2. Address compression effect of minimum wage increases on wages of house managers and supervisors.
3. Provide financial incentives for providers to ensure their staff achieves highest level of training and competency and by making available College of Direct Support training to Oregon DSPs.
4. Provide one FTE for the Office of Developmental Disabilities Services (ODDS) to coordinate provider training requirements and programs.

The estimated cost of these measures is $71,327,146.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$22,281,720**	**$0**	**$49,045,426**	**$71,327,146**

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

In order to address the critical workforce situation and record high turnover rates within I/DD service delivery system, ODDS is planning to engage in a rate setting process to ensure that provider service rates adequately reflect work requirements, qualifications, quality standards, and deliverables expected, while ensuring workforce stability and start moving in the direction of providing adequate reimbursement for Direct Support Professionals (DSPs). The new rate structure will incorporate the following cost drivers:

1. Adequate DSP wages that are above minimum wage
2. Compression effect of minimum wage increases on wages of house managers and supervisors

Another strategy for workforce development and retention proposed in this POP is implementation of a rigorous training program that supports a skill-based career ladder for DSPs and incentives to providers to support workers in achieving highest level of competency and training. As part of this strategy, ODDS will partner with Direct Course to provide credentialing through the College of Direct Support to make training available. College of Direct Support (CDS) content is developed through a consortium of academic institutions, including leading experts in the field of intellectual and developmental disabilities. The College of Direct Support Board is comprised of subject matter experts who review and contribute to the development of curriculum to ensure that every course for direct support professionals offers leading insight and nationally recognized best practices. The College of Direct Support curriculum and training programs assist in building a permanent, verifiable records of training for every member of a state's direct support workforce. ODDS, through the rate structure, will provide adequate resources to providers to incentivize their workforce to achieve high levels of competency through this, or other equivalent training. The POP will include one FTE for ODDS to coordinate tracking of providers and DSPs.

2. WHY DOES DHS PROPOSE THIS POP?

Adequate reimbursement of provider agencies delivering services to individuals with I/DD is critical to maintain a high quality and stable network of providers. A stable workforce is critical to serving children and adults with I/DD because it provides an ability to train and retain skilled DSPs who are committed to their work, ensure health and safety of individuals served, and are able to support individuals in achieving full lives in their communities.

Inadequate reimbursement rates contribute to high turnover rates, worker shortages, and high competition for workforce within the industry and with other industries that require similar qualifications and provide similar or better pay. Other outcomes of staff instability and shortages are potential risks to the health and safety of individuals served, low quality of services to individuals, gaps in critical services and inability to meet needs of individuals with high level of needs due to staffing shortages, often resulting in placement in higher cost settings.

In January, 2015, RTI International produced a report on Wages, Fringe Benefits, and Turnover for Direct Care Workers Working for Long-Term Care Providers in Oregon. “Direct care workers, such as certified nurse assistants, home health aides, and personal care aides, are the backbone of the formal long-term services and supports delivery system. These workers often receive low wages. In addition, direct care workers often receive little in the way of fringe benefits. Advocates for direct care workers argue that low wages and lack of fringe benefits have adverse consequences in terms of turnover and quality of care.”

According to the RTI report, average annual turnover among direct care workers was 64% a year, with wide variation across provider types. Residential care facilities for adults with I/DD had the highest turnover rates at 90% per year. Lower wages paid to direct care workers were listed among top four variables that were statistically significantly associated with higher turnover rates.

Direct Support Professionals perform vital tasks that require a higher level of skill than required for minimum wage jobs. With the increase in minimum wage to support workers in those positions, additional challenges have resulted for I/DD provider agencies. The difference between the state’s estimated rate for DSP wages used in ODDS rate models and minimum wage is now smaller, adding to the challenge of providers being able to recruit and retain high quality DSPs. ODDS recognizes that DSP wages must be above minimum wage to ensure adequate and fair compensation, stability and continuity of workforce to minimize turnover.

An additional outcome of the new minimum wage requirements is the compression effect on the entire provider rate structure that puts upward pressure on wages of supervisors and managers within the system. To allow for adequate management and supervision, the rate model must maintain a wage separation between the DSP and their manager or supervisor. As a result, additional rate increases will be necessary to adequately reflect compensation across all levels of work needed to deliver services to individuals with I/DD.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

This POP directly addresses issues around Agency Vision ("Safety, health and independence for all Oregonians") and multiple agency goals, including:

1. People are safe and living as independently as possible – POP ensures that I/DD provider agencies have stable and qualified workforce to ensure quality and continuity of services, individuals' health and safety, and maximum independence and integration into the community.
2. Highly qualified, effective, valued workforce – POP provides ability to recruit, train and retain qualified workers who are adequately compensated and incentivized to continuously advance their competencies.
3. In meeting the spirit of providing service equity to clients, the POP will assist in recruitment and retention of a linguistically and culturally diverse workforce.

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

- Key Performance Measure 15 – Abuse of people with intellectual and developmental disabilities: stable, well-trained, adequately compensated workforce should result in increased health and safety of individuals served and reduced rates of abuse.
- New proposed Quarterly Business Review measure: DSP turnover rate per National Core Indicators Staff Stability Report. This POP is expected to reduce current turnover rates by providing adequate

compensation to DSPs, training and career ladder opportunities and incentives to advance competencies for staff.

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?

Alternative to this POP would be for DHS to continue with an outdated rate structures that is currently resulting in record high turnover rates among DSPs, loss of qualified workers, inability to provide adequate staffing for individuals with complex needs, increased risk to health and safety of individuals with all levels of need, closure of group homes and the inability to increase capacity in residential services providers to meet the demand for residential placements and growing wait lists to high cost SACU placements. The DSP turnover rates also impact individuals' ability to work and live as members of their communities.

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

- Loss of qualified workforce to other industries, which would destabilize the lives of Oregonians with I/DD and their ability to work and live as members of their communities.
- High turnover rates among DSPs leading to lower quality of services, risks to health and safety of individuals in services, instability and gaps in services resulting in negative outcomes for Oregonians with I/DD.
- Inappropriate placements of individuals in higher cost settings such as SACU due to inability to appropriately staff supports.
- Less trained and experienced workers leading to higher level of abuse incidents and increased risk to health and safety of individuals.
- Lack of linguistically and culturally diverse workforce to meet the needs of communities needing services.

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

Other agencies will not be affected by this POP.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Provider agency associations include: Oregon Rehabilitation Association; Community Provider Association of Oregon; and the Developmental Disabilities Coalition.

10. WHAT IS YOUR EQUITY ANALYSIS?

This POP is an equity initiative. Through it, state agencies and service providers will increase the ability of people with intellectual and developmental disabilities to access needed services through provider agencies, including in rural and frontier areas. The POP will provide adequate reimbursement to providers so that they in turn can ensure fair pay for all Direct Support Professionals. The intent is to address disproportionately high turnover rates in I/DD agency provider service delivery system, provide stable qualified workforce and ensure quality of services to individuals with I/DD. The POP will also help with recruitment and retention of linguistically and culturally diverse workforce to meet the needs of diverse I/DD population, including non-English speaking workers to address shortages in multi-lingual DSPs.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

New minimum wage requirements and compression effect, documented DSP training and competency levels, cost of College of Direct Support training (annual fee).
One FTE for Provider Training Coordinator position

Implementation Date(s): January 1, 2018
End Date (if applicable): N/A

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

b. Will there be new Shared Services 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 - Shared Services 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.

Classification	Number of Positions	number of months the positions will work in each biennium	permanent, limited duration or temporary
Program Analyst 3	1	24	Permanent

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

f. What are the ongoing costs?
Annual College of Direct Support fee and DSP wage increases.

g. What are the potential savings?
N/A

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

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	181,103	0	0	181,103	1	1.00
Services & Supplies	6,221	0	6,218	12,439		
Special Payments	22,094,396	0	49,039,208	71,133,604		
Total	**$22,281,720**	**0**	**$49,045,426**	**$71,327,146**	**1**	**1.00**

DHS - Fiscal Impact Summary by Program Area:

	ODDS	Total
General Fund	**$22,281,720**	**$22,281,720**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$49,045,426**	**$49,045,426**
Total Funds	**$71,327,146**	**$71,327,146**
Positions	**1**	**1**
FTE	**1.00**	**1.00**

What are the sources of funding and the funding split for each one?
General Fund and for federal source: In exception for Employment waiver services at FMAP match and 1 FTE at Admin match, the majority of the split is at Medicaid match at K-plan enhanced FFP: FMAP+6%

Department of Human Services
2017-19 Policy Option Package

Agency Name: Department of Human Services
Program Area Name: Child Welfare
Program Name: Child Well-Being Program
Policy Option Package Initiative: Safe, Healthier Communities
Policy Option Package Title: Family Foster Care Rate Reimbursement
Policy Option Package Number: 108
Related Legislation: N/A

Summary Statement:

Reimbursement rates for Family Foster Care have not been adjusted to the cost of living for a decade. In 2009 rates were adjusted to 90% of the cost of care based on a 2007 rate methodology. In 2011, these rates were reduced by an additional 10% due to department budget cuts. Families coming forward to provide foster care has continued to diminish over the last 5 years in part due to the low reimbursement rates. The current daily rate is $18.90 per day for a child under age 5 years old or $24.36 per day for a teenager. This is intended to cover the costs of food, shelter, clothing, school supplies, extracurricular activities, etc. Based on the methodology created in 2009 Oregon is currently providing only 40-46% of the actual cost of care. Other states have been sued due to the low rate of family foster care payments and Oregon continues to increase the risk of a class action lawsuit.

The amounts for this increase assume a 6 month phase in with updated rates effective 1/1/2018.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$7,926,190**	**$0**	**$4,857,987**	**$12,784,177**

1. **WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?** This policy option package would bring the basic family foster care rate up to 60% of the actual cost of care to raise foster children. This is intended to be Phase I of a three Phase legislative process to bring the Family foster care rates back to the actual cost of care. The three phases would be intended to gain a portion of the actual costs of care per biennium until 2021-23 which would then have the family foster care rates equal to the actual cost of care to raise foster children**.** (Increase to 60% in 2017-19, 80% in 2019-21, and 100% in 2021-23).

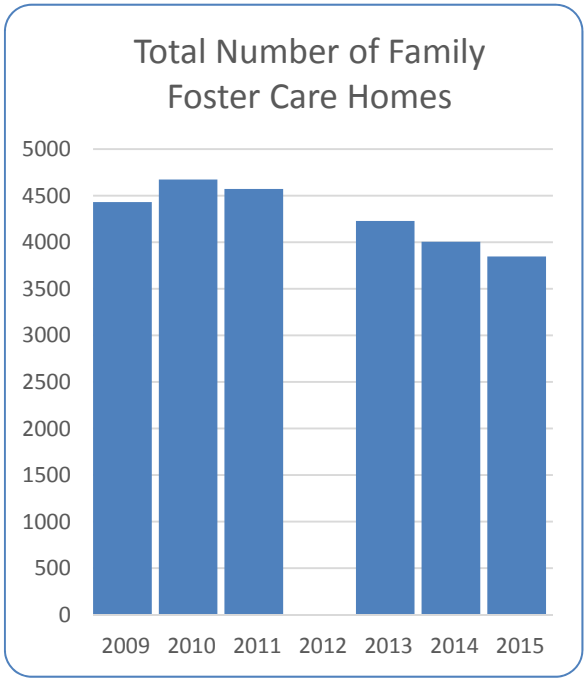
17-19 POP for Foster Care Rates					Biennial Figures	62.00%	38.00%
****Base Rate set at 60%**	**Current**	**New**	**difference**	**ADP**	**TF**	**GF**	**FF**
	rate	**rate**					
Foster care 0-5 @ 60%**	$575.00	735.49	$ 160.49	2164	$ 6,251,338.31	$ 3,875,829.75	$ 2,375,508.56
Foster Care 6-12 @ 60%**	$655.00	777.88	$ 122.88	1727	$ 3,820,391.40	$ 2,368,642.67	$ 1,451,748.73
Foster Care 13+ @ 60%**	$741.00	844.35	$ 103.35	1241	$ 2,308,632.30	$ 1,431,352.03	$ 877,280.27
					$ -	$ -	$ -
Foster care Shelter rate 0-5	$ 24.60	$ 34.04	$ 9.44	101	$ 17,185.19	$ 10,654.82	$ 6,530.37
Foster care Shelter rate 6-12	$ 28.00	$ 35.44	$ 7.44	59	$ 7,844.82	$ 4,863.79	$ 2,981.03
Foster care Shelter rate 13+	$ 31.60	$ 37.62	$ 6.02	22	$ 2,428.26	$ 1,505.52	$ 922.74
					$ -	$ -	$ -
Foster Care Enhanced Shelter rate 0-5	$ 29.40	$ 63.63	$ 34.23	1.00	$ 616.18	$ 382.03	$ 234.15
Foster Care Enhanced Shelter rate 6-12	$ 33.50	$ 65.03	$ 31.53	1.10	$ 624.22	$ 387.02	$ 237.20
Foster Care Enhanced Shelter rate 13+	$ 37.90	$ 67.21	$ 29.31	2.60	$ 1,371.78	$ 850.50	$ 521.28
					$ -	$ -	$ -
Enhanced Supervison 1**	$212.00	$ 300.00	$ 88.00	55.49	$ 87,896.16	$ 54,495.62	$ 33,400.54
Enhanced Supervison 2**	$414.00	$ 585.00	$ 171.00	31.47	$ 96,864.66	$ 60,056.09	$ 36,808.57
Enhanced Supervison 3**	$850.00	$1,200.00	$ 350.00	16.18	$ 101,934.00	$ 63,199.08	$ 38,734.92
					$ -	$ -	$ -
Personal Care Level 1	$207.00	$ 230.60	$ 23.60	55.49	$ 23,572.15	$ 14,614.73	$ 8,957.42
Personal Care Level 2	$413.00	$ 461.20	$ 48.20	31.47	$ 27,303.37	$ 16,928.09	$ 10,375.28
Personal Care Level 3	$620.00	$ 691.80	$ 71.80	16.18	$ 20,911.03	$ 12,964.84	$ 7,946.19
Personal Care Level 4	$620.00	$ 691.80	$ 71.80	11.81	$ 15,263.24	$ 9,463.21	$ 5,800.03
TOTAL request					$ 12,784,177	$ 7,926,190	$ 4,857,987

17-19 POP for Foster Care Rates					Biennial Figures	62.00%	38.00%
**Base Rate set at 100%	Current rate	New rate	difference	ADP	TF	GF	FF
Foster care 0-5 @ 100%**	$575.00	$1,225.81	$ 650.81	2164	$ 25,350,497.19	$ 15,717,308.26	$ 9,633,188.93
Foster Care 6-12 @ 100%**	$655.00	$1,296.47	$ 641.47	1727	$ 19,943,111.00	$ 12,364,728.82	$ 7,578,382.18
Foster Care 13+ @ 100%**	$741.00	$1,407.25	$ 666.25	1241	$ 14,882,692.50	$ 9,227,269.35	$ 5,655,423.15
					$ -	$ -	$ -
Foster care Shelter rate 0-5	$ 24.60	$ 50.16	$ 25.56	101	$ 46,520.89	$ 28,842.95	$ 17,677.94
Foster care Shelter rate 6-12	$ 28.00	$ 52.49	$ 24.49	59	$ 25,828.63	$ 16,013.75	$ 9,814.88
Foster care Shelter rate 13+	$ 31.60	$ 56.13	$ 24.53	22	$ 9,890.00	$ 6,131.80	$ 3,758.20
					$ -	$ -	$ -
Foster Care Enhanced Shelter rate 0-5	$ 29.40	$ 79.75	$ 50.35	1.00	$ 906.35	$ 561.94	$ 344.41
Foster Care Enhanced Shelter rate 6-12	$ 33.50	$ 82.08	$ 48.58	1.10	$ 961.80	$ 596.32	$ 365.48
Foster Care Enhanced Shelter rate 13+	$ 37.90	$ 85.72	$ 47.82	2.60	$ 2,237.87	$ 1,387.48	$ 850.39
					$ -	$ -	$ -
Enhanced Supervison 1**	$212.00	$ 300.00	$ 88.00	55.49	$ 87,896.16	$ 54,495.62	$ 33,400.54
Enhanced Supervison 2**	$414.00	$ 585.00	$ 171.00	31.47	$ 96,864.66	$ 60,056.09	$ 36,808.57
Enhanced Supervison 3**	$850.00	$1,200.00	$ 350.00	16.18	$ 101,934.00	$ 63,199.08	$ 38,734.92
					$ -	$ -	$ -
Personal Care Level 1	$207.00	$ 230.60	$ 23.60	55.49	$ 23,572.15	$ 14,614.73	$ 8,957.42
Personal Care Level 2	$413.00	$ 461.20	$ 48.20	31.47	$ 27,303.37	$ 16,928.09	$ 10,375.28
Personal Care Level 3	$620.00	$ 691.80	$ 71.80	16.18	$ 20,911.03	$ 12,964.84	$ 7,946.19
Personal Care Level 4	$620.00	$ 691.80	$ 71.80	11.81	$ 15,263.24	$ 9,463.21	$ 5,800.03
TOTAL request					$ 60,636,390.85	$ 37,594,562.33	$ 23,041,828.52

	Current Total Fund	Current Rate	New Rate	Change	New Cases/Year	Total Fund	GF	FF
Adoption Assistance							**50.02%**	**49.98%**
	136,672,213	$533	$1,063	$530	800	$635,984	$318,119	$317,865
Guardianship Assistance							**33.33%**	**66.67%**
	20,658,502	$514	$1,024	$510	300	$229,652	$76,543	$153,109
			Adoption Assistance					
80%			$851	$424		$508,787	$254,495	$254,292
			Guardianship Assistance					
80%			$819	$408		$183,722	$61,235	$122,487

2. WHY DOES DHS PROPOSE THIS POP?

The Department must bring the family foster care rates back into parity with the cost of raising a foster child due to the fact that families can no longer afford to provide family foster care due to the department's low rate of reimbursement. The department has experienced a continual decline (see chart) in the total numbers of families making themselves available to provide family foster care. A total of 826 fewer families providing foster care in 2015 than in 2010.



In addition, the wider the gap grows between actual cost of providing care and the departments actual reimbursement rate (projected as 63.1% below the actual cost of care) the department increases the risk of a lawsuit and/or federal sanction for failing to provide a reasonable maintenance payments to cover the cost of providing family foster care.

42 U.S.C. §§ 675(4) (A).

The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement.

There have been a few lawsuits in various states to enforce this federal standard. The State of California and The State of Washington to name a few.

http://www.caichildlaw.org/Misc/9thCir_Opinion.pdf

http://www.fpaws.org/content/lawsuit-media-statement-12-8-14

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

Having a strong and well supported family foster care system is critical to provide safe, nurturing and available family foster care for children in need of care. Family foster care is the primary tool in which to provide temporary safe placement for children. Over 11,000 children are served through family foster care each year in Oregon. The lower rate of available family foster care maybe attributed to reduced safety, increased placement instability, or increased workload for staff who are searching for appropriate placements for children.

The department (and children) has experienced poor outcomes for children in placement stability, placement matching, and turnover rates of foster parents. These become poor performance measures for federal reporting.

Additionally, the cost of overtime for staff working long hours seeking placements for children, and staff burnout due to stress and lack of resources for children must also be factored into the department outcomes.

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

Indirectly this POP is associated with performance measures for Safety in Foster Care and Placement Stability in foster care, and Diligent Recruitment for Children. Having available and appropriately supported family foster care is crucial to the safety and stability of children in foster care.

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 statute change is necessary.

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

This POP is one which has been attempted to be moved forward each biennium but has not been prioritized for the department since 2009. Other priorities for the department have been moved forward; Differential Response, SB964, Data supports, staff positions (OBI, OCI, Lean, etc.). Not moving all or a significant portion of this POP forward will continue to decline the resource pool for children, increase vulnerability of safety for children, over load foster families, and decline in staff retention.

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

The department will continue to be challenged to recruit a sufficient number of foster families to care for children to provide safe and supported family foster care placements. Not funding this POP will increase the

gap between the department's rates and the actual cost of care which increases the risk of lawsuits which has been brought forward in other states.

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

The other state agencies that provide a family foster care system for children with reimbursement are DHS-Developmental Disability and Oregon Youth Authority. Both of these state agencies reimburse at a rate higher than the current DHS-Child Welfare rate and even with this requested increase Child Welfare will still be below the other two state agencies.

Other Oregon Foster Care Programs	Monthly Rate (comparison for teenager)
DHS Developmentally Disabled	$1500 plus+ (individual rate assessment)
Oregon Youth Authority	$1003
Private Foster Care Agencies (BRS)	$1500
DHS Child Welfare	$ 741 (26-50% less than other agencies)

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

- Oregon Foster Parent Association is acutely aware of the deficit of reimbursement by DHS.
- Oregon Foster Youth Connection is another entity who is invested in adequate support for family foster care to ensure children and youth are afforded all opportunities in the community and need well supported and financially supported family foster families.
- Oregon Alliance of Children Program continues to advocate for rates for therapeutic foster families which are impacted by the department Child Welfare rates.

10. WHAT IS YOUR EQUITY ANALYSIS?

Family foster care reimbursement rates are the same across the state regardless of geography, race, or socio-economic status of the foster family. There is a different rate reimbursement based on the age of the child but that is consistent across the state as well. It should be addressed that there is an over-representation of

children of color in foster care which is also a factor in that the number of foster families of color does not equate to the over-representation of children of color.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?
Implementation Date(s): January 1, 2018

End Date (if applicable): N/A

a. Will there be new responsibilities for DHS? Specify which Program Area(s) and describe their new responsibilities.
No.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
No Impact.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No Impact.

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.
No Impact.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
No Impact.

f. What are the ongoing costs?

The following Charts will show the estimated costs for these rates at 100% of the current calculation, for the 2019-2021 biennium as a starting point for planning purposes. The factors will have to be updated in accordance with forecasted caseload data and calculations from the USDA, the Oregon Employments Department and the DHS Childcare Provider Guide.

17-19 POP for Foster Care Rates - Projected Start Point for 2019-2021					Biennial Figures	62.00%	38.00%
**Base Rate set at 100%	Current rate	New rate	difference	ADP	TF	GF	FF
Foster care 0-5 @ 100%**	$575.00	$1,225.81	$ 650.81	2164	$ 33,800,662.92	$ 20,956,411.01	$ 12,844,251.91
Foster Care 6-12 @ 100%**	$655.00	$1,296.47	$ 641.47	1727	$ 26,590,814.67	$ 16,486,305.09	$ 10,104,509.57
Foster Care 13+ @ 100%**	$741.00	$1,407.25	$ 666.25	1241	$ 19,843,590.00	$ 12,303,025.80	$ 7,540,564.20
					$ -	$ -	$ -
Foster care Shelter rate 0-5	$ 24.60	$ 50.16	$ 25.56	101	$ 62,027.86	$ 38,457.27	$ 23,570.59
Foster care Shelter rate 6-12	$ 28.00	$ 52.49	$ 24.49	59	$ 34,438.17	$ 21,351.67	$ 13,086.50
Foster care Shelter rate 13+	$ 31.60	$ 56.13	$ 24.53	22	$ 13,186.67	$ 8,175.73	$ 5,010.93
					$ -	$ -	$ -
Foster Care Enhanced Shelter rate 0-5	$ 29.40	$ 79.75	$ 50.35	1.00	$ 1,208.47	$ 749.25	$ 459.22
Foster Care Enhanced Shelter rate 6-12	$ 33.50	$ 82.08	$ 48.58	1.10	$ 1,282.40	$ 795.09	$ 487.31
Foster Care Enhanced Shelter rate 13+	$ 37.90	$ 85.72	$ 47.82	2.60	$ 2,983.83	$ 1,849.98	$ 1,133.86
					$ -	$ -	$ -
Enhanced Supervison 1**	$212.00	$ 300.00	$ 88.00	55.49	$ 117,194.88	$ 72,660.83	$ 44,534.05
Enhanced Supervison 2**	$414.00	$ 585.00	$ 171.00	31.47	$ 129,152.88	$ 80,074.79	$ 49,078.09
Enhanced Supervison 3**	$850.00	$1,200.00	$ 350.00	16.18	$ 135,912.00	$ 84,265.44	$ 51,646.56
					$ -	$ -	$ -
Personal Care Level 1	$207.00	$ 230.60	$ 23.60	55.49	$ 31,429.54	$ 19,486.31	$ 11,943.22
Personal Care Level 2	$413.00	$ 461.20	$ 48.20	31.47	$ 36,404.50	$ 22,570.79	$ 13,833.71
Personal Care Level 3	$620.00	$ 691.80	$ 71.80	16.18	$ 27,881.38	$ 17,286.45	$ 10,594.92
Personal Care Level 4	$620.00	$ 691.80	$ 71.80	11.81	$ 20,350.99	$ 12,617.62	$ 7,733.38
TOTAL request					$ 80,848,521.14	$ 50,126,083.11	$ 30,722,438.03
					$ 80,848,521.14	$ 50,126,083.11	$ 30,722,438.03

	Current Total Fund	Current Rate	New Rate	Change	New Cases/Year	Total Fund	GF	FF
Adoption Assistance							**50.02%**	**49.98%**
	136,672,213	$533	$1,063	$530	800	$847,978.08	$424,159	$423,819
Guardianship Assistance							**33.33%**	**66.67%**
	20,658,502	$514	$1,024	$510	300	$306,203.20	$102,058	$204,146

In addition to what is already in the 2017-2019 budgeted amounts for these programs and not including the increases or decreases for changing data points, the estimated additional costs for the 2019-2021 Biennium at 100% funding would be:

TF	GF	FF	Description of figures
$ 82,002,702	$ 50,652,299	$ 31,350,403	100% Funding for 2019-2021
$ (37,222,254)	$ (22,964,172)	$ (14,258,082)	2017-2019 Funding @ 80% @ 18 Months
$ 44,780,448	$ 27,688,127	$ 17,092,321	Minimum Increase with 6 month phase in

g. What are the potential savings?

There are not direct cost savings assumed in this POP. Indirectly, the savings gained will be for child's safety and placement stability and a reduction in staff workload by having an adequate supply of stable family foster care settings.

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

Yes

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF
Special Payments	7,926,190	0	4,857,987	12,784,177
Total	**7,926,190**	**$0**	**4,857,987**	**12,784,177**

DHS - Fiscal Impact Summary by Program Area:

	Foster Care	Adoptions	Guardianship	Total
General Fund	**$7,817,214**	**$87,840**	**$21,136**	**$7,926,190**
Other Fund	**$0**	**$0**	**$0**	**$0**
Federal Funds- Ltd	**$4,729,612**	**$86,642**	**$41,733**	**$4,857,987**
Total Funds	**$12,546,826**	**$174,482**	**$62,869**	**$12,784,177**
Positions	**0**	**0**	**0**	**0**
FTE	**0.00**	**0.00**	**0.00**	**0.00**

What are the sources of funding and the funding split for each one?

Child Welfare Revenue Impact:

Description of Revenue	OF	FF	TF
Title IV-E Foster Care (Comp Srce 0975)	0	$4,857,987	4,857,987
Title IV-E Adoptions (Comp Srce 0975)	0		
Title IV-E Guardianship (Comp Srce 0975)	0		
Total	**$0**	**4,857,987**	**4,857,987**

2017-19 Policy Option Package

Agency Name:	**Department of Human Services**
Program Area Name:	**Child Welfare**
Program Name:	**Child Well-Being Program**
Policy Option Package Initiative:	**N/A**
Policy Option Package Title:	**Behavioral Rehabilitation Services – Daily Rate Increase**
Policy Option Package Number:	**109**
Related Legislation:	**N/A**
Program Funding Team:	**Safe, Healthier Communities**

Summary Statement:

Update the rate model for Behavioral Rehabilitation Services (BRS) program to pay contracted providers for cost increases above inflation. Rates directly impact state agencies access to these programs. The BRS rate model has not been kept current since first established in 1998. Simply adding inflation to the previous biennium rate has not kept pace with significant cost increases. Some of the most heavily used programs have closed over the past two biennia. More programs have signaled if they don't receive more financial support from the state they will also have to close soon.

This package is most importantly about child and youth safety as well as maintaining access to this essential part of the system serving Oregon's most vulnerable children. Without increases to the rate state agencies will continue to have pressure on the BRS system as provider costs increase and the rate remains inadequate.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$2,116,547**	**$0**	**$3,823,804**	**$5,940,351**

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

This POP is a three State Agency initiative and must be moved forward as a consistent package; Oregon Health Authority, Oregon Youth Authority and Department of Human Services.

The policy option package updates the model for an accurate relief factor, staff and proctor/foster home training due to turnover and training for all staff keeping current on new standards trauma informed, developmentally appropriate, gender and culturally responsive programs.

This policy option package updates the rate model as follows:

1. Update the relief factor included in the rate model. The rate model includes a relief factor for direct care/front line staff. The relief factor provides the additional staff in the model needed to cover supervision of children/youth when staff call in sick, schedule vacations, take holidays, and attend training. The relief factor is updated to meet current staffing standards. (Comprehensive Workgroup recommendation #3)

2. Update the rate model for costs to continually train new staff and proctor/foster homes. The turnover rate for direct care/front line staff and proctor/foster homes is significant for these programs. The training investment and costs for providers is significant. The model update includes 33% turnover rate and provides additional resources necessary to continually reinvest and train these essential front line staff and proctor/foster homes. (Comprehensive Workgroup recommendation #4)

3. Update the rate adding resources for all staff to receive training so staff remain current on new standards and expectations for trauma informed, developmentally appropriate, gender and culturally responsive programs. (Comprehensive Workgroup recommendation #5)

   These updates will all be factored into an increase in the daily rate per child served.

2. WHY DOES DHS PROPOSE THIS POP?

OYA, DHS and OHA participate in the Medicaid State Plan Behavior Rehabilitation Services program. The updates to the rate model included in the policy option package were based on work completed through a joint effort of the three state agencies, providers and child advocates. A 2011 lawsuit filed by providers and settled in 2014 included a requirement for a comprehensive review of the program including eligibility, program standards, design and rates. The settlement agreement stipulated State Agencies shall seek "approval to pursue additional funding for BRS programs during the 17-19 budget cycle." BRS is a Medicaid program and Foster Care Title IV-E program used by OYA, DHS and OHA. County Juvenile Departments access the federal match for BRS through contracts with OHA.

A subgroup of the larger BRS review committee spent a year reviewing the rate model. The subcommittee made a number of recommendations. Some of those changes were included current service level. This POP includes only recommendations; 3, 4, and 5 as noted above.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

Adequate and appropriately funded training is essential if Oregon is to meet its obligation in protecting and caring for the most vulnerable children and youth.

1. Child and Youth safety will be improved.
2. The number of programs closing will be eliminated or significantly reduced to one to two programs.
3. State agencies will be able to recruit more providers expanding the geographically locations in Oregon.

4. Increase the number of regularly contracted beds enhancing state agencies ability to place some of the state's most challenging children.
5. Improve the quality of the programs through enhancing training resources.

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

DHS must provide safe and therapeutic services for children in need. DHS does this through the Medicaid funded program for BRS. OYA, DHS and OHA participate in the Medicaid State Plan Behavior Rehabilitation Services program. During this past 3 years these agencies have worked to bring parity among the state agencies in the rates (Oregon Administrative Rules), it is imperative the three state agencies remain committed to the same rate structure.

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 Impact.

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

The department has already been experiencing the alternative of doing nothing with some providers giving their contracts back and ending their service due solely to their lack of ability to provide supplemental funding for this program. The department has been struggling to recruit and retain quality programs for children.

The department has moved forward in the Comprehensive Review process as a result of a Settlement Agreement from the original lawsuit which began in 2011. Failure to move forward may result in a new lawsuit.

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

The department will continue to experience programs ending their service due to financial reasons and it is likely the remaining programs will bring forward a lawsuit once again due to the lack of funding.

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

Oregon Youth Authority
Oregon Health Authority

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Oregon Alliance for Children Programs
Oregon Foster Youth Connection
Youth M.O.V.E Oregon
Disability Rights of Oregon
Coalition of Advocates for Equal Access for Girls

10. WHAT IS YOUR EQUITY ANALYSIS?

The BRS comprehensive review committee sought to be as inclusive as possible from varying perspectives of service recipients, advocacy groups, private agencies and state agencies. Collectively these groups moved forward the recommendations for system reform and system financing,

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2017

End Date (if applicable): N/A

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

☒ Child Welfare – Contract Amendments

b. Will there be new Shared Services 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 - Shared Services LC/POP Impact Questionnaire (at the end of this document).
No impact.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No impact.

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.
No impact.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
No impact.

f. What are the ongoing costs?
Daily rate changes will be built into standard contracts.

g. What are the potential savings?
No direct savings.

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

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Special Payments	2,116,547	0	3,823,804	5,940,351		
Total	**$2,116,547**	**$0**	**$3,823,804**	**$5,940,351**	**0**	**0.00**

DHS - Fiscal Impact Summary by Program Area:

	Well Being	Total
General Fund	**$2,116,547**	**$2,116,547**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$3,823,804**	**$3,823,804**
Total Funds	**$5,940,351**	**$5,940,351**
Positions	**0**	**0**
FTE	**0.00**	**0.00**

What are the sources of funding and the funding split for each one?
Federal Funds are Medicaid.

Department of Human Services
2017-19 Policy Option Package

Agency Name:	**Department of Human Services**
Program Area Name:	**Child Welfare Program, Delivery and Design**
Program Name:	**N/A**
Policy Option Package Initiative:	**N/A**
Policy Option Package Title:	**SB222 Legal Representation Package**
Policy Option Package Number:	**110**
Related Legislation:	**N/A**
Program Funding Team:	**Safe, Healthier Communities**

Summary Statement:

Historically, DOJ's billable hour model has been considered cost-prohibitive in juvenile dependency cases and has been a deterrent to DHS accessing and utilizing DOJ for full representation—including attendance at all hearings, regular case consultation, impromptu legal advice, and regular participation in case worker training, meetings, and staffing. A block grant model will allow DOJ to manage cases according to a workload method of case assignment with each DOJ attorney carrying a consistent number of weighted cases. In this model, each dependency case is assigned to an attorney who handles it from petition to permanency. This case assignment method will provide DHS caseworkers with continuous representation which, in turn, will promote attorney-caseworker collaboration, improve caseworker job satisfaction and retention, avoid the risk for unlawful practice of law by case workers, and improve the overall efficiency and cost-effectiveness of the system. This POP is in addition to the above the legal representation POP that will provide DHS sufficient resources to cover current estimated AG billings. This POP assumes a total fund block grant funding model of $45 million TF for full representation and assumes the exception to DHS representation in these cases is lifted.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$6,916,041**	**$0**	**$12,957,561**	**$19,873,602**

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

This POP would change require that the Department of Justice represent the Department of Human Services Child Welfare Program from the point of petition to case closure, and all things in between. In addition, this POP would change the financial relationship from hourly billing to a "Block Grant".

2. WHY DOES DHS PROPOSE THIS POP?

There are a number of reasons that this POP is being proposed at this time. The primary issue is that it support the work of the Oregon Task Force on Dependency Representation that was established by Senate Bill 222 during the 78th Oregon Legislative Assembly. In addition, Oregon statutes require that "any action, suit, or proceeding may be prosecuted or defended by a party in person, or by attorney, *except that the state or a party that is not a natural person appears by attorney in all cases, unless otherwise specifically provided by law.*" Under most circumstances, the Attorney General is the legislatively mandated attorney for the state. An exception to this legislative requirement is in place for the DHS in dependency proceedings. Temporary legislation passed in 2014 and extended by Senate Bill 222 in 2015 currently provides that DHS "may appear without the Attorney General at: (1) Any hearing held after the hearing required under ORS 419B.305 has been held; and (2) Any proceeding where the district attorney represents the state, provided the positions of the department and the state are not in conflict with respect to issues raised for consideration or determination in the proceeding."[i] This Legislation sunsets in 2017.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

Currently the agency is in a position of creating savings from an already distressed workforce. If this program is funding at 100% we could reduce the vacancy rate of Child Welfare and be better able to respond to and meet the Safety, Permanency, and Well Being needs of children and families.

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

This POP is expected to impact the following measures:

Performance Measure	Indicator	National documents that recommend this performance measure	Is this collected/ reported?
Outcome Measures			
Successful Permanency	Total percentage of children reaching permanency*	ABA Indicators of Success for Parent Attorneys ("Indicators of Success")[ii]; Toolkit for Court Toolkit for Court Performance Measures in Child Abuse & Neglect Cases ("Toolkit Measures")[iii]	Currently Collected and Reported by DHS

Performance Measure	Indicator	National documents that recommend this performance measure	Is this collected/ reported?
	Reunification • Median Months to Reunification (FO.02.1) • Percent of cases where permanency found though reunification	Indicators of Success; Toolkit Measures	Currently Collected and Reported by DHS
	Adoption • Median Months to Adoption (FO.02.2) • Percent of cases where permanency found through adoption	Indicators of Success; Toolkit Measures	Currently Collected and Reported by DHS
	Guardianship • Median Months to Guardianship • Percent of cases where permanency found through guardianship	Indicators of Success; Toolkit Measures	Currently Collected by DHS

Performance Measure	Indicator	National documents that recommend this performance measure	Is this collected/ reported?
Parent and Child Contact	Visitation Between Parents & Children • Type • Location • Supervision	Louisiana Child Attorney Quality Assurance Indicators ("LA Indicators")[iv]	Currently Collected by DHS
Timeliness of Hearings	Continuances and set overs • Number • Person requesting • Reason	National Center for State Courts CourTools (with regard to hearings/trials)[v]	Not currently collected
*Although the total percentage of children achieving permanency may increase, it is important to note that permanency outcomes may not necessarily all improve together. Getting more children reunified and into guardianships, for example, might lead to a reduction in the percentage of children who are adopted, nonetheless, this scenario would still be an improvement in overall permanency outcomes.			

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, however the Task Force recommends, if adopted, would eliminate a pending Leg Concept pertaining to Continued Legal Representation.

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

Continue the current suspension of legislation that allows Child Welfare staff to appear in court without legal representation and continue the practice of delaying the hiring of staff to generate the savings necessary to pay for the nearly $12 million of DOJ expenses in excess of current budget authority. This consideration is currently occurring and is impacting the department's ability to respond to and adequately manage the safety, permanency, and well-being of children.

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

The Department would continue to absorb the cost which impacts our ability to respond to and adequately manage the safety, permanency, and well-being of children which impacts our ability to meet federal performance expectations, resulting in substantial loss of IV-E Funding.

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

The Department of Justice, Attorney General's Office, would be effected. They would need to manage the entirety of Child Welfare legal representation within legislatively established budget.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

By way of their participation in the Oregon Dependency Representation Task Force the composition of the Task Force included:

- Two members of the Oregon Senate appointed by the President of the Senate;
- Two members of the Oregon House of Representatives appointed by the Speaker of the House;
- Two Department of Human Services (DHS) representatives appointed by the Governor;
- Two District Attorneys (DAs) appointed by the Governor;
- Three attorneys who provide legal defense services to children and parents in the dependency system appointed by the Governor;

- Three judges with juvenile court experience appointed by the Chief Justice of the Oregon Supreme Court;
- One Court Appointed Special Advocates (CASA) appointed by the Chief Justice of the Oregon Supreme Court;
- One person representing the Citizen Review Board (CRB) appointed by the Chief Justice of the Oregon Supreme Court; and
- Two representatives from the Attorney General's Office.

10. WHAT IS YOUR EQUITY ANALYSIS?

Not available at this time.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

The primary assumption affecting this POP is that that recommendations from the Oregon Dependency Representation Task Force will be accepted as is.

Implementation Date(s): July 1, 2017
End Date (if applicable): N/A

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

No

b. Will there be new Shared Services 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.

Yes, this would prevent delays in hiring which in turn decreases caseloads to a level that is closer to the legislative intent. Exact numbers are difficult if not impossible to calculate

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.
No

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

f. What are the ongoing costs?
The ongoing costs would be consistent with the current requested amount.

g. What are the potential savings?
None

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

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Services & Supplies	0	0	12,957,561	12,957,561		
Special Payments	6,916,041	0	0	6,916,041		
Total	**$6,916,041**	**$0**	**$12,957,561**	**$19,873,602**	**0**	**0.00**

DHS - Fiscal Impact Summary by Program Area:

	CW Delivery & Design	Total
General Fund	**$6,916,041**	**$6,916,041**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$12,957,561**	**$12,957,561**
Total Funds	**$19,873,602**	**$19,873,60297**
Positions	**0**	**0**
FTE	**0.00**	**0.00**

What are the sources of funding and the funding split for each one?
Federal Funds are Medicaid.

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[i] 2014 Or. Laws Chap. 106 (H.B. 4156, 77th Leg. Assemb., Reg. Sess. [Or. 2014]).
[ii] *ABA Indicators of Success, supra* note 115.
[iii] Flango & Kauder, *supra* note 113.
[iv] *Indicators of Quality Representation for Louisiana Children's and Parents' Attorneys* (2014).
[v] NATIONAL CENTER FOR STATE COURTS, COURTOOLS: TRIAL COURT PERFORMANCE MEASURES, MEASURE 5 (2005), *available at* http://www.courtools.org/~/media/Microsites/Files/CourTools/courtools_Trial_measure5_Trial_Date_Certainty.ashx.

Department of Human Services / Oregon Health Authority
2017-19 Policy Option Package

Agency Name:	**Department of Human Services / Oregon Health Authority**
Program Area Name:	**Program Design Services**
Program Name:	**Information Technology Business Supports**
Policy Option Package Initiative:	**DHS Integrated Eligibility Project**
Policy Option Package Title:	**Integrated Eligibility**
Policy Option Package Number:	**201**
Related Legislation:	**N/A**

Summary Statement:

This POP will provide resources to support the continuation of the Department's Integrated Eligibility Project during FY17-19 resulting in a single eligibility determination system for Non-MAGI Medicaid, Supplemental Nutrition Assistance Program (SNAP Food Stamps), Temporary Assistance for Needy Families (TANF Cash Assistance), and Employment Related Day Care (ERDC Child Care subsidies).

This POP would further the design, development, and implementation period for the Integrated ONE System – jointly shared by DHS and OHA for the purposes of Eligibility Determination work. DHS plans to put the system into pilot in the summer of 2018, followed by a four month implementation roll-out. This POP takes advantage of enhanced federal funds across two separate federal agencies. Without funding, DHS will not be able to continue its project in a timely manner, resulting in increased state general fund cost for work after the A87 Cost Allocation exception process expires.

This POP also has a corresponding POP at DAS Enterprise Technology Services for support of DHS' business needs, and is related to the Legacy System Project that DHS is undertaking to

ensure that functionality not assumed into the IE system from legacy systems will still be available for DHS business usage.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing Total:	**$11,959,788**	**$29,037,599**	**$101,794,707**	**$142,792,094**
DHS – PDS (ITBS)	$7,609,969	$18,275,000	$101,794,707	$127,679,676
DHS – DEBT SERVICE	$4,349,819	$0	$0	$4,349,819
OHA (DHS Sister POP)	$0	$10,762,599	$0	$10,762,599

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

This POP will provide resources, primarily in the form of federal fund limitation, XI Q-Bond financing proceeds, and position authority) to support the continued work of the DHS Integrated Eligibility Project and its transition into maintenance and operations.

DHS has engaged with system integrator, Deloitte Consulting, in a transfer project to expand the functionality of the OregONEligibility system for MAGI Medicaid, known as the ONE system. DHS seeks to bring the human service financial eligibility determination functionality from Kentucky's Benefind system to Oregon, resulting in a single system that Oregonians can apply for and receive benefits from OHA or DHS in Medicaid, SNAP, TANF, or ERDC program areas. By the conclusion of the 15-17 biennium, the Department will have completed the Fit/Gap phase of the project, and begun the design, development, and implementation phase. Using iterative development, DHS will have completed

all of the design, and development activities should be underway. The first DHS testing activities are scheduled to occur in May 2017.

This POP continues those efforts, and sees the project through complete implementation and transition to maintenance & operations of the system. Implementation activities should be completed by December of 2018, followed by a warranty period and the beginning of maintenance and operation by June 30, 2019, resulting in the roll-out of the Integrated ONE system which will be used by both OHA and DHS.

2. WHY DOES DHS PROPOSE THIS POP?

DHS wishes to maximize the increased federal funding associated with this system project, by utilizing the A87 Cost Allocation Exception process, which allows for CMS 90/10 funding to be used for any system functionality that benefits Medicaid recipients. This increased federal funding greatly exceeds the amount of federal funds available from either USDA Food & Nutrition Services in support of SNAP system enhancements or Administration on Children & Families in support of TANF or ERDC system enhancements. This reduces the amount of state general fund necessary to support the technology upgrade off of legacy, mainframe based eligibility determination systems.

It will also enhance the potential for better care coordination for Oregonians by having all financial eligibility information in a singular system of record. It sets a common platform for both OHA and DHS eligibility, allowing for a systematic approach to further work to bring in additional programs and fully transition to a single eligibility system over the coming years.

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

The project will assist Oregonians to achieve wellbeing and independence by providing timely and efficient eligibility determinations for the Department's programs. It will allow Oregonians to self-service by applying through the applicant portal at times that are convenient for them, minimizing time needed in DHS field offices to complete the process. The system will also generate notices in seven languages and in five alternate formats, helping to reduce barriers for traditionally underserved populations. It will also gather and store applicants preferred race and ethnicity values allowing for culturally competent care.

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

This POP supports clients accessing our services and measurements around outreach and quality of 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?

No new alternatives were considered as this is an extension of previous investment.

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

Failure to fund this POP would result in the IE project coming to a halt; and increased general fund cost to bring it to its eventual completion.

(a) What services and programs would be affected?

APD Non-MAGI Medicaid eligibility determination, SSP eligibility determination for SNAP, TANF, ERDC.

(b) What client or population groups would be affected?

All department clients of programs in (a) above, including aged and disabled adults, people living nearest to poverty line.

(c) What providers would be affected?

Medicaid providers, CDDPs/Brokerages (for financial eligibility only) and child care providers potentially

(d) Would federal or other funding be reduced?
Enhanced federal funding for the project runs out on December 31, 2018.

(e) Would the agency be out of compliance with federal requirements?
N/A

(f) What are the expected results?

Timely and correct eligibility determinations and redeterminations for Non-MAGI Medicaid, SNAP, TANF, ERDC

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

OHA is impacted because POP enhances their current system.
DAS is impacted because equipment and services at ETS are required to support POP.
DOJ is impacted because DHS system will need to interface with new Child Support system.
OED is impacted because DHS system will have interface with Employment Department.
ODE is impacted because DHS system will interface with system that makes payments to Early Learning Division Child Care Providers.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

None

10. WHAT IS YOUR EQUITY ANALYSIS?

DHS System will be able to support notice generation in seven languages and five alternate formats. It will gather applicants preferred written and spoken language as well as race and ethnicity to help department providers provide culturally competent care. This will bring us into compliance with REAL+D work, and allow another way for communities and individuals in Oregon to interact with DHS.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2017 (ongoing-continuing 15-17 Investment)

End Date (if applicable): June 30, 2019

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

☒ Aging & People with Disabilities
☒ Intellectual/Developmental Disabilities
☒ Self-Sufficiency Program
☒ IT Business Supports
☒ OIS

b. Will there be new Shared Services 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 – Shared, OIS and Central Offices Services LC/POP Impact Questionnaire.

Yes – OIS and ITBS.
There will be additional costs associated with facilities for staffing.

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

No, however, through the process of updating the system Oregon may find some of our eligibility criteria or work around determining benefits may not have been accurate and have subsequent changes to eligibility. We don't expect any substantial changes from this at this time and cannot model or predict beyond anecdotal assumptions.

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.

Yes.

1.50 FTE of PEM G for 24 months (LD) (DHS)
1 Pub Affairs Specialist 3 for 24 months (LD) (DHS)
16 OPA3 for 18 months (LD) (DHS)
1 Office Mgr 2 for 18 months (LD) (DHS)
2 TDS 2 for 18 months (LD) (DHS)
1 ISS4 for 18 months (LD) (OHA)
3 ISS6 for 18 months (LD) (OHA)
10 ISS8 for 18 months (LD) (OHA)
3 PM2 for 18 months (LD) (OHA)
3 PM3 for 18 months (LD) (OHA)

These limited duration positions are being requested to allow program to backfill individuals that come onto the project. As part of our solutions for success, this project is bringing key subject matter experts from our field structure and from policy and business support to participate throughout the process. We want these individuals to come with their knowledge, so we will utilize the limited duration authority to allow program to fill behind key individuals while they are on the project.

1 PEME for 24 months (Perm) (DHS)
1 PEME for 24 months (Perm) (OHA)
6 OPA3 for 9 months (Perm) (DHS)
1 OPA4 for 24 months (Perm) (DHS)
1 OPA 4 for 24 months (Perm) (OHA)
2 TDS2 for 9 months (Perm) (DHS)

4 HSS4 for 24 months (Perm) (DHS)
2 PA1 for 24 months (Perm) (DHS)

There are also a PEM H and ESS2 who are work charging towards the IE project from DHS.
9 ISS8, an ISS7, FA3, PM1, PM3, PEM F, and PEM E dedicating time to this project from OIS.

There are 4 positions (2 OPA3 and 2 OPA4) from ITBSU who are on Modernization positions and working on this project. They will NOT be charging to IE, their time will be charged to ITBSU where the budget sits for their positions.

There are 9 positions from OIS who are on Modernization positions and working on this project. They will NOT be charging to IE, their time will be charged to the Shared Services Budget where their budget sits for those positions.

Additional modernization positions continue to support the original infrastructure that exists even with the implementation of Integrated ONE. OHA and DHS will continue to evaluate these positions and in subsequent releases and updates to the system, as legacy systems are sunset, these positions may be reallocated to Integrated ONE support. These positions continue to support the totality of the Modernization goal, in which Integrated ONE is the first step in setting the platform realization of that goal.

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

There may be additional infrastructure costs, such as servers or costs to ETS, but these are being developed and projected into this POP.

f. What are the ongoing costs?

There are ongoing costs associated with maintenance and operations of the system, and is included in the cost projections.

g. What are the potential savings?
None.

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

TOTAL FOR THIS PACKAGE (DHS+OHA)

Category	GF	OF	FF	TF	Position	FTE
Personal Services	976,299	9,893,732	4,661,661	15,531,692	60	48.04
Services & Supplies	6,489,137	18,626,010	96,473,691	121,588,838		
Special Payments	144,533	517,857	659,355	1,321,745		
Debt Service	4,349,819	0	0	4,349,819		
Total	**$11,959,788**	**$29,037,599**	**$101,794,707**	**$142,792,094**	**60**	**48.04**

DHS - Fiscal Impact Summary by Program Area:

	DHS PDS (ITBS)	DHS Debt Svc	OHA/OIS	Total
General Fund	**$7,609,969**	**$4,349,819**	**$0**	**$11,959,788**
Other Fund	**$18,275,000**	**$0**	**$10,762,599**	**$29,037,599**
Federal Funds- Ltd	**$101,794,676**	**$0**	**$0**	**$101,794,676**
Total Funds	**$127,679,676**	**$4,349,819**	**$10,762,599**	**$142,792,094**
Positions	**38**	**0**	**22**	**60**
FTE	**28.29**	**0.00**	**19.75**	**48.04**

What are the sources of funding and the funding split for each one?

(DHS – PDS-ITBS) Revenue Impact:

Description of Revenue	OF	FF	TF
Medicaid (Comp Srce 0995)	0	102,867,645	102,867,645
GF Q-Bonds(Comp Srce 0555)	18,000,000	0	18,000,000
Other (Comp Srce 0975)	626,010	0	626,010
Total	**$18,626,010**	**$102,867,645**	**$121,493,655**

(OHA -OIS) Revenue Impact:

Description of Revenue	OF	FF	TF
NON-Add OF Limitation (0975)	$10,762,599	0	$10,762,599

Department of Human Services / Oregon Health Authority
2017-19 Policy Option Package

Agency Name:	**Department of Human Services / Oregon Health Authority**
Program Area Name:	**Shared Services Human Resources Center**
Program Name:	**Background Check Unit (BCU)**
Policy Option Package Initiative:	**N/A**
Policy Option Package Title:	**Background Check Unit Workload**
Policy Option Package Number:	**205**
Related Legislation:	**N/A**

Summary Statement:

Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines. BCU completes checks for a variety of groups including but not limited to:

- Home Care Workers (HCWs);
- Personal Support Workers (PSWs);
- Subsidized child care providers;
- Child caring agencies (CCAs) staff, volunteers, and proctor foster parent applicants;
- System of Care (SOC) and Strengthening, Preserving and Reunifying Families (SPRF) providers;
- Staff and volunteers from residential care, nursing, and adult foster home facilities;
- Department of Human Services (DHS) and Oregon Health Authority (OHA) employees, volunteers, and contractors.

The staff requested in this Policy Option Package (POP) would meet currently required needs to maintain timely background checks for all regulated groups handled by BCU, and meet all Supplies & Services needs and a majority of projected staffing needs due to program growth and new federal and state statutes to be implemented during the 2017-19 biennium if fully funded for the 24 months of the biennium.

The result would be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for vulnerable Oregonians through quality background checks.

In addition, DHS has identified a variety of expansion options to current background check criteria for DHS and OHA providers whose fitness determination is completed by the Background Check Unit (BCU).

These options would provide more intensive background checks by improving communication about adverse actions on providers across unit and program lines, and increasing use of child protective service (CPS) information across the DHS provider community. The result would be increased health, safety and financial wellness for vulnerable Oregonians.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing Total:	**$6,231,800**	**$7,271,014**	**$1,263,747**	**$14,766,561**
DHS	$6,118,266	$7,251,800	$1,221,826	**$14,591,892**
OHA	$113,534	$19,214	$41,921	**$174,669**

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

WORKLOAD-RELATED INCREASES

Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines for background checks.

Examples of how task complexity will have shifted from 2012-2017 are:

2012

- For almost all 2012 checks BCU only acquired Oregon criminal history records and sent those records to Qualified Entities (QEs) for fitness determination. By the end of 2012, to improve consistency of determinations and broaden depth of checks, BCU centralized fitness determination with BCU.

2013-14

- In addition to running criminal history, BCU began evaluating that history, court and police records, abuse records, counseling and treatment records, weighed safety and risk factors, and documented and sent fitness determination to QEs.

2015-16

- Centers for Medicare and Medicaid Services (CMS) required mandatory fingerprinting of all "high risk" roles.
- Increasing requirements for FBI checks from new legislative programs. FBI and other national checks using out-of-state history are more difficult.
- New review criteria for specific Adam Walsh programs.
- CMS requirements necessitated a January 2016 rule change for many DD providers that previously did not require recertification. In 2015, 23,819 or 77.8% of DD providers did not require recertification but will now be on a two-year cycle.

- Changes in how FBI information was provided via LEDS requires due diligence fingerprinting in cases where an out-of-state identifier code is not present. Expected to increase fingerprinting and related workload by 15% or more.

2017

- As of October 2017 new Child Care Development Fund Block Grant (CCDFBG) requirements will add mandatory FBI and ***national*** child protective service (CPS) checks of ***all*** child care providers and household members (12,000+ individuals). Currently:
  - Only 5.7% of child care cases currently require FBI checks.
  - Only Oregon CPS checks are now required.

The staff requested in this policy option package would meet currently required needs to maintain timely background checks for all regulated groups handled by BCU, and meet projected needs due to program growth and new federal and state statutes implementing during the 2017-19 biennium.

Regulated groups for whom BCU completes background checks include but are not limited to home care workers, developmental disability and mental health personal support workers, subsidized child care providers, Child Caring agencies, Traditional Health Workers, System of Care (SOC) and Strengthening, Preserving and Reunifying Families (SPRF) providers, and staff and volunteers from residential care, nursing, and adult foster home facilities. BCU also handles background checks for employees, volunteers and contractors of the Department of Human Services and Oregon Health Authority.

The result of increased staffing would be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for vulnerable Oregonians through quality background checks.

Implementation would require the following staff:

- +15 POS/14.40 FTE permanent Administrative Specialist 1 (Fitness Determiner) positions

  These positions are to handle 2017 and 2018 growth in complexity and volume, including work from new federal CCDBG out-of-state child protective service checks and other exclusion list checks effective 10/2017, and changes from the Centers of Medicare and Medicaid Services (CMS).

  Please note: These positions at 24 month funding are insufficient to match workload increases through 2019. Consequently even at 24 months DHS anticipates some backlog at the end of the biennium due to projected increases in complexity and numbers over the biennium. Reduced to only 12 months of funding commencing July 2018, between July 2017 and June 2018 the backlog will increase to approximately 6.78 weeks. Permanent staff placed after July 2018 will not be sufficient to reduce that backlog, nor sufficient to hold the backlog steady.

- +1 POS/0.88 FTE permanent Principle Executive/Manager C (BCU Supervisor) positions

  The PEM-C position would be added for the 2017-19 since staff additions would bring the total BCU classified staff to 58 (a 1:19 staffing proportion; without the position, the staffing ratio would be 1:29).

  Managers provide crucial clinical supervision of fitness determination, hearings and policy staff, and improve consistency, manage audit and review processes, and maintain quality customer service in background check processes supporting client safety, security and health.

Current 2015-17 costs in Services & Supplies are expected to increase to a total $8,842,569 for the 2017-19 biennium. These additional costs are itemized as:

- +$5,335,316 from Oregon State Police and FBI fingerprint processing fees
- +$37,739 total for Adam Walsh and Child Care out-of-state CPS check costs.
- +$12,000 total for background check research site costs.
- +$307,514 total for agency-paid fingerprint capture for DHS and OHA employees and volunteers, Criminal Justice Information Services (CJIS) clearance, and Child Welfare foster and adoptive parents.
- +$50,000 for annual maintenance on the Criminal Records Information Management System (CRIMS).

These Services & Supplies costs are expected to increase due to the following factors:

- Increased statutory requirements for fingerprinting.

  For example, the federal Child Care Development Block Grant Act of 2014 (CCDBG) requires mandatory fingerprinting for all child care providers by October 2017. This alone will require fingerprinting on approximately 11,000 more background checks for DHS child care providers per year.

- Steadily increasing numbers of background checks. Fingerprinting averages over 40% in non-mandatory programs and 100% fingerprinting when mandatory.

  In 2012, BCU completed 111,538 background checks across all DHS and OHA programs served. By 2015 that number had grown to 157,038, a 41% increase. These numbers are anticipated to increase

+80% by the end of the 2017-19 biennium, resulting in approximately 207,654 checks in 2019, of which approximately 170,812 would require fingerprinting.

- To comply with FBI requirements, a reduced amount of FBI information is being presented in Oregon's Law Enforcement Data System (LEDS) checks, requiring increased fingerprinting for due diligence on potential out-of-state history.

- New CCDBG requirements for out-of-state child protective service checks on child care providers. Many states charge fees for these checks; the average is $17 per check.

Remaining S&S costs would be consistent with trends from the 2015-2017 biennium.

BACKGROUND CHECK EXPANSION

DHS has identified a variety of expansion options to current background check criteria for DHS providers whose fitness determination is completed by the Background Check Unit (BCU). These include home care workers, personal support workers, subsidized child care providers, private licensed agencies, System of Care and Strength, Preserving and Reunifying Families (SPRF) providers, and staff and volunteers from residential care, nursing, and adult foster home facilities.

Each of these expansions will necessitate the following to implement:

- Permanent rules changes to allow use of the selected expansions as potentially disqualifying conditions.
- Additional permanent staffing to handle the increased workload per expansion option.
- Training on selected expansions for veteran background check staff and new staff.

The selected expansions are as follows, in order of DHS-recommended priority for implementation:

1. Establish a comprehensive process for sharing adverse actions and terminations taken by one unit with another (i.e. Provider Relations Unit, Office of Licensing and Regulatory Oversight and other licensing units, Direct Payment Unit and Background Check Unit).

   This communication would allow separate units to review other units' adverse actions and terminations for fraud, health or safety concerns and apply that information to their provider enrolment processes where statute or rule allows.

   Implementation would require one (1 POS/0.88 FTE) Administrative Specialist 1 to coordinate the information sharing at a total cost of $146,319 per biennium.

2. Provide child protective service (CPS) checks on all Aging and People with Disabilities (APD), Intellectual/Developmental Disability (I/DD), and mental health (OHA Health Systems) providers, regardless of whether they directly serve children.

   BCU currently does CPS checks on all DHS and OHA employees and volunteers, all child care providers and their household members, Child Welfare provider (SOC, SPRF, etc.) determinations, Adam Walsh determinations, and various other positions serving children through other programs. Child Welfare (CW) foster and adoptive parents have CPS checks completed by branches as part of CW evaluation process. Most APD, DD and mental health (OHA Health Systems) providers have not received CPS checks.

   Implementation requires four (4 POS/3.52 FTE) Administrative Specialist 1 positions to perform CPS research and fitness determination at a total cost of $585,276 per biennium. It would also require one (1 POS/0.88 FTE) Compliance Specialist 2 position to handle increases in hearing requests based on increases in abuse-related denials at a total cost of $180,912 per biennium. Permanent rules were published December 1, 2016 to allow information from this option to be considered as potentially disqualifying conditions.

Please note that projected numbers of these checks would require an additional +2.87 FTE Administrative Specialist 1 to maintain staffing-to-workload by 2019. Consequently at the requested staffing level there is anticipated to be some backlog from this expansion by the end of the biennium.

Limited duration staff are currently in place to implement this expansion effective December 2016 in order to improve child safety. However if this expansion is chosen for continuance into the 2017-19 biennium at a prospective 12-month staffing level, any workload-related backlog will be increased by approximately +1.42 weeks.

Another recommendation would be the use of the placement on the Centers for Medicare and Medicaid Services (CMS) Office of the Inspector General (OIG) Fraud List for Medicaid and Medicare, and other states' exclusion lists as potentially disqualifying conditions for all long term care-related subject individuals handled by the Background Check Unit. The CMS OIG and other states' exclusion lists may hold currently unconsidered information that reveal past history of abuse or fraud. The addition of these exclusion list checks to long term care background checks is a requirement of the CMS National Background Check Program (NBCP) grant for which DHS was approved by the Oregon Legislature in 2013.

However, implementation of the CMS exclusion lists across required programs would require additional staffing beyond this request, and based on the current level of funding**,** further expansion into CMS grant requirements would be impossible without incurring considerable backlogs.

FEE-FOR-SERVICE

Currently the Background Check Unit (BCU) does not charge background check fees to subject individuals or Qualified Entities of DHS and OHA; the costs for regulatory checks are currently paid by the DHS and OHA programs BCU serves. ORS 181.534 (9) (g) grants authority to charge fees for criminal history portions of checks but is not currently doing so. Fee-for-service is a potential manner of acquiring additional funds for criminal history portions of each check. Statutory changes to ORS 181.534 (9)(g) would be

required to charge fees for costs from labor, research, and out-of-state fees related to providing protective service checks for Adam Walsh and the Child Care Development Block Grant Act of 2014.

Each fingerprinted background check requires $28 in processing fees to the Oregon State Police. In addition, as of October 2016 the FBI charges $10.75 for volunteers or $12.00 for employment/licensing/certification in processing fees per check.

If only fingerprint processing fees are charged to subject individuals or Qualified Entities when fingerprints are required for a check, at approximately 207,654 subject individuals fingerprinted during the course of 2017-19, BCU could gain back $8,330,203 in funds to offset Services and Supplies costs.

Other options, including a set background check fee based on average costs, are possible. BCU could work with DHS Budget to establish an appropriate fee-for-service schedule if the Legislature determined fee-for-service was the most appropriate funding mechanism for the Background Check Unit.

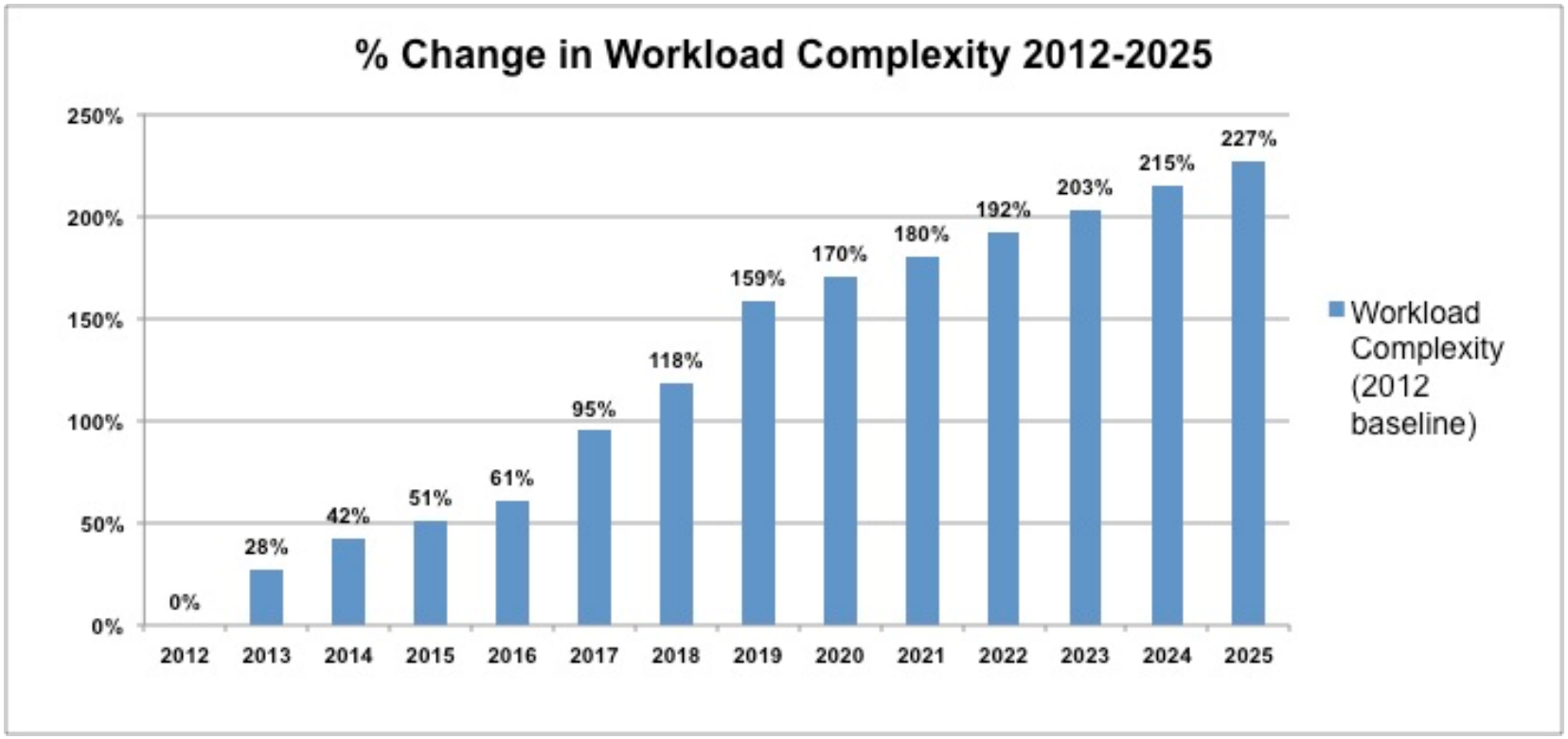
2. WHY DOES DHS PROPOSE THIS POP?

From 2012-2015, BCU has experienced a 41% increase in the total number of background checks. Workload complexity, as measured by the average time required to perform various tasks resulting in a fitness determination and annual background checks per year, has increased in the same period 51% due to new federal and state requirements. During that time BCU underwent a 15% decrease in total permanent staffing. As of 2017, complexity will have increased 95% over 2012.

Numerous process improvements have been attempted without success in stemming growing backlog. As of March 2016 DHS has partially met this workload gap by hiring an additional fifteen (15) limited duration AS1 positions and one (1) PEM-C position for the 2015-17 biennium. However these positions meet only the workload needs of BCU through the 2015-17 biennium.

Due to ongoing program growth and federal statutory changes implementing in the 2017-2019 biennium, BCU workload complexity is expected to increase 159% over 2012 numbers by 2019. Without sufficient permanent staffing increases for 2017-19, delays in processing background checks will begin increasing again.

The following chart relates increasing complexity from 2012 through 2025 based on current background check growth and known federal and state program changes occurring during the 2017-19 biennium. This chart does not include complexity per background check added by the expansion options. It does include the effects of process improvements such as the Long Term Care Registry.



In terms of the expansion portion, each option increases the depth of the background check provided for each subject individual, thereby increasing the likelihood of identifying past history that might affect the health and safety of vulnerable Oregonians. In addition, as noted, the CMS exclusion lists are a requirement of the CMS National Background Check Program grant.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

Comprehensive background checks promote the following:

- Safety and independence of those aging, disabled and intellectually/developmentally disabled Oregonians receiving services from DHS and OHA.
- Safety and wellness for children and youth served by DHS and OHA providers.
- Qualified staff and volunteers successfully passing background checks are able to support themselves and their families as providers through stable living wage employment.

Timely background checks due to matching workload versus staffing means that:

- Vulnerable Oregonians receiving care services from DHS and OHA acquire safe care and support more quickly, improving quality of life for especially those Oregonians requiring emergent in-home services.
- Employers of facilities are able to maintain staffing levels and provide better care to vulnerable Oregonians receiving care and support in facilities.
- Employers in residential care, nursing, adult foster home, skilled nursing, and child care facilities and centers are able to attract and keep top recruits due to faster hiring processes. In addition, they are able to meet licensing requirements for staffing more easily.
- Many licensing and certification processes are affected, thereby extending their timelines. Such processes include but not limited to licensing of facilities for APD, DD and mental health, and certification of home care workers and personal support workers, Traditional Health Workers, and exempt and subsidized Child Care centers and providers.

- Oregonians who may be seeking employment, licensure or certification for their own or their family's independence and quality of life are able to acquire jobs faster.

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

Quality Service Engagement – increased speed of quality of background checks performed on providers in support of effective, safe employment, certification and licensing processes for vulnerable Oregonians and Oregon employers.

Safety – Re-abuse rates reduced through more timely identification of provider history.

People Living as Independently as Possible – Faster quality checks on in-home providers leading to safer care, more independence, and better support of Oregonians receiving in-home services. Enhanced checks on in-home and other long term care providers leading to safer care and better support of Oregonians receiving in-home 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.

N/A.

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

A variety of internal solutions to meet service delivery agreements have been attempted by BCU to match increases in raw numbers and workload complexity.

- Ongoing work with IT vendor Tailored Solutions and the Oregon State Police (OSP) to achieve numerous process improvements via technology solutions. While useful in automating many time-consuming manual tasks it did not eliminate time spent on core fitness determination work.

- Day-long background check ‘events’ where all teams in the unit contribute to processing background checks. Assisted fitness determination work, but caused backlogs in Hearings, Compliance and Fingerprint teams’ processes.
- Consistent monthly overtime work from October 2014 to August 2016. During that period BCU staff worked 1407.5 overtime hours and processed 25,227 background checks.

  To maximize the quantity processed, BCU staff working overtime focused on “cleans”, background checks that had no criminal or abuse history. Cleans are the quickest and easiest checks to complete. Useful in eliminating cleans, but did not address the core fitness determination work of the majority of cases requiring careful research and evaluation of criminal and abuse history.

- Implemented the Long Term Care Registry (LTCR) in January 2015.

  To become active on the LTCR, a provider of long term care must pass an LTCR-related background check. Active status avoids redundant background checks between employers as subject individuals change roles within or between LTCR-covered facilities throughout Oregon.

  Since implementation, 73,961 providers of long term care have achieved active status. As of December 2016, employers have been able to bypass over 33,000 redundant background checks.

  In addition to savings of time for employers and clients in need of services, the LTCR has saved BCU approximately $1.478 million as of December 2016 in labor and fingerprint processing costs for duplicative background checks.

  The LTCR is expected to create a 17% reduction on long term care-related checks. However, per DAS population statistics, the long term care population in Oregon will have exceeded 18% growth between 2014 and 2018, eliminating that gain by 2019.

Despite these efficiencies, background check numbers and complexity have continued to increase beyond what staffing and process improvements could complete, leading to growing backlogs.

The final alternative is to not expand background check staffing despite backlogs. This alternative has been rejected for the following reasons:

1. Potential health and safety factors from vulnerable Oregonians not receiving support from vetted, safe providers sooner.
2. Providers already on the job with new, unreported history not being caught earlier due to delayed recertification background checks.
3. Employers being unable to meet license-related staffing requirements established to maintain client safety and wellbeing.
4. Employers having staffing delays or losing quality candidates due to delays in background check processing.
5. Potentiality of increased tort claims due to compromised health and safety, and financial abuse

For the background check expansion options, the alternative is to not expand background check criteria. This alternative was rejected for potential health and safety factors to those receiving DHS and OHA providers.

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

Adverse effects of not funding the workload-related section of this POP are as follow:

1. Without timely background checks, vulnerable Oregonians requiring emergent in-home care or facility-provided care may not have providers hired or facilities staffed sufficiently nor quickly for their health and safety needs.
2. Without timely review of background checks for currently working providers, providers with new, unreported history may not be removed from work for extended periods of time. Such an extension of review periods may lead to ongoing or repeated abuse and neglect of vulnerable clients, and causing harm or sometimes death.
3. Employers requiring certain staffing levels for licensing purposes may encounter licensing problems which affect the health, safety and wellness of the vulnerable clients they serve, and the financial security of the employees and their families who depend on the viability of the facility or center being licensed.

4. Employers serving DHS and OHA clients may lose highly competitive candidates to other facilities or centers that are not regulated by the Background Check Unit (i.e., facilities not serving Medicare and Medicaid-dependent clients) due to delays in background check processing.
5. Potentially escalating tort claims due to compromised health and safety, and financial abuse.

Adverse effects of not funding the background check expansion sections of this POP are as follow, by recommended expansion option:

1. Without sharing adverse actions and terminations between DHS units, providers terminated for health, safety or fraud concerns in one provider unit may successfully transfer to another provider unit without communication of the circumstances of the initial adverse action. This may in turn affect the health, safety or financial wellness of vulnerable Oregonians.
2. While BCU utilizes APS information when completing fitness determinations for all APD, DD, and addictions and mental health providers, some providers from those groups have not historically received CPS checks per agreements with Oregon community stakeholders initiated by the HB2175 (2007) Workgroup.

   This gap affects over 100,000 background checks per year performed by BCU, each check representing a subject individual serving at least one if not multiple vulnerable Oregonians. Not funding this option will continue this gap for increasing numbers of long term care providers.

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

Other agencies may be affected as necessary to create intergovernmental agreements in support of information sharing on adverse actions.

Currently providers certified by the Office of Child Care (Department of Education) are able under rule, interagency agreement and state plan can bypass our background check process. There have been ongoing concerns with this process. The Office of Child Care also automatically approved providers under age 18

while DHS will background check providers age 16 and older. Office of Child Care providers also do not have the requirement to report new abuse substantiations or criminal history.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Adults and People with Disabilities Program
Child Care Unit
Child Welfare Program
Intellectual/Developmental Disabilities Program
Human Resources
Office of Adult Abuse Protection and Investigation
Office of Licensing and Regulatory Oversight

10. WHAT IS YOUR EQUITY ANALYSIS?

Timely background checks provide greater equity of:

1. Care and service to vulnerable Oregonians;
2. Hiring for Oregon employers;
3. Employment, licensure or certification for Oregonians employed or seeking employment in BCU-regulated programs.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): 22 staff July 1, 2018
End Date (if applicable): Permanent

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

☒ Background Check Unit
☒ APD/DD Provider Relations Unit
☒ Office of Licensing and Regulatory Oversight
☒ Child Care Unit/Direct Pay Unit
☒ APD/DD
☒ Child Welfare
☒ Office of Adult Abuse Prevention and Investigation

The majority of new responsibilities will lie with the Background Check Unit.

For the cross-communication portion of the POP, APD/DD Provider Relations Unit, OLRO, CCU, DPU, APD/DD, OAAPI and Child Welfare may all have new cross-reporting duties.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
Background Check Unit will receive the majority of impacts. Currently BCU's facilities are at maximum occupancy. New facilities and work stations will be required for current and additional staff. Training will be required for veteran and new staff on administrating the new background check options. Updates to the Criminal Records Information Management System may be necessary to implement all additions.

Additional positions for Background Check Unit will increase impact for Records, FMLA/OFLA, Recruitment, Human Resource Analyst and Payroll units.

There will also be workload for Facilities and the Office of Information Services.

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

No changes to client caseloads or direct client services.

However DHS, OHA, Allied Agencies on Aging, DD Brokerage, and other direct service staff assisting clients to find qualified, safe providers or assisting providers with enrollment processes will be beneficially affected by faster turnaround on background checks. Enrollment processes dependent on background checks will be completed more quickly leading to faster connections of clients with needed service providers.

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.

The staff required for permanent positions (24 months per biennium) are as follow:

- Workload-Related: 5.00 FTE permanent Administrative Specialist 1 (Fitness Determiner) and 1.0 FTE permanent Principle Executive/Manager C (BCU Supervisor) positions
- Communication Option: 1.00 FTE permanent Administrative Specialist 1
- CPS Expansion Option: 4.00 FTE permanent Administrative Specialist 1 (Fitness Determiner) and 1.00 FTE Compliance Specialist 2 (Hearings Representative) positions

The staff required for permanent positions (21 months per biennium) are as follow:

- Workload-Related: 10.00 FTE permanent Administrative Specialist 1 (Fitness Determiner) positions

Additional positions for Background Check Unit will increase impact for Records, FMLA/OFLA, Recruitment, Human Resource Analyst and Payroll units. There will also be workload for Facilities and the Office of Information Services.

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

Training would be required for all new staff.

Automatic URL access of OIG, SAM, and out-of-state exclusion lists by state(s) required for CMS grant-related checks will require one-time IT costs.

f. What are the ongoing costs?

Current 2015-17 costs in Services & Supplies are expected to increase to a total $8,842,569 for the 2017-19 biennium. These costs are expected to increase due to the following factors:

- +$5,335,316 from Oregon State Police and FBI fingerprint processing fees
- +$37,739 total for Adam Walsh and Child Care out-of-state CPS check costs.
- +$12,000 total for background check research site costs.
- +$307,514 total for agency-paid fingerprint capture for DHS and OHA employees and volunteers, Criminal Justice Information Services (CJIS) clearance, and Child Welfare foster and adoptive parents.
- +$50,000 for annual maintenance on the Criminal Records Information Management System (CRIMS).

Remaining S&S costs would be consistent with trends from the 2015-2017 biennium.

g. What are the potential savings?

Potential savings from timely, quality background checks are based on reductions in risks to health and safety for vulnerable Oregonians served by DHS and OHA. There are savings for clients who receive more timely care, thereby preventing additional medical or support costs that might be incurred. By increasing health, safety and wellness, money will also be saved through prevention of investigations, hearings, and potential tort claims.

Employers will receive savings due to more timely hiring processes, fewer qualified staff lost due to waits on background checks, and potential fines or other licensing problems for not retaining statutorily-mandated staffing levels.

Approved subject individuals seeking work will be employed more quickly, which may preclude those who are currently unemployed from continuing to receive unemployment benefits or other State-provided support services.

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

Yes.

TOTAL FOR THIS PACKAGE (DHS+OHA)

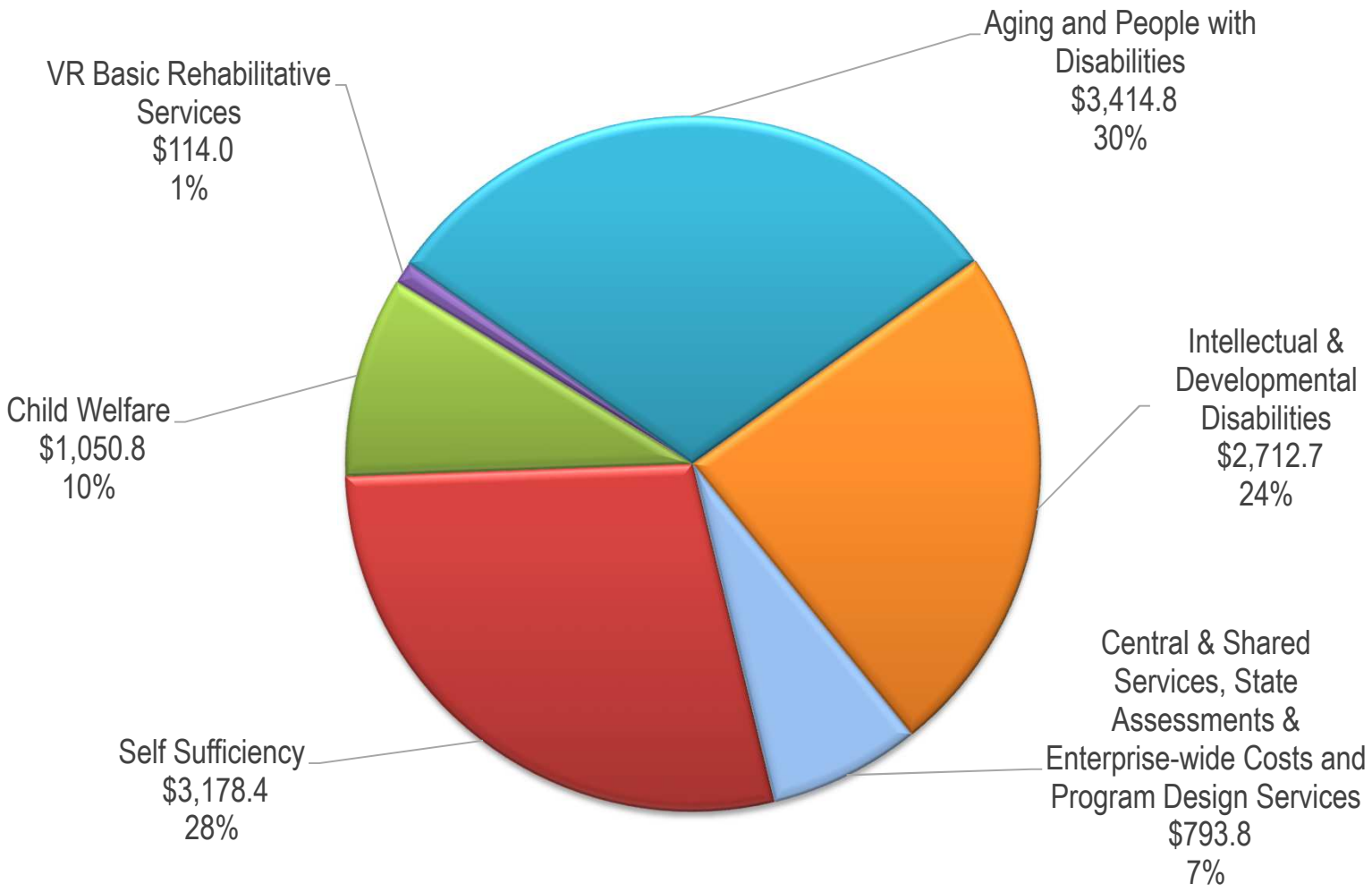
Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	1,353,317	0	1,353,317	22	11.00
Services & Supplies	316,365	5,898,483	61,446	6,276,294		
Special Payments	5,915,435	19,214	1,202,301	7,136,950		
Total	**$6,231,800**	**$7,271,014**	**$1,263,747**	**$14,766,561**	**22**	**11.00**

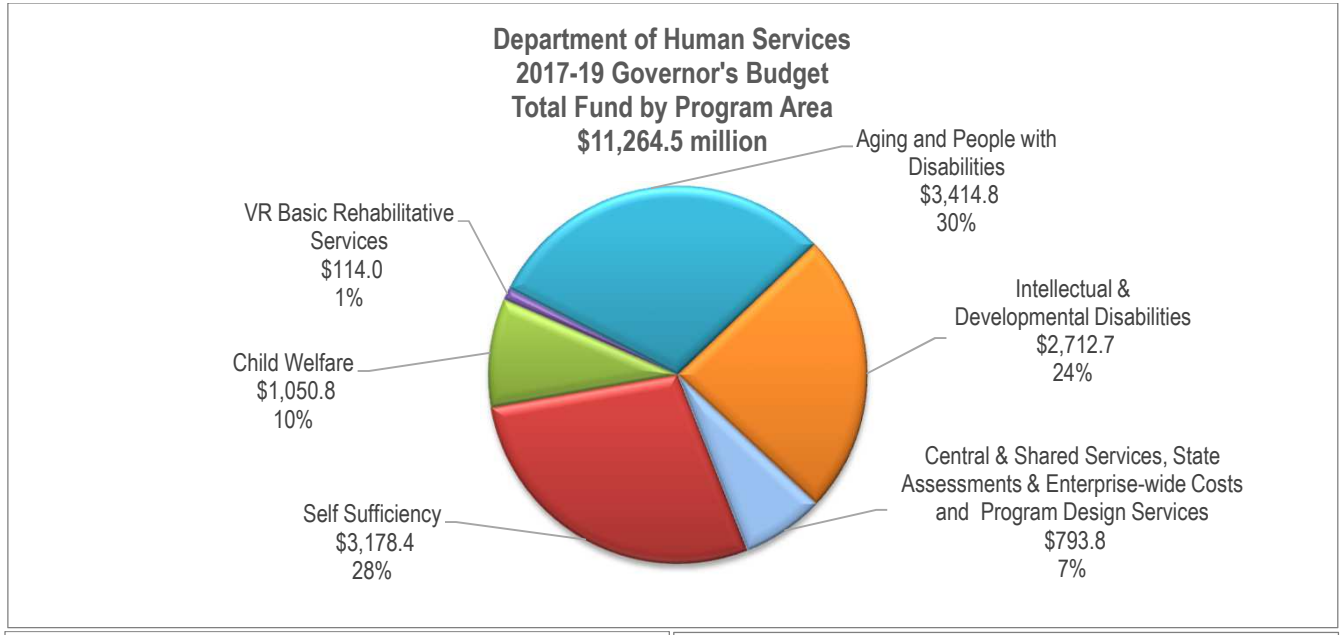
DHS/OHA - Fiscal Impact Summary by Program Area:

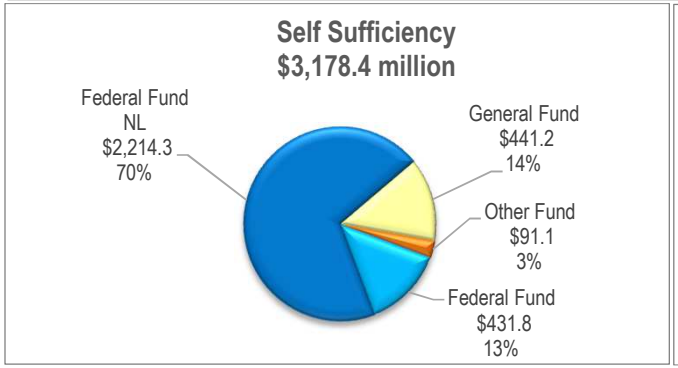
	DHS Shared Services	DHS SAEC	OHA SAEC	Total
General Fund	**$0**	**$6,118,266**	**$113,534**	**$6,231,800**
Other Fund	**$7,251,800**	**$0**	**$19,214**	**$7,271,014**
Federal Funds- Ltd	**$0**	**$1,221,826**	**$41,921**	**$1,263,747**
Total Funds	**$7,251,800**	**$7,340,092**	**$174,669**	**$14,766,561**
Positions	**22**	**0**	**0**	**22**
FTE	**11.00**	**0.00**	**0.00**	**11.00**

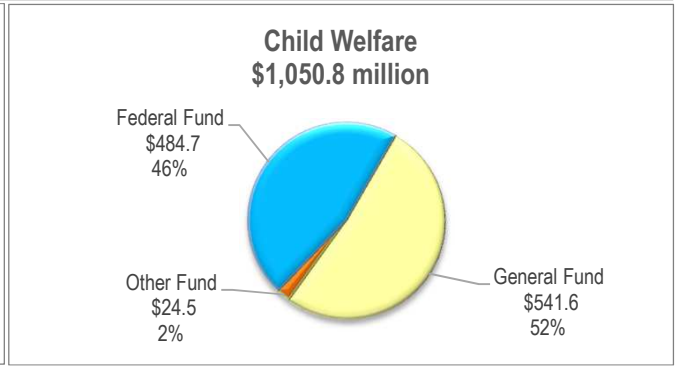
What are the sources of funding and the funding split for each one?
For purposes of this analysis, the cost allocation and fund splits for DHS/OHA are based on the 15-17 Cost Allocation model where we have applied the aggregate DHS/OHA fund splits of GF, OF and FF. Available revenue sources are based on Grants which are entitlement grants that are matched and grants that are not federally capped and are available to program or office within DHS/OHA.

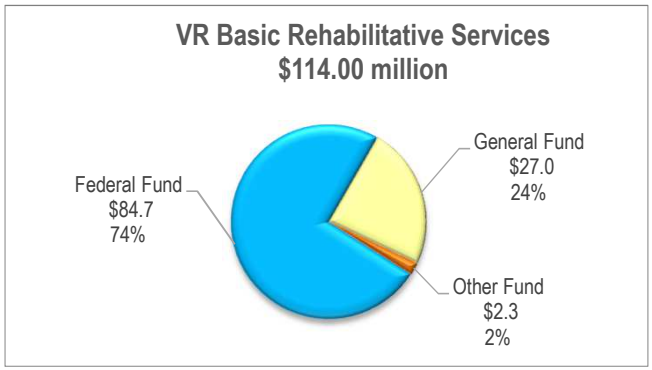
Department of Human Services
2017-19 Governor's Budget
Total Fund by Program Area
$11,264.5 million

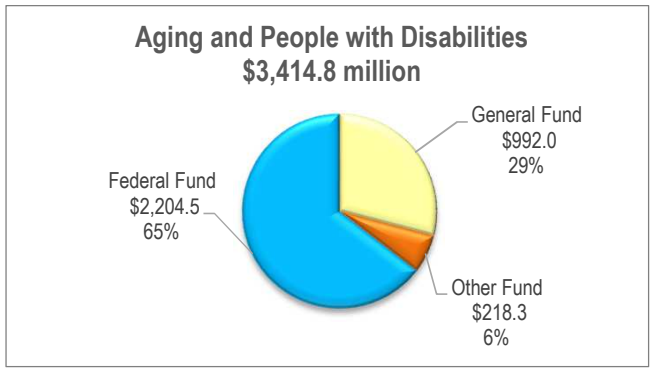


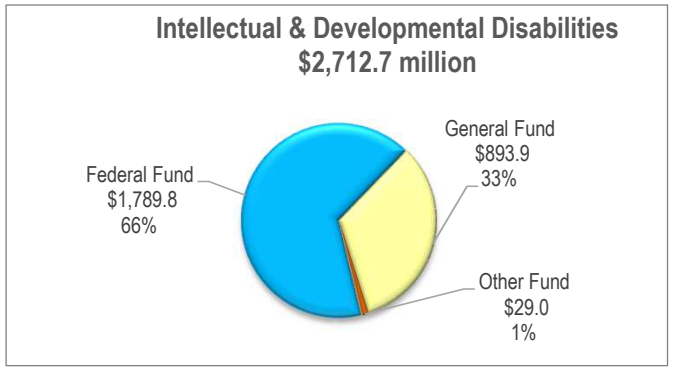

Department of Human Services
2017-19 Governor's Budget
Total Fund by Program Area
$11,264.5 million
Aging and People with Disabilities
$3,414.8
30%
Intellectual & Developmental Disabilities
$2,712.7
24%
Central & Shared Services, State Assessments & Enterprise-wide Costs and Program Design Services
$793.8
7%
Self Sufficiency
$3,178.4
28%
Child Welfare
$1,050.8
10%
VR Basic Rehabilitative Services
$114.0
1%

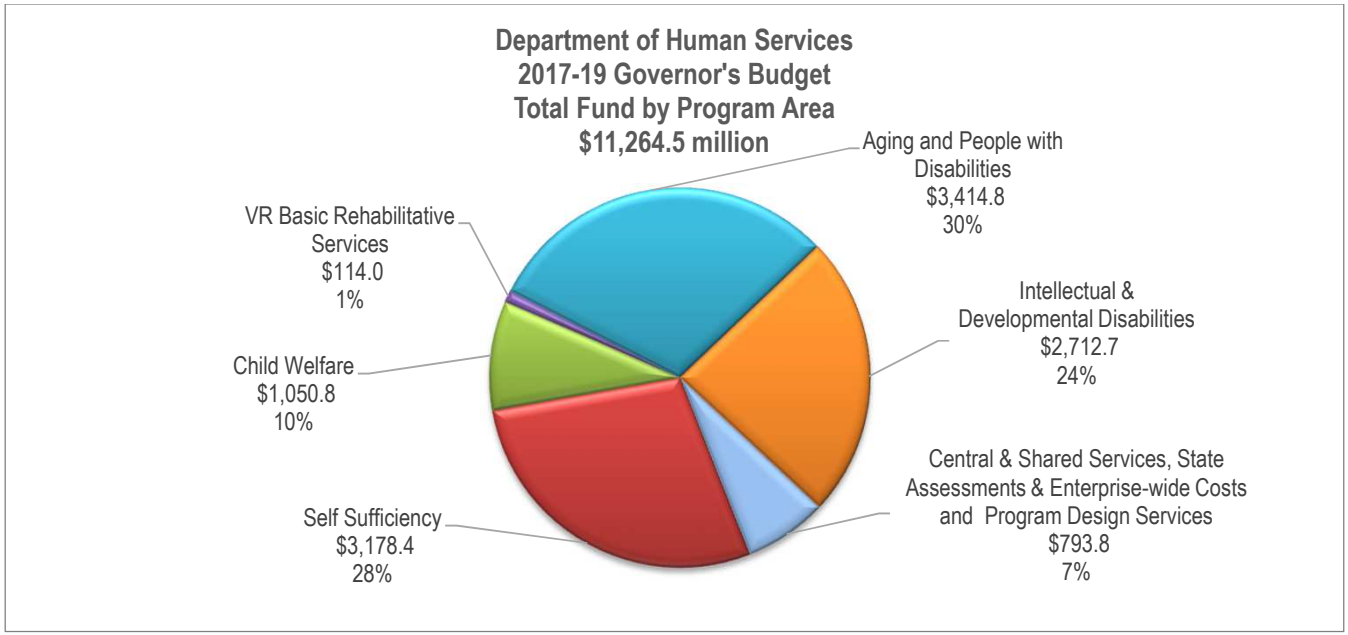

Self Sufficiency
$3,178.4 million
Federal Fund NL
$2,214.3
70%
General Fund
$441.2
14%
Other Fund
$91.1
3%
Federal Fund
$431.8
13%


Child Welfare
$1,050.8 million
Federal Fund
$484.7
46%
Other Fund
$24.5
2%
General Fund
$541.6
52%


VR Basic Rehabilitative Services
$114.00 million
Federal Fund
$84.7
74%
General Fund
$27.0
24%
Other Fund
$2.3
2%


Aging and People with Disabilities
$3,414.8 million
Federal Fund
$2,204.5
65%
General Fund
$992.0
29%
Other Fund
$218.3
6%


Intellectual & Developmental Disabilities
$2,712.7 million
Federal Fund
$1,789.8
66%
General Fund
$893.9
33%
Other Fund
$29.0
1%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2017-19 Governor's Budget
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$793.8
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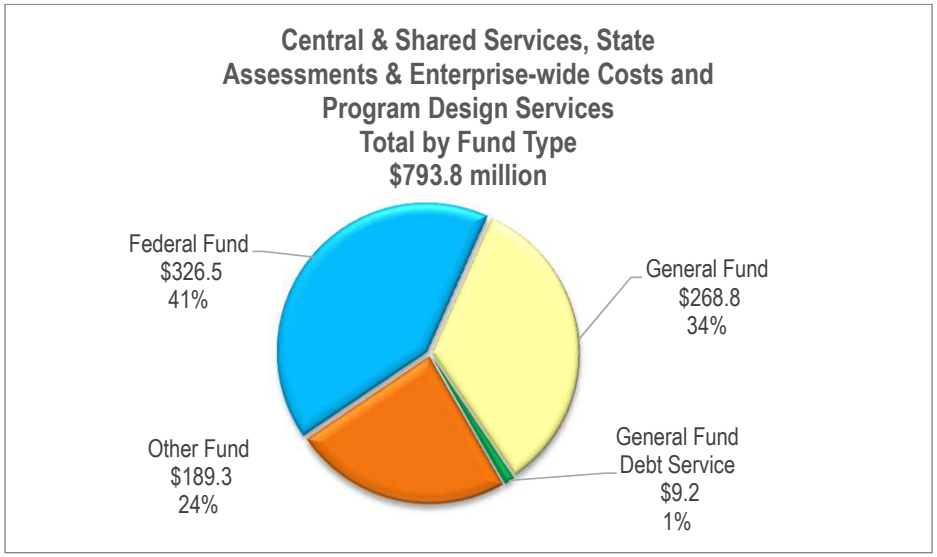
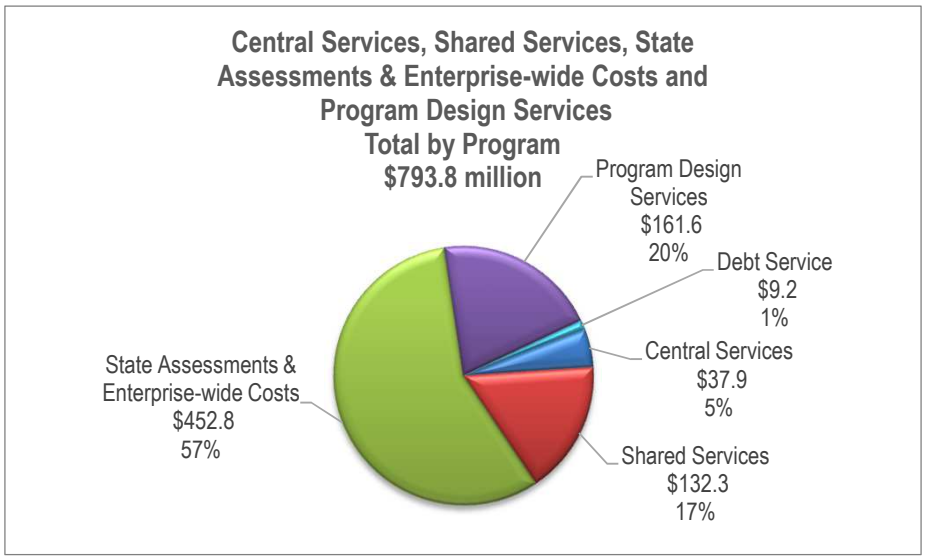
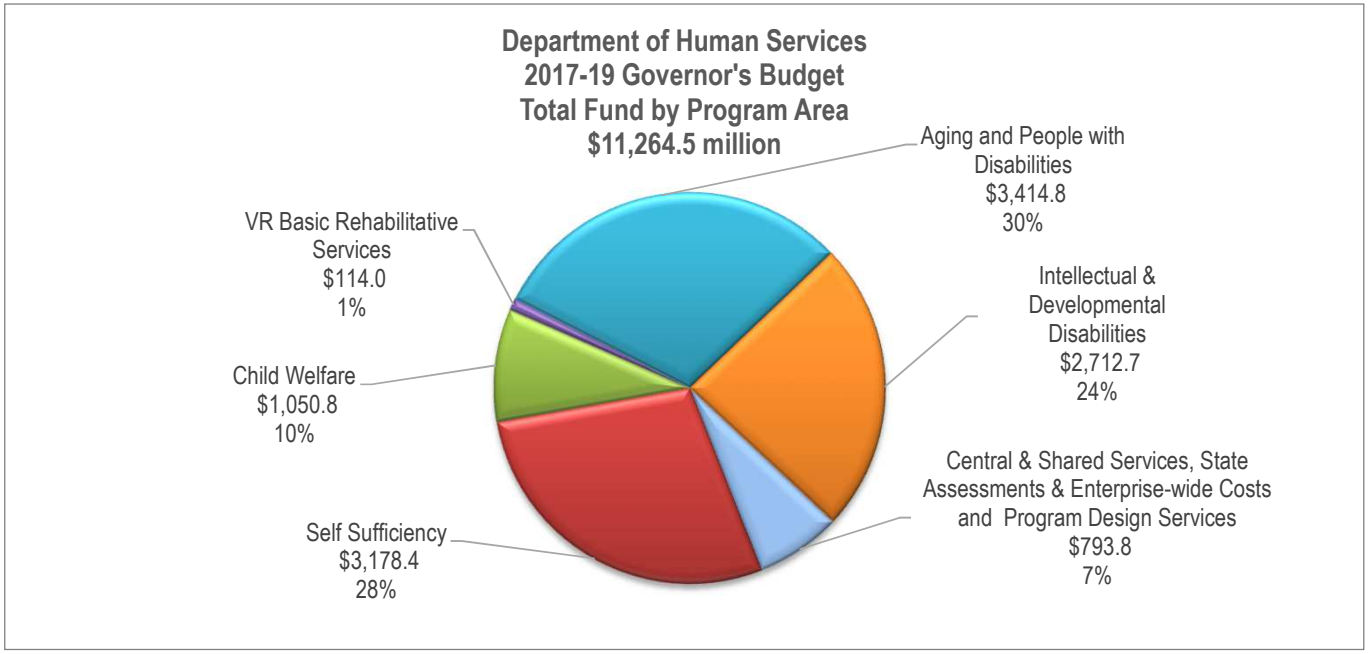
28%
Child Welfare
$1,050.8
10%
VR Basic Rehabilitative Services
$114.0
1%


Central & Shared Services, State Assessments & Enterprise-wide Costs and Program Design Services
Total by Fund Type
$793.8 million
Federal Fund
$326.5
41%
General Fund
$268.8
34%
General Fund Debt Service
$9.2
1%
Other Fund
$189.3
24%


Central Services, Shared Services, State Assessments & Enterprise-wide Costs and Program Design Services
Total by Program
$793.8 million
Program Design Services
$161.6
20%
Debt Service
$9.2
1%
Central Services
$37.9
5%
Shared Services
$132.3
17%
State Assessments & Enterprise-wide Costs
$452.8
57%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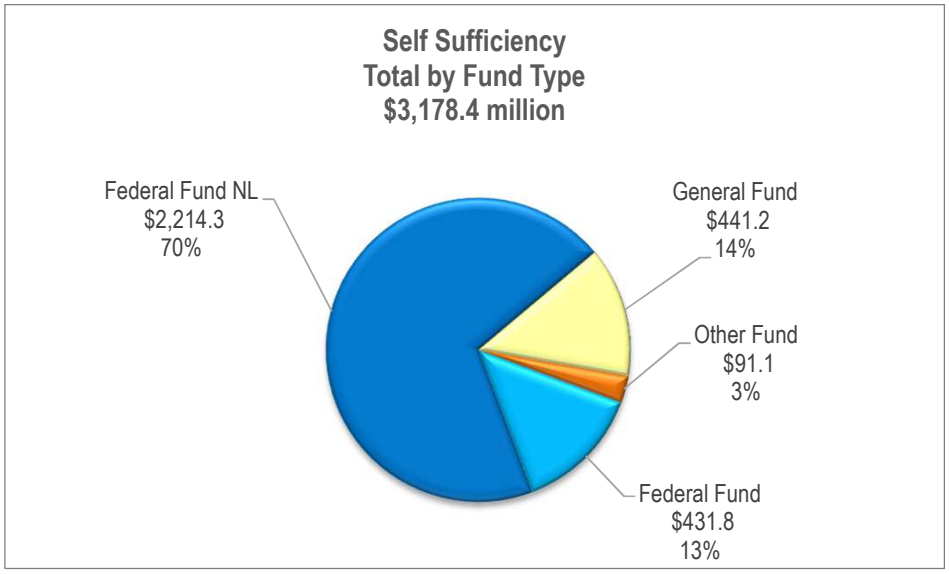
Self Sufficiency $3,178.4 28%
Child Welfare $1,050.8 10%
VR Basic Rehabilitative Services $114.0 1%


Self Sufficiency
Total by Fund Type
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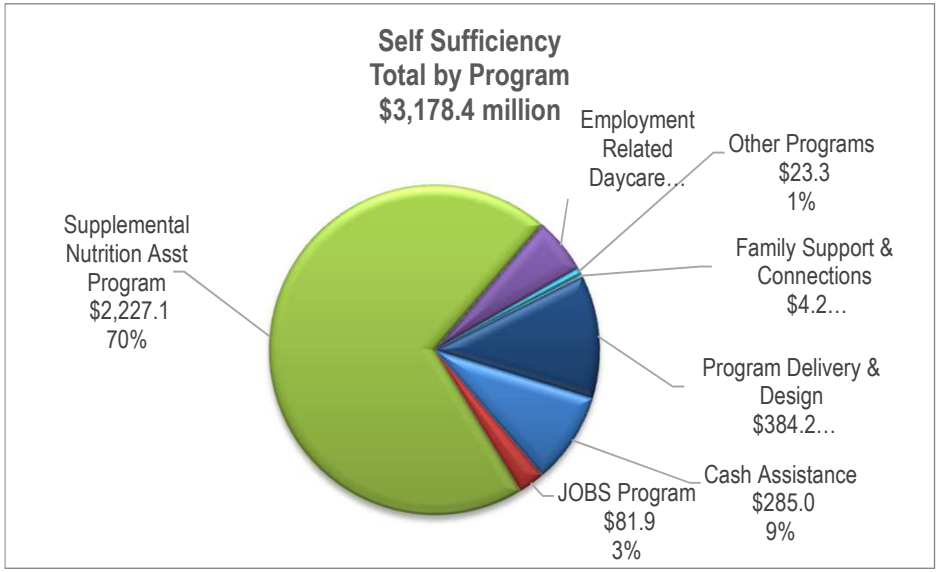
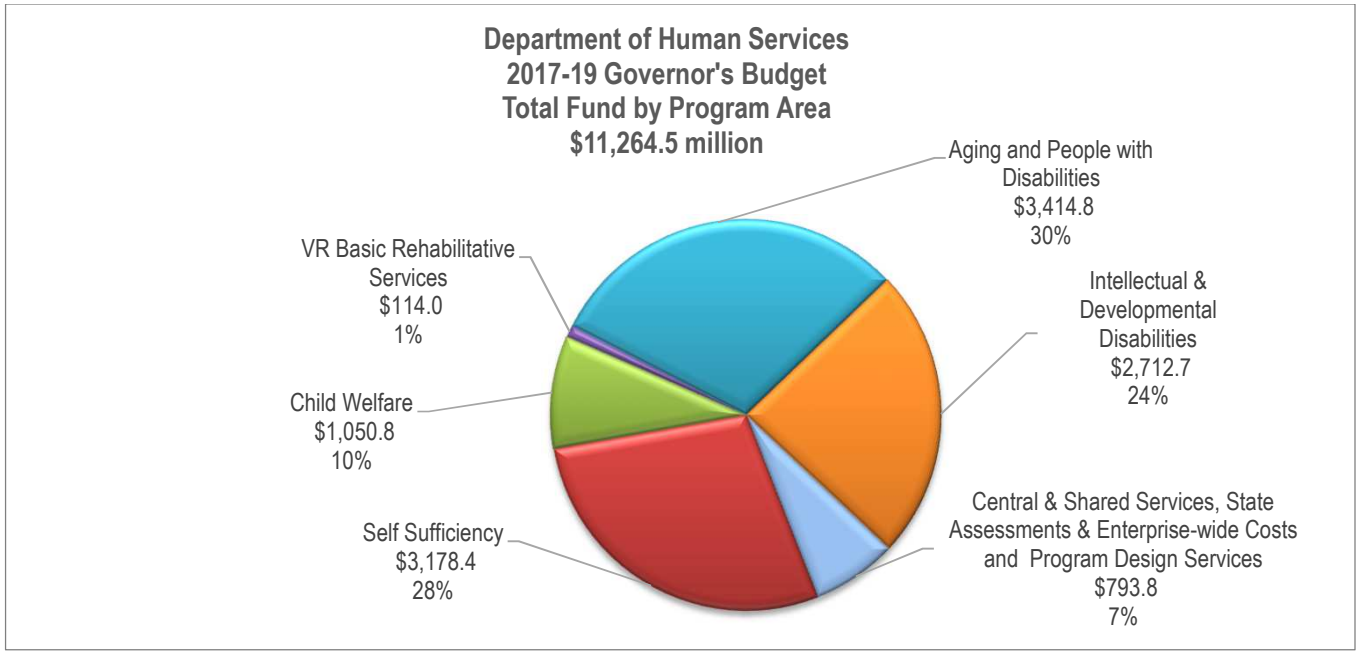
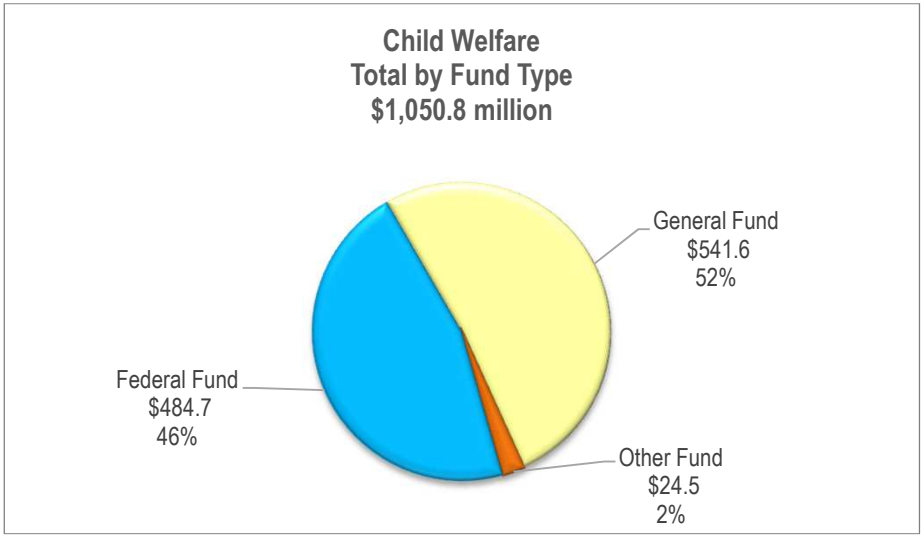
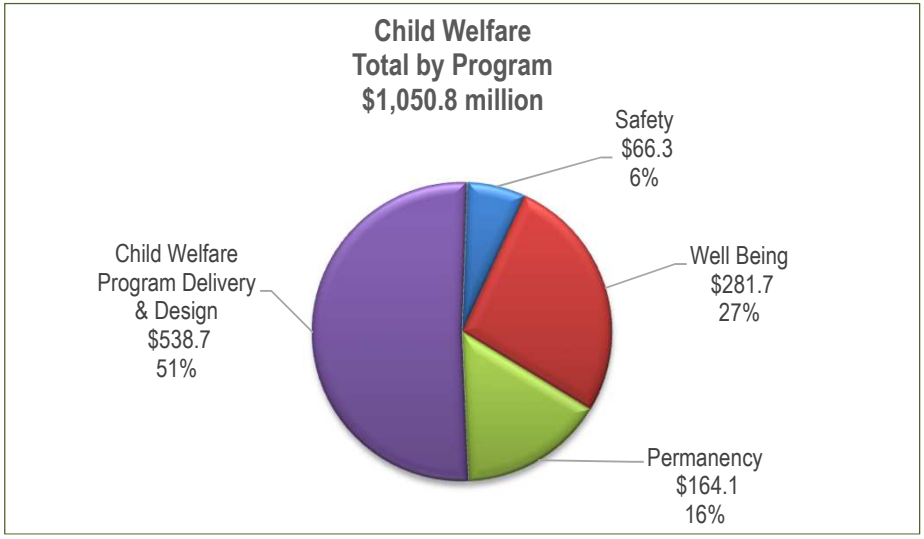
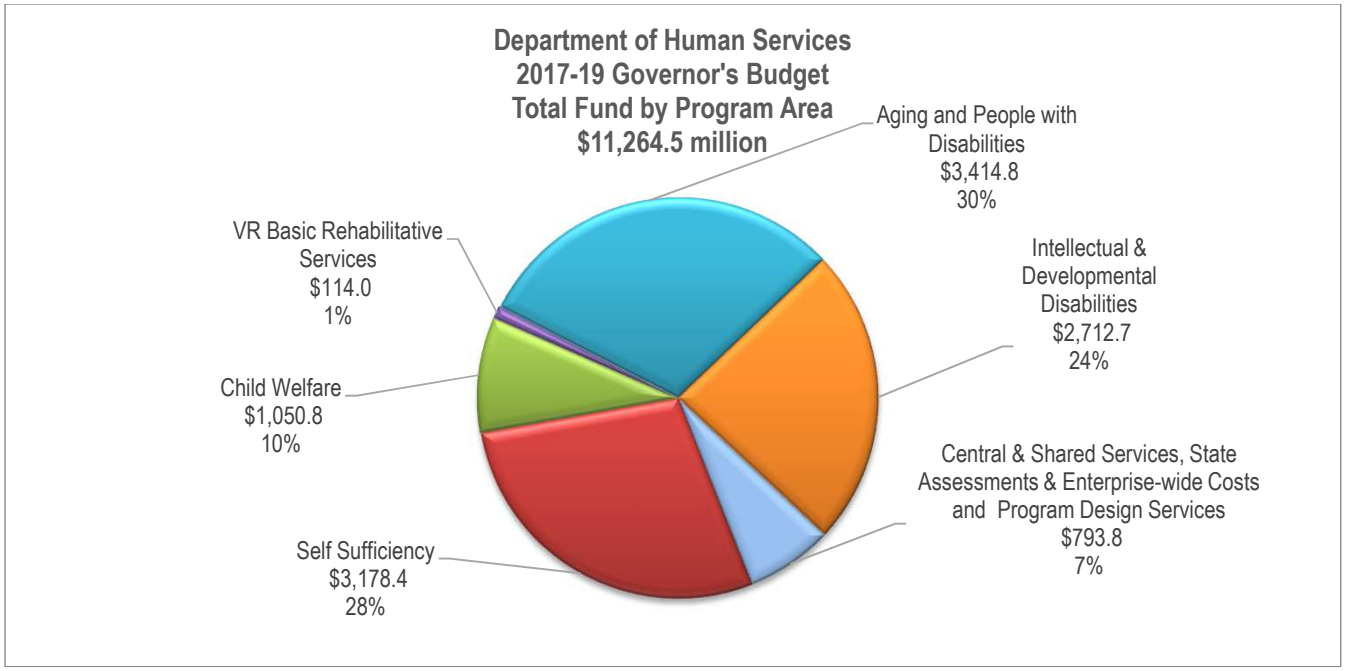
Federal Fund NL $2,214.3 70%
General Fund $441.2 14%
Other Fund $91.1 3%
Federal Fund $431.8 13%


Self Sufficiency
Total by Program
$3,178.4 million
Employment Related Daycare…
Other Programs $23.3 1%
Family Support & Connections $4.2…
Program Delivery & Design $384.2…
Cash Assistance $285.0 9%
JOBS Program $81.9 3%
Supplemental Nutrition Asst Program $2,227.1 70%


Department of Human Services
2017-19 Governor's Budget
Total Fund by Program Area
$11,264.5 million
Aging and People with Disabilities $3,414.8 30%
Intellectual & Developmental Disabilities $2,712.7 24%
Central & Shared Services, State Assessments & Enterprise-wide Costs and Program Design Services $793.8 7%
Self Sufficiency $3,178.4 28%
Child Welfare $1,050.8 10%
VR Basic Rehabilitative Services $114.0 1%


Child Welfare
Total by Fund Type
$1,050.8 million
General Fund $541.6 52%
Federal Fund $484.7 46%
Other Fund $24.5 2%


Child Welfare
Total by Program
$1,050.8 million
Safety $66.3 6%
Well Being $281.7 27%
Permanency $164.1 16%
Child Welfare Program Delivery & Design $538.7 51%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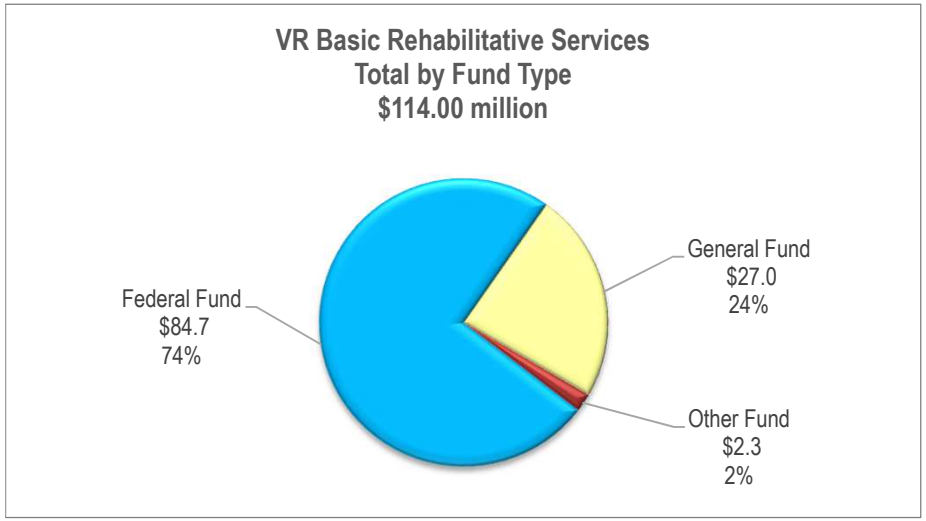
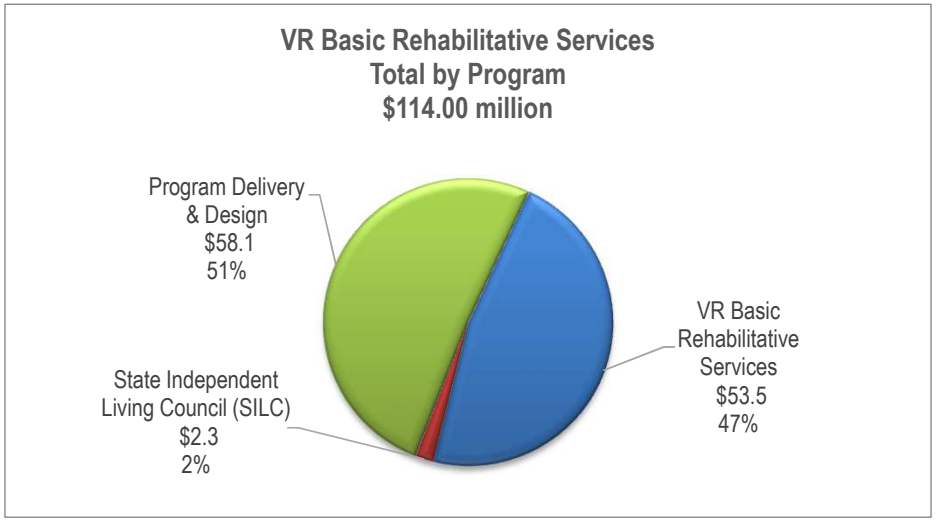
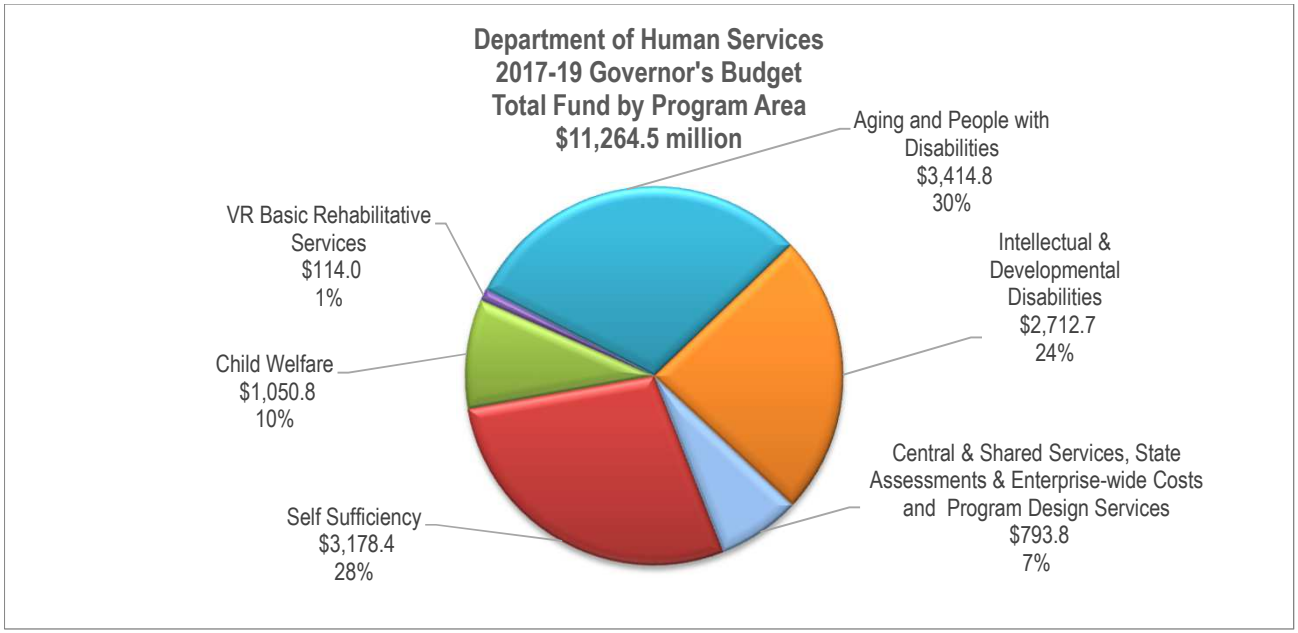
Self Sufficiency $3,178.4 28%
Child Welfare $1,050.8 10%
VR Basic Rehabilitative Services $114.0 1%


VR Basic Rehabilitative Services
Total by Fund Type
$114.00 million
Federal Fund $84.7 74%
General Fund $27.0 24%
Other Fund $2.3 2%


VR Basic Rehabilitative Services
Total by Program
$114.00 million
Program Delivery & Design $58.1 51%
VR Basic Rehabilitative Services $53.5 47%
State Independent Living Council (SILC) $2.3 2%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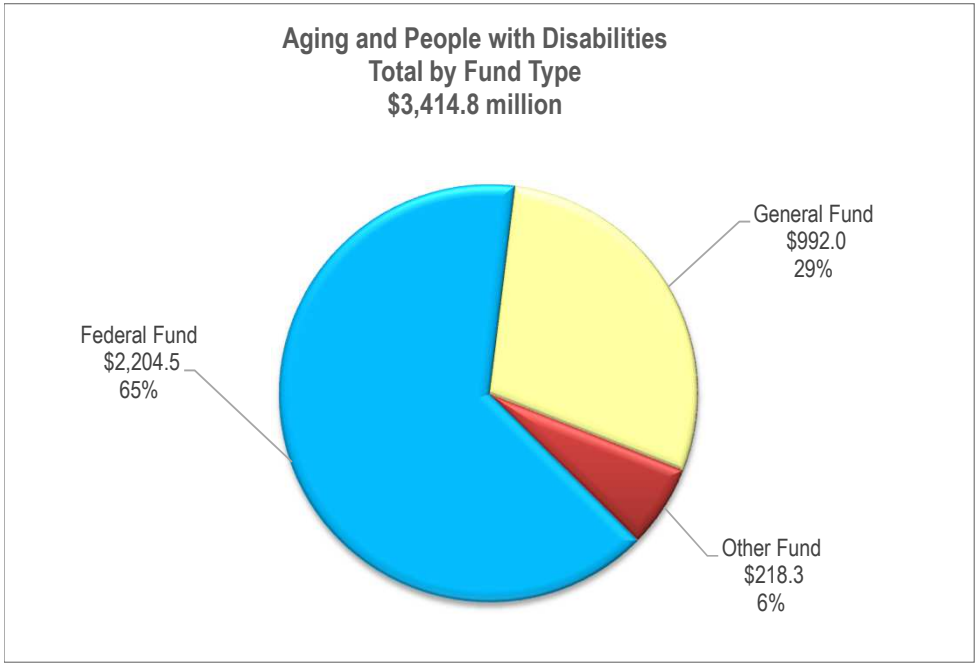
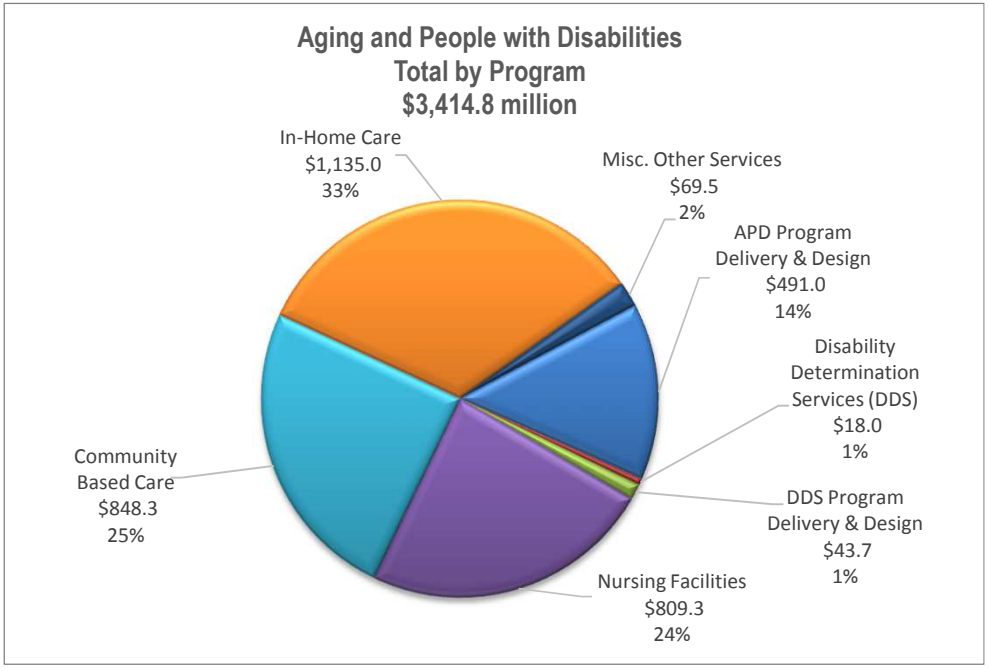
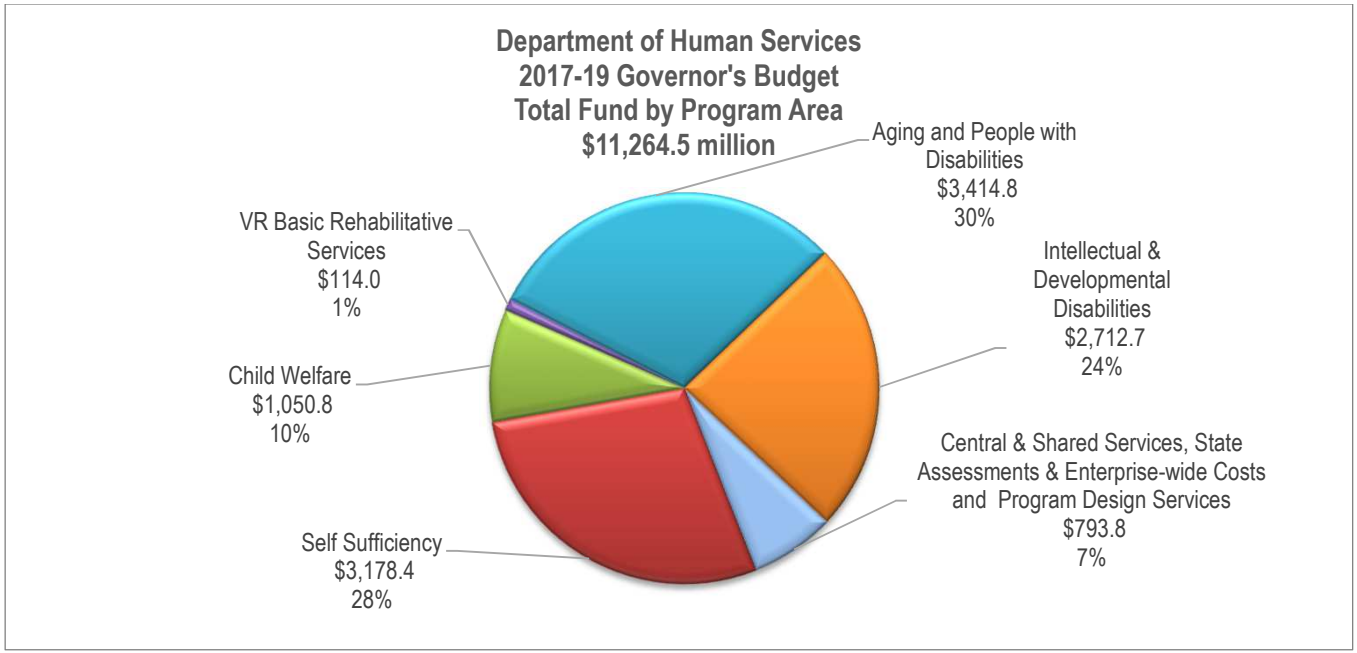
30%
Intellectual & Developmental Disabilities
$2,712.7
24%
Central & Shared Services, State Assessments & Enterprise-wide Costs and Program Design Services
$793.8
7%
Self Sufficiency
$3,178.4
28%
Child Welfare
$1,050.8
10%
VR Basic Rehabilitative Services
$114.0
1%


Aging and People with Disabilities
Total by Fund Type
$3,414.8 million
General Fund
$992.0
29%
Federal Fund
$2,204.5
65%
Other Fund
$218.3
6%


Aging and People with Disabilities
Total by Program
$3,414.8 million
In-Home Care
$1,135.0
33%
Misc. Other Services
$69.5
2%
APD Program Delivery & Design
$491.0
14%
Disability Determination Services (DDS)
$18.0
1%
DDS Program Delivery & Design
$43.7
1%
Nursing Facilities
$809.3
24%
Community Based Care
$848.3
25%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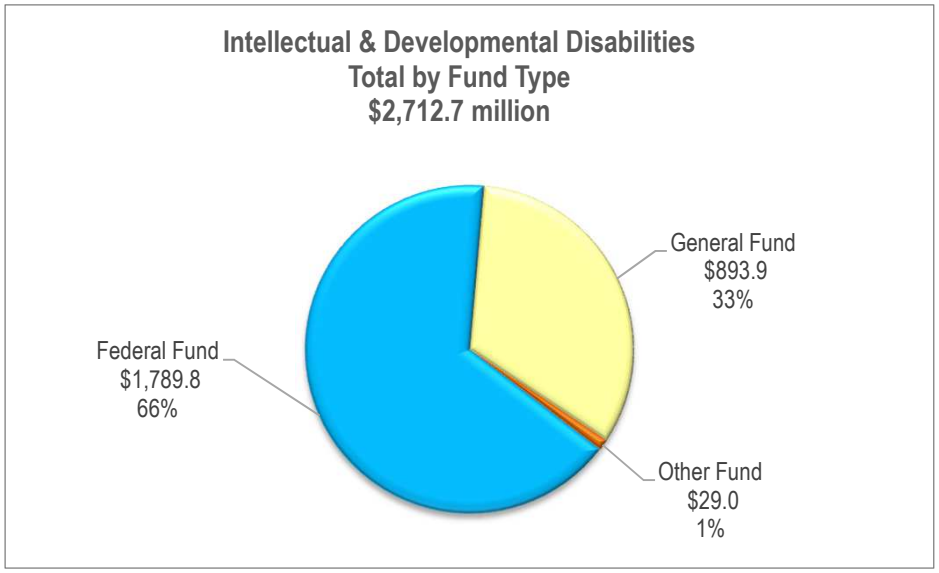
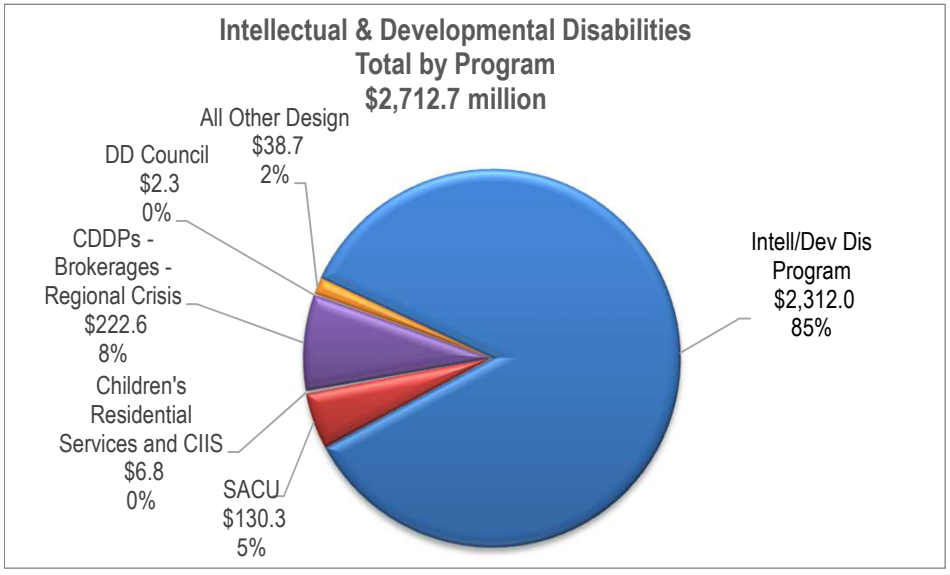

Intellectual & Developmental Disabilities
Total by Fund Type
$2,712.7 million
General Fund
$893.9
33%
Federal Fund
$1,789.8
66%
Other Fund
$29.0
1%


Intellectual & Developmental Disabilities
Total by Program
$2,712.7 million
All Other Design
$38.7
2%
DD Council
$2.3
0%
CDDPs - Brokerages - Regional Crisis
$222.6
8%
Children's Residential Services and CIIS
$6.8
0%
SACU
$130.3
5%
Intell/Dev Dis Program
$2,312.0
85%

FALL 2016 DHS|OHA CASELOAD FORECAST

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

OCTOBER 2016

DHS
Oregon Department of Human Services

Office of Forecasting, Research & Analysis
500 Summer Street N.E.
Salem, Oregon 97301
Voice: 503-947-5185
TTY: 503-945-6214
Fax: 503-378-2897

Oregon Health Authority

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EXECUTIVE SUMMARY

The 2015-17 **Supplemental Nutrition Assistance Program (SNAP)** biennial average forecast is 405,142 households, which is 0.2 percent lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 371,503 households, which is 8.3 percent lower than the 2015-17 forecast average.

The 2015-17 **Temporary Assistance to Needy Families (TANF)** biennial average forecast is 23,299 families, which is 0.9 percent lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 21,241 families, which is 8.8 percent lower than the 2015-17 forecast average.

The 2015-17 **Child Welfare (CW)** biennial average forecast is 21,293 children, which is 0.4 percent higher than the Spring 2016 forecast. The 2017-19 biennial average forecast is 21,584 children, which is 1.4 percent higher than the 2015–17 forecast average.

The 2015-17 **Vocational Rehabilitation (VR)** biennial average forecast is 9,570 clients, which is 2.8 percent higher than the Spring 2016 forecast. The 2017-19 biennial average forecast is 10,275 clients, which is 7.4 percent higher than the 2015-17 forecast average.

The 2015-17 **Aging and People with Disabilities Long–Term Care (LTC)** biennial average forecast is 34,086 clients, which is slightly lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 36,561 clients, which is 7.3 percent higher than the 2015-17 forecast average.

The 2015-17 **Intellectual and Developmental Disabilities Case Management (I/DD)** biennial average forecast is 25,309 clients, which is slightly higher from the Spring 2016 forecast. The 2017-19 biennial average forecast is 28,218 clients, which is 11.5 percent higher than the 2015-17 forecast average.

The 2015-17 **Health Systems Medicaid (HSM)** biennial average forecast is 1,116,810 clients, which is 0.4 percent lower than the Spring 2016 Forecast. The 2017-19 biennial average forecast is 1,057,045 clients, which is 5.4 percent lower than the 2015-17 forecast average.

The 2015-17 **Mental Health (MH)** biennial average forecast is 45,646 adults, which is 0.5 percent higher than the Spring 2016 Forecast. The 2017-19 biennial forecast average is 47,523 adults, which is 4.1 percent higher than the 2015-17 forecast average.

INTRODUCTION

This document summarizes the Fall 2016 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 in the spring and fall each year. DHS caseload forecasts cover the major program areas administered by the department: Self Sufficiency Programs, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Intellectual and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Health Systems: Medicaid and Mental Health. Forecasts are used for budgeting and planning and usually extend through the end of the next biennium. Forecasts are developed using a combination of time-series techniques, input-output deterministic models and expert consensus. Forecast accuracy is tracked via monthly reports that compare actual caseload counts to the forecasted caseload, and through the annual forecast quality report which compares forecast accuracy across programs and over time.[1]

1.For more information, please visit *http://www.oregon.gov/DHS/BUSINESS-SERVICES/OFRA/Pages/About-Us.aspx*

Forecast Environment and Risks

Oregon's economy continues to recover from the 2008-2009 Great Recession. Since the recovery began, Oregon has steadily gained jobs and recently entered "full-throttle growth" mode. In 2015, job growth reached its highest level in 20 years. Oregon job gains are outpacing the average state, and wages are growing in all parts of the state. Participation in the labor force has improved from its recession-era low, but remains below historic averages. Much of this is driven by demographics – baby boomers retiring and voluntarily exiting the workforce and younger adults staying in school longer; however, some is also due to a lack of job opportunities and the business cycle.

According to the U.S. Bureau of Labor Statistics, in 2015, 11.7 percent of potential workers in Oregon said they were unemployed, marginally attached to the workforce, or were working part-time involuntarily (due to economic reasons). That is higher than the national average and affects DHS clients. An examination of employment among adults on SNAP in 2013 and 2014 shows that although almost half of them are employed, 70 percent of those who are employed are working less than full-time (defined as 30 hours per week) and forty percent work less than half-time. The most common employment for SNAP recipients fall into three primary industries – Food Services, Social Assistance, and Retail Trade – that tend to offer few full-time jobs. This helps explain why Oregon's SNAP caseload has remained stubbornly high in spite of overall job gains.

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, whereas economic factors can have a dramatic effect on some caseloads, both during recessions and during recoveries. 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 Office of Economic Analysis (OEA) identifies major risks to Oregon's economy in its quarterly forecasts. Some of the major risks listed in the third quarter 2016 edition are volatility of the U.S. economy in general, the strength of the housing market, the affordability of housing, the drought impacting the western states, and restructuring of federal timber payments. The full OEA economic forecast can be found at *http://www.oregon.gov/DAS/OEA/pages/index.aspx.*

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. In addition, some new policies lack the necessary case history to be used accurately in forecasts. Future policy changes or uncertainty about recent policy changes represent a major risk to the caseload forecasts.

Oregon Miniumm Wage

Enacted in the 2016 legislative session, Senate Bill 1532 establishes a series of increases to the Oregon minimum wage beginning July 2016 and continuing in phases through July 2022. These phased increases are specified at three separate rates for different parts of the state. The Portland Metro area will have a rate higher than the standard, and certain specified “Non-urban” counties will have a rate slightly lower than the standard. More on the rates can be found at the Oregon Bureau of Labor and Industries website: *http://www.oregon.gov/boli/Pages/index.aspx*.

A good deal has been written about the economic effects of an increase in minimum wage. Summarizing the various arguments and evidence is beyond the scope of this document; however, there is no clear consensus on the impact of a minimum wage increase on public assistance caseloads. Given this lack of consensus, the minimum wage increase must be considered a risk to the forecast. The Office of Forecasting Research and Analysis will monitor caseloads and wages paid to those on our caseloads for evidence of a minimum wage effect.

Department of Human Services

Total Department of Human Services Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Self-Sufficiency								
Supplemental Nutrition Assistance Program (Households)	405,818	405,142	-676	-0.2%	405,142	371,503	-33,640	-8.3%
Temporary Assistance for Needy Families - Basic & UN (Families: Cash Assistance)	23,508	23,299	-209	-0.9%	23,299	21,241	-2,057	-8.8%
Child Welfare (children served)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care[1]	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Vocational Rehabilitation	9,310	9,570	260	2.8%	9,570	10,275	705	7.4%
Aging & Physical Disabilities								
Long-Term Care: In Home	18,155	17,959	-196	-1.1%	17,959	19,982	2,023	11.3%
Long-Term Care: Community Based	11,834	11,886	52	0.4%	11,886	12,456	570	4.8%
Long-Term Care: Nursing Facilities	4,184	4,241	57	1.4%	4,241	4,123	-118	-2.8%
Intellectual and Developmental Disabilities								
Total Case Management Enrollment[2]	25,281	25,309	28	0.1%	25,309	28,218	2,909	11.5%
Total I/DD Services	19,141	19,254	113	0.6%	19,254	21,009	1,755	9.1%

1. Includes residential and foster care.

2. Some clients enrolled in Case Management do not receive any additional I/DD services.

Self Sufficiency Programs (SSP)

In July 2016 there were 398,352 households (706,792 persons) receiving SNAP benefits, which constitutes approximately 17.4 percent of all Oregonians. The SSP portion of SNAP (made up mostly of parents and children) rose rapidly in 2009 and continued to grow until leveling off in mid-2012 when it began it decline. The caseload has declined by 67,106 households since June 2012. The smaller APD SNAP caseload (designed for people aged 60 and older) also rose rapidly due to the Great Recession, but now is returning to its traditional, less-steep growth pattern. The combined 2015-17 SNAP biennial average forecast is 405,142 households, which is 0.2 percent lower than the Spring 2016 forecast. The projected biennial average for 2017–19 is 371,503 households, which is 8.3 percent lower than the 2015-17 biennial average forecast.

APD SNAP is in the pilot phase of increasing from 12-month to 24-month redeterminations (the formal scheduled re-evaluation of eligibility). When this policy is implemented statewide it may decrease the "churn" in the APD SNAP caseload. Churn occurs when clients do not complete the redetermination process in a timely manner and temporarily drop off the caseload. All other things being equal, implementation of this change could increase the total caseload, and should be considered a risk.

The federal government reinstated the "Able Bodied Adults without Dependents" or ABAWD rule in January 2016 for Washington and Multnomah Counties. The ABAWD rule is a three-month limit to SNAP benefits that applies to non-disabled adults without dependents age 50 and under. Oregon was granted an exemption from this time limit for all counties during the Great Recession. As a result of the reinstatement of ABAWD in Washington and Multnomah counties, caseloads dropped by between 5 and 6 percent. Despite the fact that these counties are the most populous in the state, the reduction had only a modest effect on the overall statewide caseload. The rule is due to be applied to Clackamas County in the fall of 2016, and may be applied to other counties through the coming years.

Although reintroduction of this rule is likely to have only a minor impact on the caseload, it must be considered a risk to the forecast.

In addition, the SNAP caseload could be affected by the issues stated in the "Forecast Environment and Risks" section, above.

Temporary Assistance for Needy Families (TANF) – In April 2016, there were 23,007 families receiving TANF benefits, representing 63,088 persons. Starting in January 2008, the TANF caseload underwent nearly uninterrupted growth until leveling off in mid-2012. After a seasonal increase in the winter of 2012-2013, the caseload declined rapidly, and is currently 13,604 cases below its February 2013 peak, a drop of approximately 37 percent. The 2015-17 TANF biennial average forecast is 23,299 families, which is 0.9 percent lower than the Spring 2016 forecast. The 2017-19 biennial average is 21,241 families, which is 8.8 percent lower than the biennial average forecast for 2015-17.

TANF Reinvestment and Data Accuracy

The 2015 Legislature passed House Bill 3535 and House Bill 5026. Taken together, these two acts provide the statutory authority and funding to modify TANF in order to provide better opportunities for families to successfully transition out of the program. This set of policy changes are commonly called "TANF Reinvestment." These reforms began in May 2016.

The elements of TANF Reinvestment that were expected to impact caseloads – and have therefore been built into the forecast – included an increase in the income limit for existing TANF households, expanding the definition of a caretaker relative, the elimination of deprivation as an eligibility requirement, and the creation of a post-TANF Employment Payment (TANF-EP) which provides a cash payment for three months to TANF households exiting TANF due to employment.

Additional elements of TANF Reinvestment which are not forecast, but are considered risks included increasing the use of support and stabilization services to prevent families from entering TANF; and increased client engagement.

Implementation of TANF Reinvestment has led to unintended consequences in the area of data accuracy. For caseloads to be accurately forecast, a case must be in one program – and only one program – within a given month. In the early months of TANF Reinvestment (starting in May 2016) it appeared that cases were being counted in both the TANF category as well as the post-TANF Employment Payments category. In order to reconcile this duplicate count, cases that appeared in both categories were counted only in the TANF-EP caseload, and dropped from the active TANF caseload. This reduced the number of TANF cases, putting them more in line with prior forecast assumptions. The Fall 2016 forecast is based on this revised caseload count.

Given that budget and program timing dictated that the forecast be completed before these data accuracy issues could be fully investigated and understood, the Fall 2016 TANF forecast and the caseload actuals it is built upon must be considered subject to revision. This possibility must be considered a risk to the forecast.

In addition to the risks associated with TANF Reinvestment, the caseload could also be affected by the more general demographic and economic issues stated in the "Forecast Environment and Risks" section of this document.

Because of the increases due to TANF reinvestment, the overall caseload is expected to essentially flatten over this biennia and the next, but with small seasonal increases during the winter months and decreases in the summer.

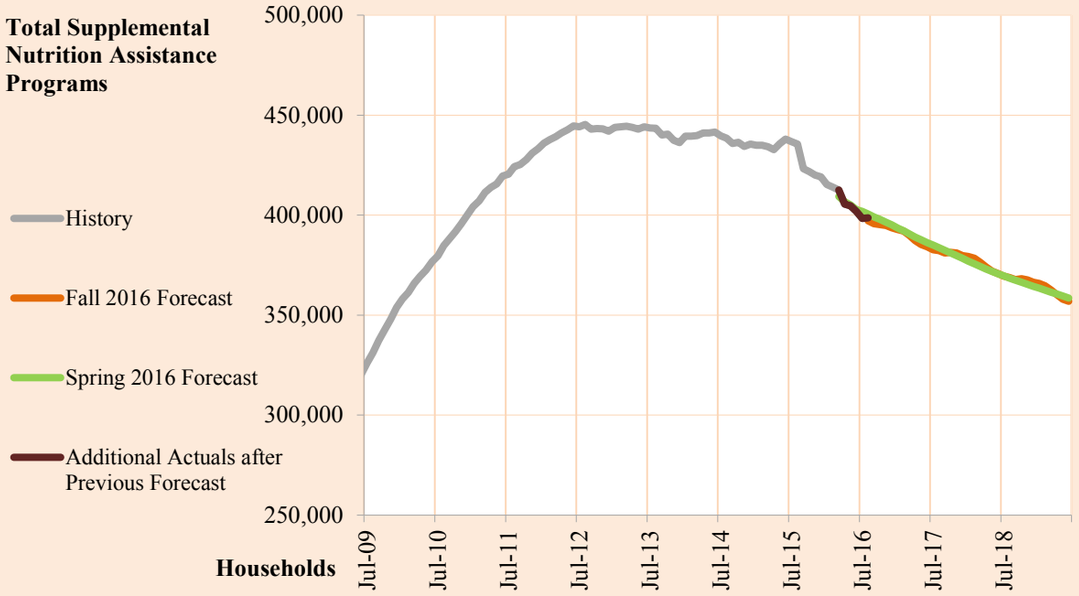
Pre SSI – The 2015–17 biennial average forecast is 517 families, which is 4.2 percent lower than the Spring 2016 forecast. This decrease is due to a reduction in the number of backlogged cases being addressed by staff. With the backlog addressed, the caseload is forecast to return to its recent historical level. The 2017-19 biennial average caseload is expected to be 512 families, which is 0.8 percent lower than the forecast for the current biennium.

Temporary Assistance for Domestic Violence Survivors (TA-DVS) – In the past, the portion of the TA-DVS program that was forecast in this document was limited to those domestic violence survivors who accepted TA-DVS payments (which are used to help defray the costs of housing). Over the course of the past few years, the proportion of TA-DVS clients being seen in DHS field offices but NOT accepting TA-DVS payments has grown. This is likely due to the inadequacy of housing payments at a time of high rents and limited housing availability. This dichotomy has led us to expand the forecast to include both TA-DVS with payments and TA-DVS without payments.

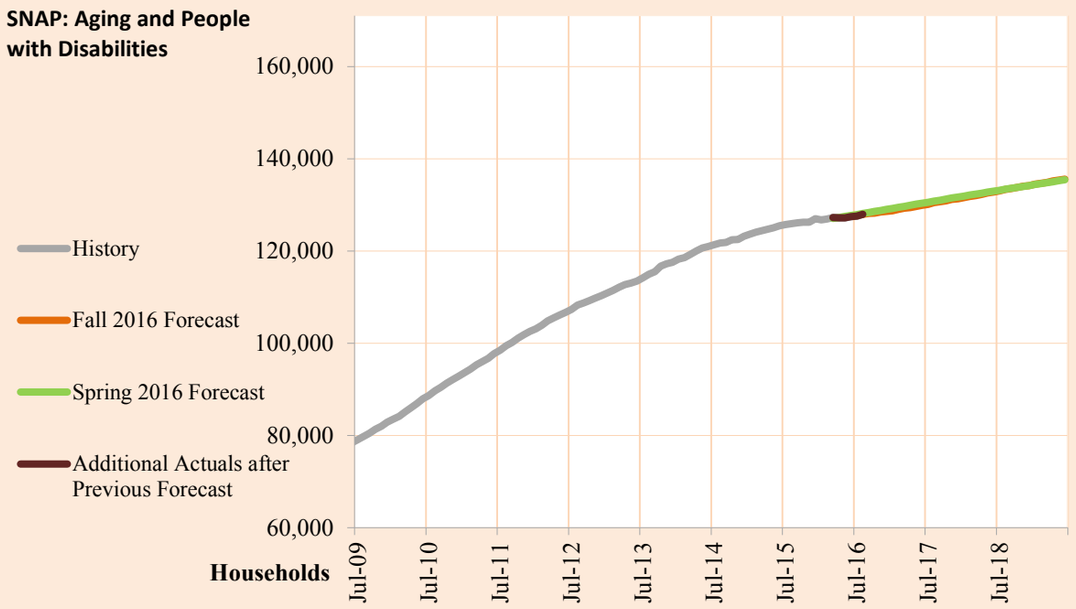
The TA-DVS with-payment caseload is a relatively small caseload that has been falling steadily amid strong seasonal fluctuations. After reaching an historic low in January 2016 of 311 cases, it began its usual seasonal increase before that usual increase also faltered. The TA-DVS with-payment caseload is expected to continue falling, with a 2015–17 biennium average projected at 377 families, which is 6.8 percent lower than the Spring 2016 forecast. The caseload is expected to continue to fall to 282 families per month during the 2017–19 biennium.

The TA-DVS without-payment caseload has been holding relatively steady despite the decreases in the with-payment category. TA-DVS without-payment is expected to average 1,184 cases per-month through the remainder of the 2015-17 biennium, and average 1,188 cases per month in the 2017-19 biennium, a change of only 0.3 percent.

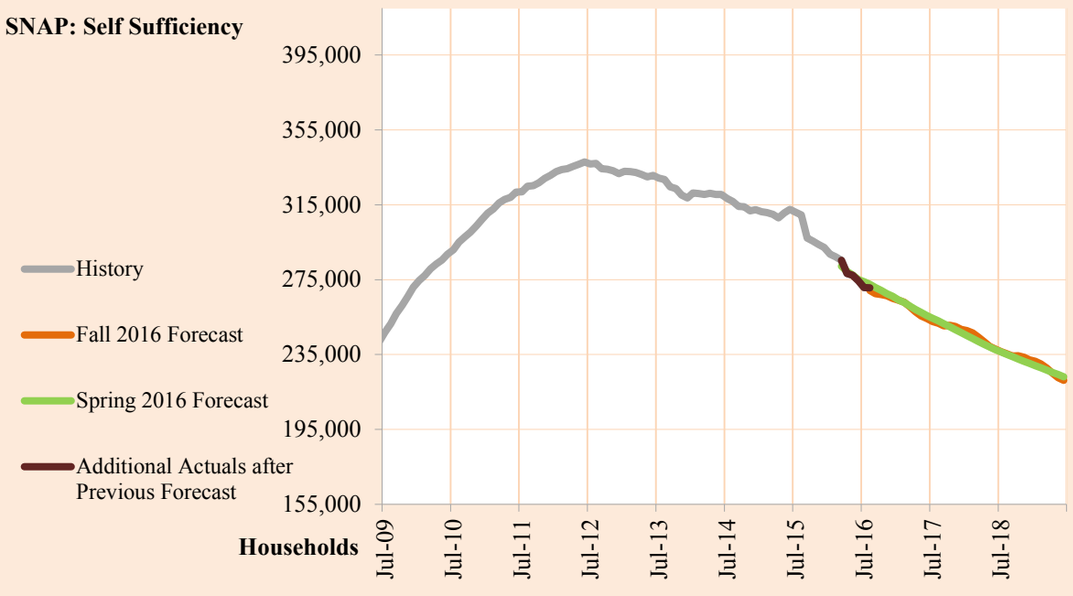
Total Supplemental Nutrition Assistance Programs



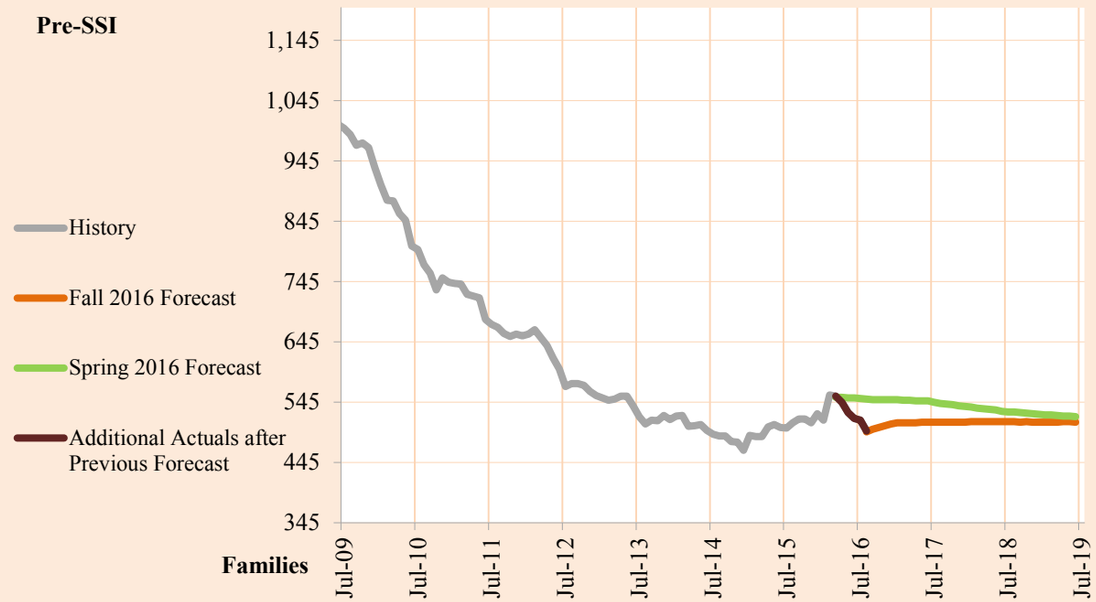
SNAP: Aging and People with Disabilities



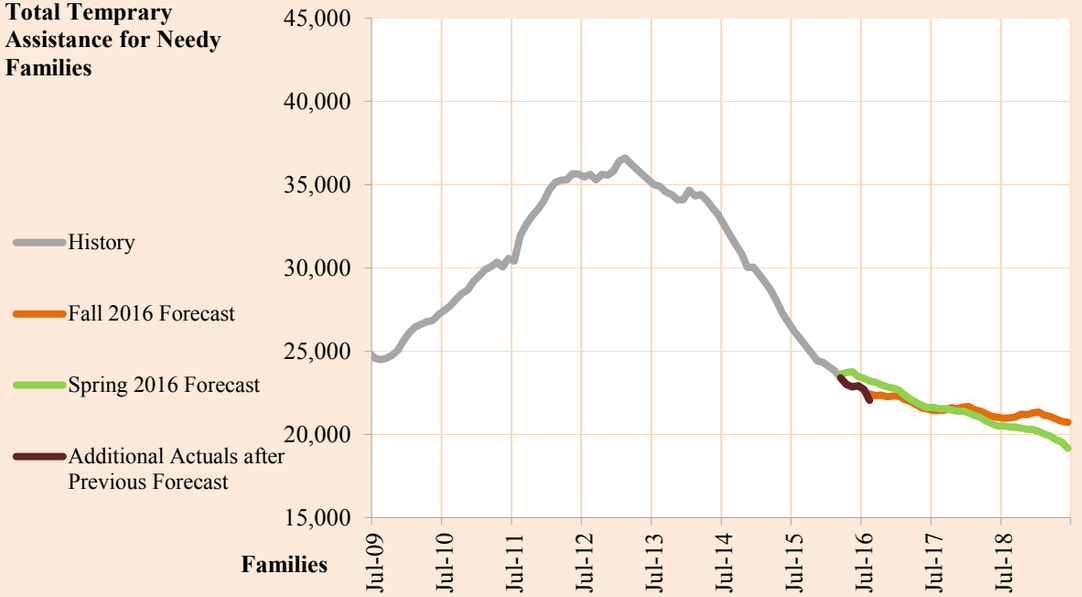
SNAP: Self Sufficiency



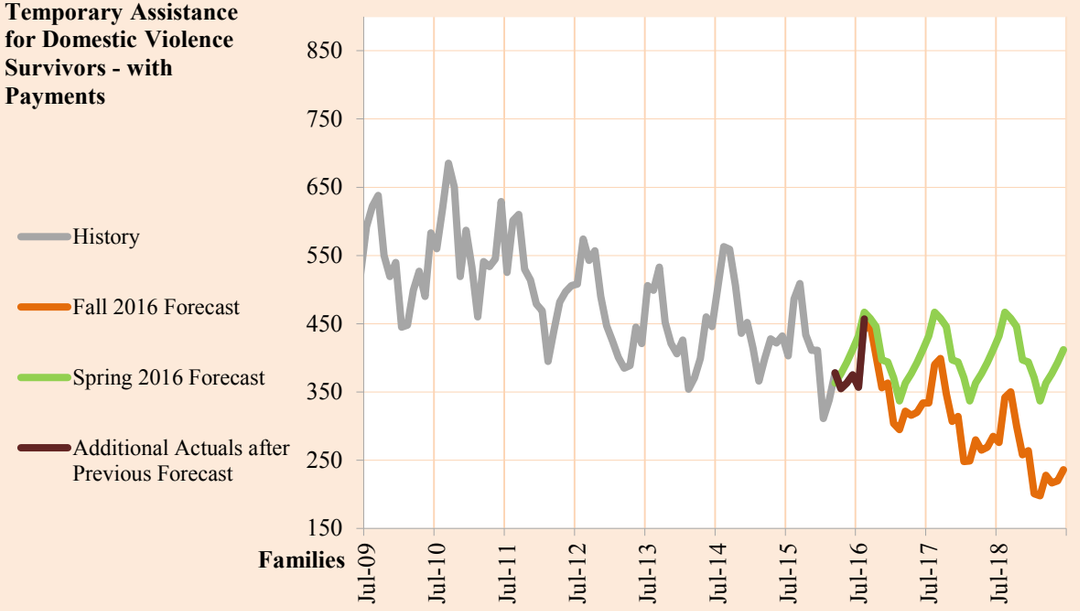
Pre-SSI



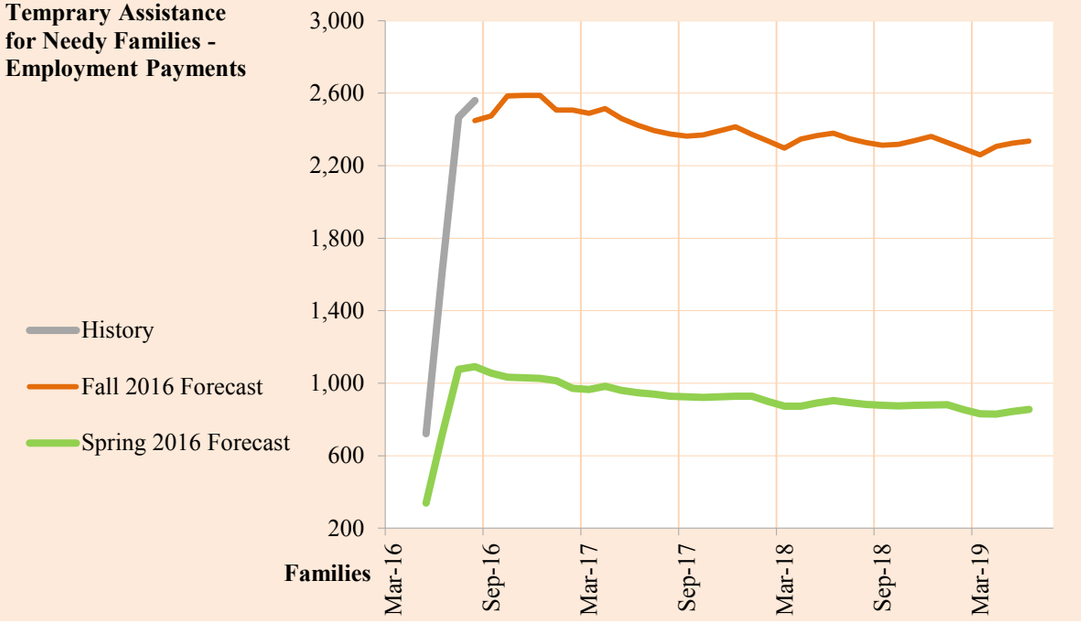
Total Temprary Assistance for Needy Families



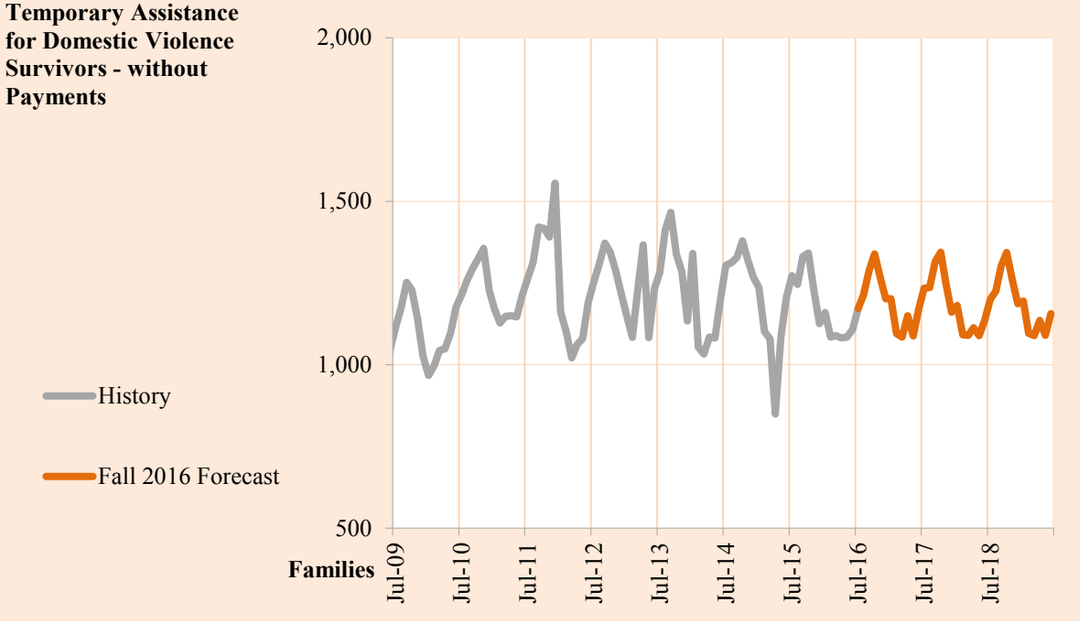
Temporary Assistance for Domestic Violence Survivors - with Payments



Temprary Assistance for Needy Families - Employment Payments



Temporary Assistance for Domestic Violence Survivors - without Payments



Self Sufficiency Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
SELF SUFFICIENCY PROGRAMS								
Supplemental Nutrition Assistance Program (Households)								
Children, Adults and Families	277,902	277,427	-475	-0.2%	277,427	238,594	-38,832	-14.0%
Aging and People with Disabilities	127,916	127,716	-200	-0.2%	127,716	132,908	5,193	4.1%
Total SNAP	**405,818**	**405,142**	-676	-0.2%	**405,142**	**371,503**	-33,640	-8.3%
Temporary Assistance for Needy Families (Families: Cash/Grants)								
Basic	20,303	20,113	-190	-0.9%	20,113	19,046	-1,067	-5.3%
UN	3,205	3,186	-19	-0.6%	3,186	2,195	-991	-31.1%
Total TANF	**23,508**	**23,299**	**-209**	**-0.9%**	**23,299**	**21,241**	**-2,057**	**-8.8%**
TANF Employment Payments	1,165	2,269	1,104	94.8%	2,269	2,348	79	3.5%
Pre-SSI	540	517	-23	-4.3%	517	512	-4	-0.8%
Temp. Assist. For Dom. Violence Survivors (Families)								
TADVS: With Payment	404	377	-28	-6.8%	377	282	-94	-25.0%
TADVS: Without Payment*	-	1,184	-	-	1,184	1,188	4	0.3%
Total TADVS	**-**	**1,561**	**-**	**-**	**1,561**	**1,471**	**-90**	**-5.8%**

*TADVS: Without Payment is a new forecast category.

Child Welfare (CW)

Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups, and typically enter the Child Welfare system via an Assessment. The number of children on open assessments has climbed over the past several years, however a plateau is expected, as there is an executive directive for branches to complete assessments in less than sixty days.

Adoption Assistance – This caseload exhibited moderate growth beginning in early 2012, but during the second half of 2015 the caseload leveled off. Since January 2016, there has been a slow decline to the caseload due to an increase in children aging out. Almost all new clients are from paid foster care so changes to the foster care caseload can directly increase or decrease the adoption assistance caseload. The caseload is expected to average 11,141 for the 2015-17 biennium, which is 0.9 percent lower than the Spring 2016 forecast. The caseload is expected to average 11,135 over the 2017-19 biennium, which is 0.1 percent lower than the 2015-17 biennial average forecast.

Guardianship Assistance – This caseload has exhibited steady growth for its entire history. The caseload grew 5 percent from March 2015 to March 2016. Policies are in place to shorten the length of time to permanent placement, so this caseload will continue to increase as children move out of foster care. In recent months, however, workers have been re-prioritizing work around safety issues and this may be affecting caseload numbers. Recent caseload numbers following the Spring 2016 forecast were about 1.5 percent lower than forecasted. The new forecast for 2015-17 caseload is expected to average 1,555 for the 2015-17 biennium, which is 1.9 percent lower than the Spring 2016 forecast. The caseload is expected to average 1,690 over the 2017-19 biennium, which is 8.7 percent higher than the 2015-17 biennial average forecast.

Out of Home Care – This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and residential care. Paid foster care is the largest portion of the group. The total foster care caseload experienced a 16.5 percent drop between 2010 and 2015, declining from 8,408 children in December 2010 to 7,024 children in December 2015. During this period, the number of children supervised in-home also declined overall, as well as the percentage of in-home children who transferred into foster care. Many initiatives now in place are designed to decrease the foster care caseload even though the child population in Oregon continues to grow. However, in recent months the caseload has leveled off and exhibited some growth. Between November 2015 and March 2016 the caseload grew 1.3 percent. The caseload is expected to average 7,092 for the 2015-17 biennium, which is 1.3 percent higher than the Spring 2016 forecast. The caseload is expected to average 7,173 over the 2017-19 biennium, which is 1.1 percent higher than the 2015-17 biennial average forecast.

Child In-Home – Following implementation of the OR-KIDS data system in 2011, this caseload exhibited an almost continuous decline until 2015. Since January 2015 the caseload has been climbing. In March 2016 the caseload rose to 1,572, and between April 2015 and March 2016 the caseload increased 22 percent. Recent increases are likely due to a change in reporting. There has been an increase in data entry, which may reflect a more accurate number of children served in-home. The caseload is expected to average 1,505 for the 2015-17 biennium, which is 9.5 percent higher than the Spring 2016 forecast. The caseload is expected to average 1,586 over the 2017-19 biennium, which is 5.4 percent higher than the 2015-17 biennial average forecast.

Risks and Assumptions

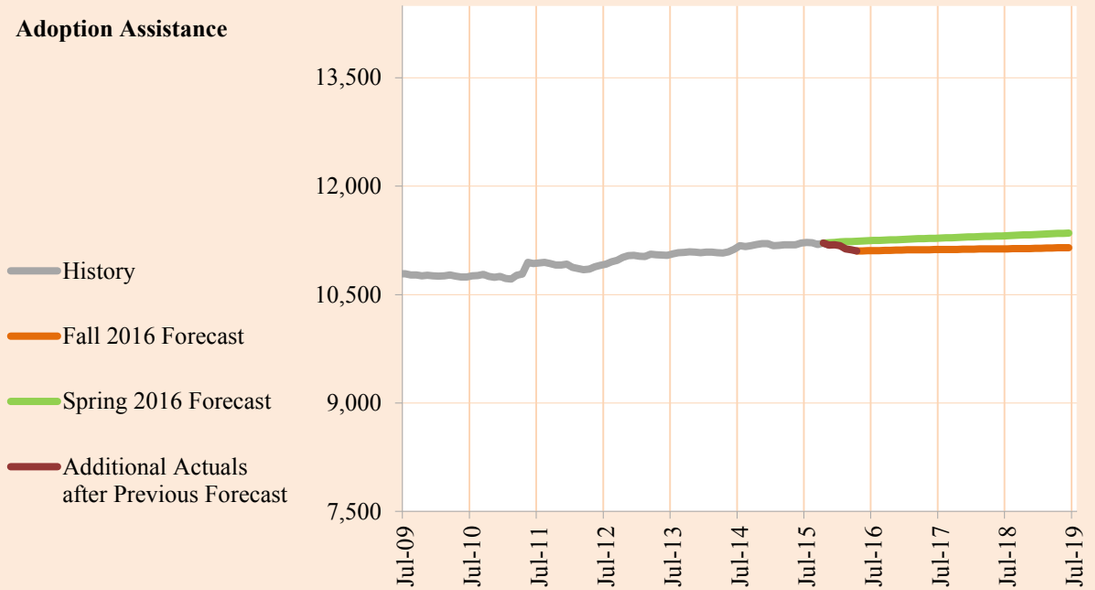
In the past year the Child Welfare Program has experienced changes in leadership, and there is a new review process for licensed residential facilities. Since January 2016, there has been a shift in prioritization to child protective services work, and this may affect Adoption Assistance and Guardianship Assistance caseloads.

Risks to the Out of Home Care caseload mainly involve the treatment foster care program. Providers may close suddenly or not accept referrals. They also

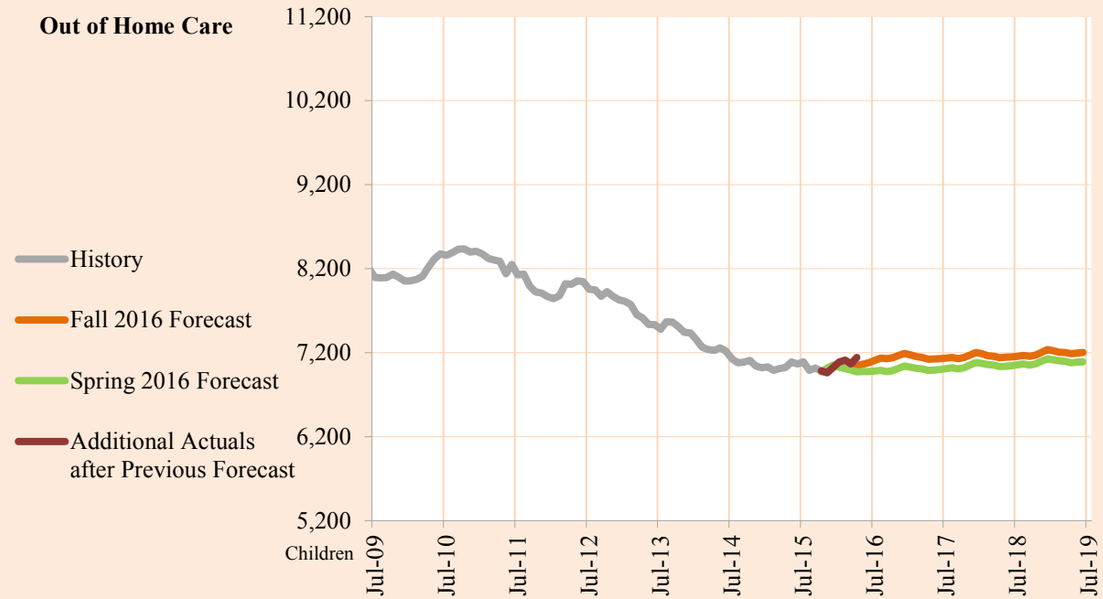
face challenges recruiting foster parents. There may be a need for services but a lack of people to provide those services. As new programs start, it is unknown how quickly the beds will fill.

The Child In-Home data are still being worked on and checked. The percentage of case plans entered into the system increased for the first half of 2016. This led to more children being counted in the Child In-Home caseload. Another risk to the forecast of the Child In-Home caseload is the number of overdue or unclosed assessments that have not been entered into the data system. In May 2016 a clean-up effort around overdue assessments began, and overdue assessments have started to decline. The Child In-Home caseload may increase as a result.

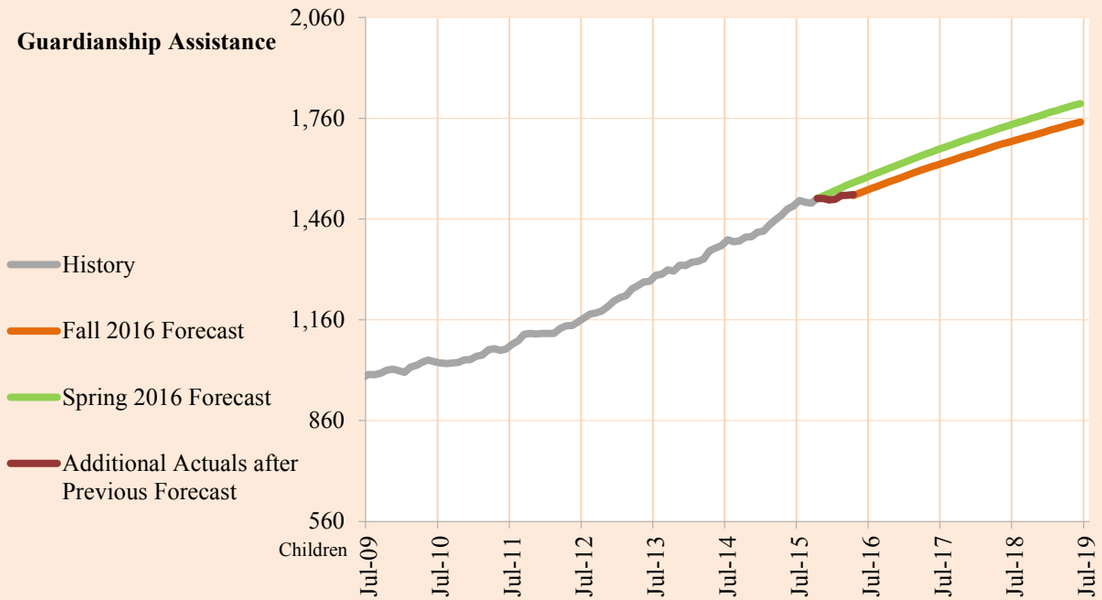
Adoption Assistance



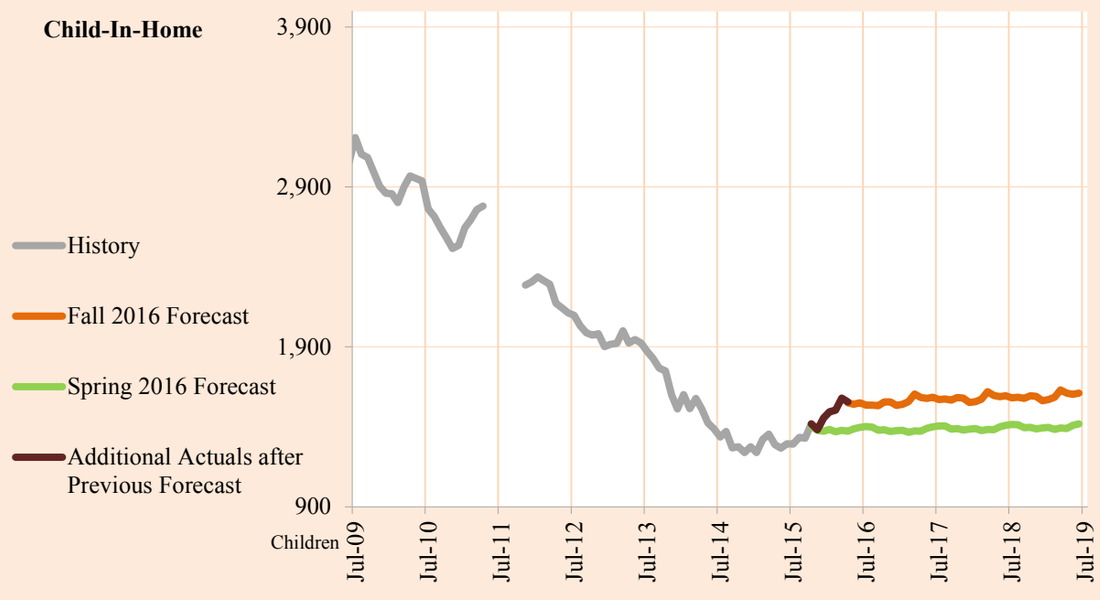
Out of Home Care

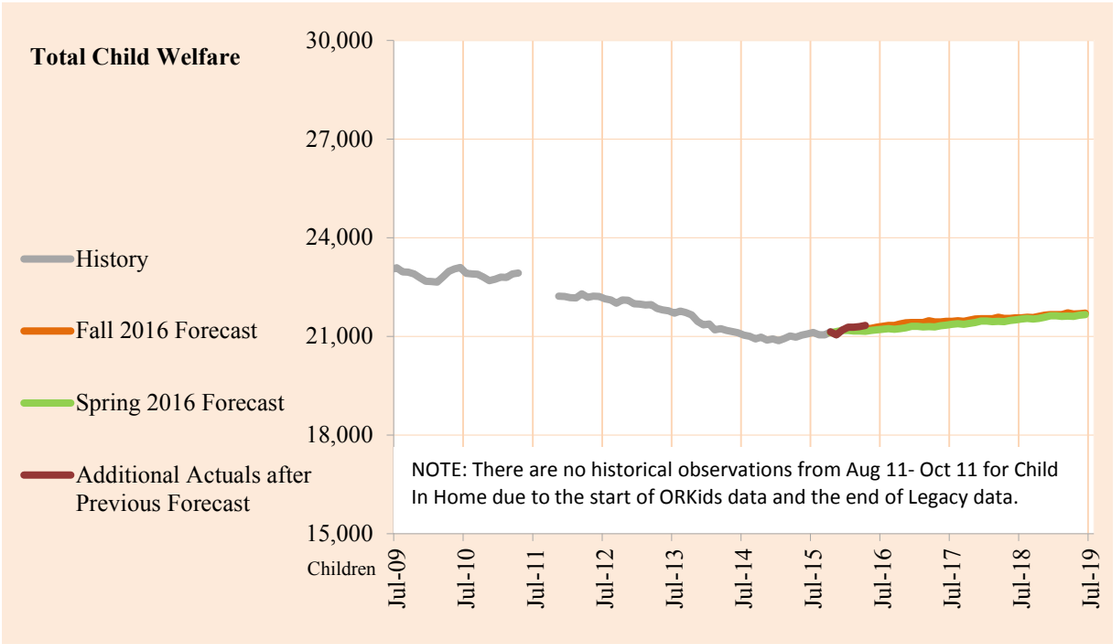


Guardianship Assistance



Child-In-Home




Total Child Welfare
30,000
27,000
24,000
21,000
18,000
15,000
Children
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
NOTE: There are no historical observations from Aug 11- Oct 11 for Child In Home due to the start of ORKids data and the end of Legacy data.
Jul-09
Jul-10
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

Child Welfare Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
CHILD WELFARE (Children)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care[1]	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Total Child Welfare	**21,209**	**21,293**	**84**	**0.4%**	**21,293**	**21,584**	**291**	**1.4%**

1. Includes residential and foster care.

Vocational Rehabilitation (VR)

Vocational Rehabilitation (VR) assists individuals with disabilities to get and keep a job that matches their skills, interests and abilities. VR staff work in partnership with the community and businesses to develop employment opportunities for people with disabilities. VR services are individualized to help each eligible person to receive services that are essential to their employment success.

In the last few years, there have been several important program changes. The Workforce Innovation and Opportunity Act (WIOA) was passed by Congress in 2014 and regulations were completed July 2016. Among other things, it mandates provision of services to school-age youth, with joint responsibility between Local Education Agencies and VR. State Executive Order 15-01 instituted an Employment First policy to increase competitive integrated employment of people living with Intellectual and Developmental Disabilities (I/DD). The Lane v. Brown settlement set specific numeric targets for moving clients out of sheltered workshops and into competitive integrated employment, and also for providing services to transition age clients.

These changes are all fairly complex and interwoven, and have combined to have substantial impacts on the VR caseload. This recent period of rapid change started approximately in January of 2015 and changes are expected to continue through at least the next biennium.

Prior to the Spring 2016 forecast, only the total program caseload was officially forecast. Although counts for the Application, Eligibility, In Plan and Post Employment Services stages of VR were forecasted and shared internally, they were not published in the official forecast. Due to changes in the last year that have impacted how clients move through the program stages, the official forecast now includes the caseload for each stage of VR rather than just the total.

The most significant ongoing change is a large increase in the number of clients who are currently In Plan, receiving services. Policy and process changes have also resulted in larger numbers of clients applying for service each month, particularly from individuals with I/DD.

Since individuals with I/DD typically have more completed paperwork when they apply, they move through the Application and Eligibility stages faster. This has resulted in a substantial decrease in the average number of clients who have been determined eligible, but who are not yet In Plan each month. So while the number of clients In Plan has increased substantially, there are also fewer clients waiting at the Eligibility stage. Consequently, the total number of clients in VR has risen only modestly. This is a significant increase in clients receiving services that would be largely invisible to anyone looking only at the total number of people served by the VR program.

Risks and Assumptions

There is a risk that the program may have to enter order of selection in the 2017-19 beinnium. This could happen if the program has insufficient funds to provide services to all eligible clients. The program did receive some federal re-allotment dollars recently, but insufficient state funds in the 2017-19 budget could also trigger order of selection, changing caseloads dramatically.

There is also a risk that additional clients from the ‘woodwork effect’ of the settlement may drive application numbers above those forecast.

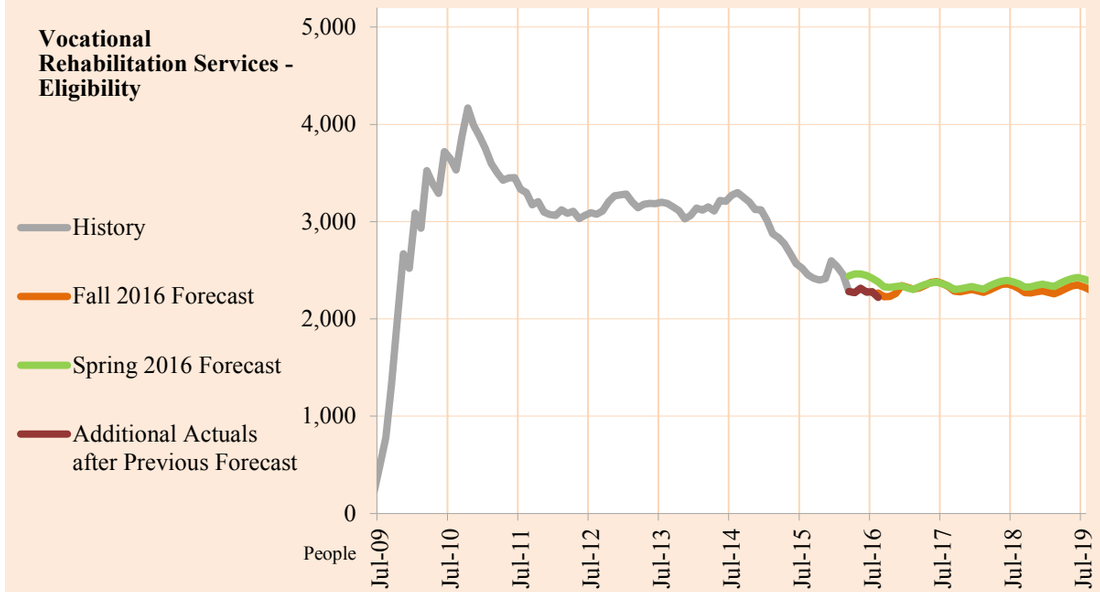
Pre-employment Transition Services started in October 2014. This is a new mandate of the Workforce Investment and Opportunity Act (W.I.O.A.) designed to help high school students with disabilities make the transition to employment or higher education. This mandate includes a 15 percent set aside of the Federal dollars each year, to be spent on specific core services. The five core services being;

- Job exploration counseling
- Work-based learning experiences
- Counseling on opportunities for enrollment in comprehensive transition or postsecondary educational programs at institutions of higher education
- Workplace readiness training to develop social skills and independent living
- Instruction in self-advocacy

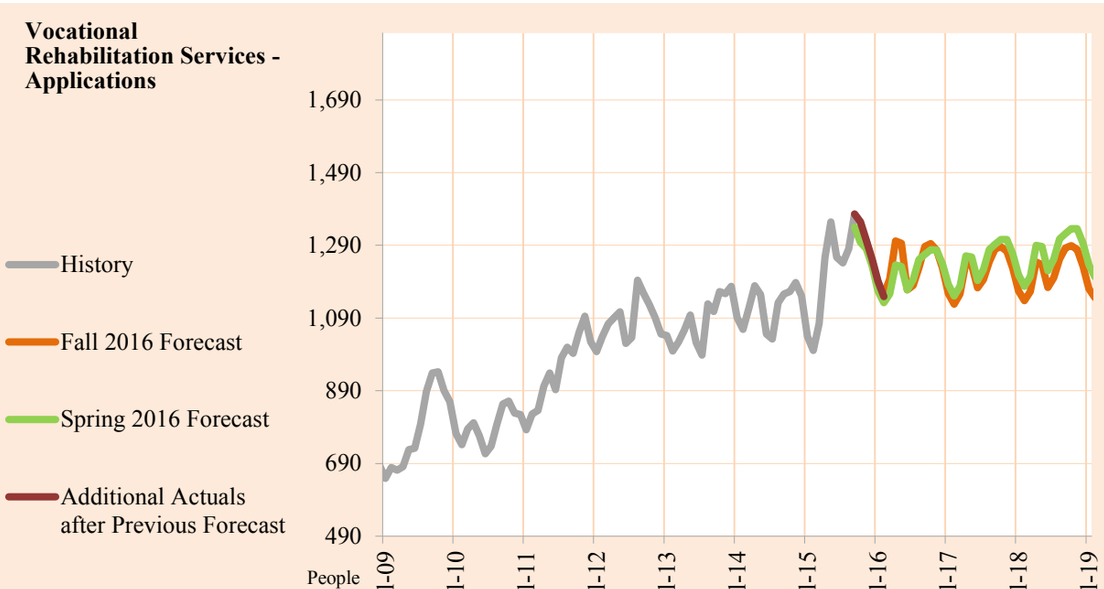
It is expected to have an impact on VR caseload, but as a new mandate, its full impacts are not yet known.

Vocational Rehabilitation Services

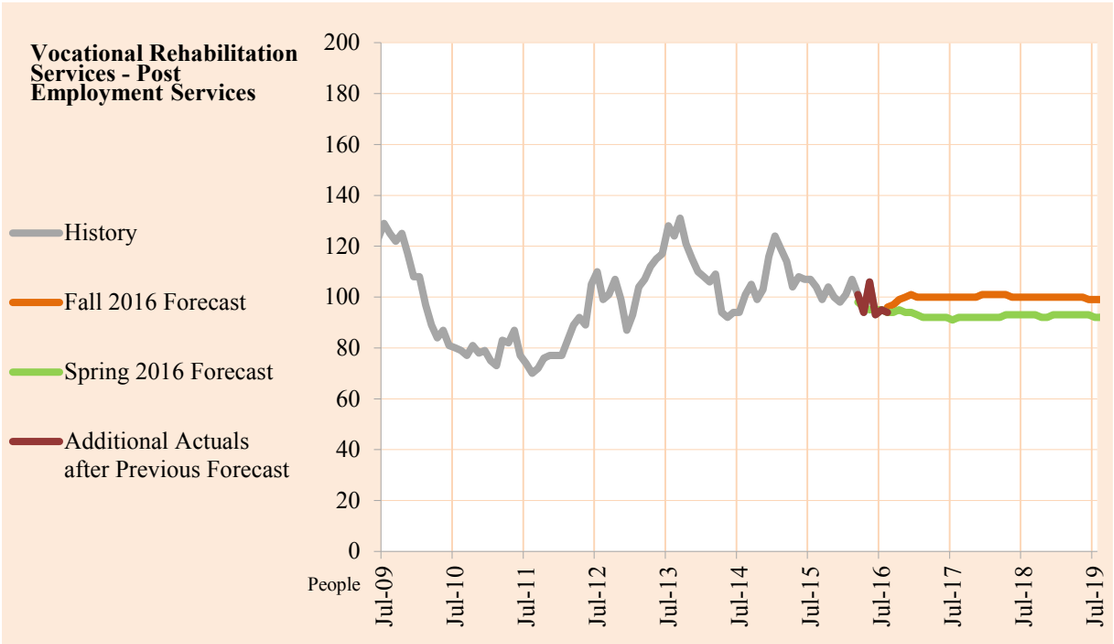
Vocational Rehabilitation Services - Eligibility



Vocational Rehabilitation Services - Applications



Vocational Rehabilitation Services - In Plan


Vocational Rehabilitation Services - Post Employment Services
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
People
200
180
160
140
120
100
80
60
40
20
0
Jul-09
Jul-10
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

Vocational Rehabilitation Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
VOCATIONAL REHABILITATION								
Application	1,224	1,238	14	1.1%	1,238	1,219	-19	-1.5%
Eligibility	2,407	2,359	-48	-2.0%	2,359	2,305	-54	-2.3%
In Plan	5,582	5,872	290	5.2%	5,872	6,650	778	13.2%
Post Employment Services	97	100	3	3.1%	100	100	0	0.0%
Total Vocational Rehabilitiation	**9,310**	**9,570**	**260**	**2.8%**	**9,570**	**10,275**	**705**	**7.4%**

Aging and People with Disabilities (APD)

Historically, Oregon's Long Term Care (LTC) services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as "K Plan"); and now most services are provided through the K Plan rather than the HCBS Waiver.

During the last 13 years, the total Long-Term Care (LTC) caseload has varied from a high of 31,500 clients in November 2002 to a low of 25,900 clients in May 2008; with slightly more than half of that decline occurring between November 2002 and June 2003 when the LTC eligibility rules were modified to cover only clients in Service Priority Levels 1 to 13. From 2008 to 2013 the caseload grew by an average of 2.5 percent a year, despite a serious recession, driven in part by a significant growth in the number of Oregon seniors. Between 2014 and 2015 the average annual caseload grew by 6.7 percent due to factors such as implementation of the K Plan, expansion of Medicaid, and policy changes to make in-home care more attractive. We will not know for some time how long this new trend will continue.

Total Long-Term Care (LTC) – A total of 33,815 clients received long-term care services in April 2016. The 2015-17 biennial average is projected to be 34,086 clients, which is slightly lower than the Spring 2016 Forecast. The 2017-19 forecast is 7.3 percent higher than the forecast for 2015-17.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. Most of the projected increase from 2015-17 to 2017-19 is in In-Home Care. In-Home Care continues to be a popular placement choice, particularly since 2013 when APD implemented several changes designed to make In-Home services comparatively more attractive to clients. CBC is still forecasted to grow, although at a reduced rate to reflect the anticipated shift toward In-Home Care. Community-Based Care will continue to be a stable placement choice for many LTC clients because this type of care is easier to set up and coordinate than In-Home Care and because hospitals prefer discharging patients to higher service settings in order to reduce the risk of repeat emergency visits or readmission. On the other hand, Medicaid reimbursement rates continue to lag behind private market rates, thus making Medicaid clients relatively less attractive to CBC providers.

In-Home Care – In April 2016, 17,779 clients received In-Home Care, which accounted for 52.6 percent of total LTC services. The 2015-17 biennial average forecast of 17,656 clients is slightly lower than the Spring 2016 forecast. The 2017-19 forecast is expected to be 11.3 percent higher than 2015-17, and by June 2019 In-Home Care is projected to be 55.4 percent of total LTC services.

Recent growth in the In-Home Care caseload is due to several factors including implementation of the K Plan, expansion of Medicaid, and implementation of policy and program changes intended to promote the use of In-Home Care rather than more expensive forms of service. For example, under the new rules, clients who want long-term care services are required to contribute to their own support by relinquishing to the State all income over $1,210 per month. Previously, the limit for how much a client could keep was $710 per month – an amount that was difficult to live on. Clients who may have been reluctant to relinquish some of their limited income, even in exchange for needed supports, might now find the program more attractive. In addition, the fact that options exist which allow family members, friends, or neighbors (natural supports) to be paid (under certain circumstances) for providing services may lead more individuals to request In-Home Care.

Community-Based Care (CBC) – In April 2016, 11,815 clients received Community-Based Care, which accounted for 34.9 percent of total LTC. The 2015-17 projected biennial average is 11,886 clients, which is slightly higher than the Spring 2016 forecast. The 2017-19 projection is 4.8 percent higher than 2015-17, and by June 2019 Community-Based Care is forecasted to be 33.7 percent of total LTC.

Community-Based Care includes several different types of services. Each caseload type is revised to more accurately reflect clients' recent, actual utilization of services. Consequently, Assisted Living and Residential Care have become a larger portion of the forecast, while Adult Foster Care (AFC) became smaller.

Several factors are contributing to the recent decline in AFC caseload: policy changes that make In-Home Care more attractive; providers' perception of inadequate reimbursement rates; increasing adversarial relationship between workers and providers; and declining capacity as individual providers retire.

Nursing Facility Care – In April 2016, 4,221 clients received Nursing Facility Care, which accounted for 12.5 percent of total LTC. The 2015-17 biennial average forecast is 4,241 clients, slightly higher than the Spring 2016 forecast. The 2017-19 projection is 2.8 percent lower than 2015-17, and by June 2019 Nursing Facility Care is forecasted to be 10.9 percent of Total LTC.

Affordable Care Act (ACA) Long-Term Care

Starting in January 2014, a new population of individuals became eligible for medical and long-term care services under the Affordable Care Act of 2010 (ACA). When discussed in the forecast, these clients will be referred to as "ACA LTC" clients. ACA LTC clients are, by definition, citizens aged 18-64 with income under 138 percent of FPL and who require the institutional Level of Care (LOC) of a hospital or skilled nursing facility. Under Oregon's CMS waiver, these clients may be served through any of the approved long-term care channels – nursing facilities, community-based care, or in-home.

These clients constitute a small sub set of the total LTC population, but their funding sources are significantly different. Consequently, OFRA is beginning to track these clients separately within the LTC population. Data allowing OFRA to know which individuals are ACA LTC has only recently become available. OFRA anticipates that when sufficient data is available, these clients will be forecast separately within the LTC caseload.

Risks and Assumptions

Patient Protection and Affordable Care Act of 2010 – Implementation of ACA changed the playing field for long-term care in Oregon and introduced significant new risks to the forecast. By shifting from operating under the HCBS Waiver to the K Plan in late 2013, the eligibility rules for long-term care were changed.

At roughly the same time, Oregon chose to extend Medicaid coverage (including long-term care) to a significantly larger pool of low income adults. To qualify for LTC under the prior HCBS Waiver, clients had to meet four separate criteria: 1) be assessed as needing the requisite Level of Care; 2) be over 65 years old or have an official determination of disability; 3) have income below 300 percent of SSI (roughly 225 percent of FPL); and 4) have very limited assets. However, under the ACA's K Plan option, clients only need to meet two criteria: 1) be assessed as needing requisite Level of Care, and 2) have income below 138 percent of FPL. Note that the HCBS Waiver allows clients with higher incomes than the K Plan; but the K Plan has no asset limits and no requirement that clients to be over 65 or officially determined disabled. Recent changes in the pattern of new clients entering long-term care indicates that the ACA (the combined effects of the K Plan and Medicaid expansion) is contributing to long-term care caseload growth. However, the new service use patterns have not yet emerged and normalized.

Policy and Program Changes – Another significant risk was created by policy and program changes implemented in 2013 which were designed to increase the attractiveness of In-Home Care relative to more expensive forms of care, and to delay or prevent individuals from even needing LTC assistance. While successful prevention measures should save money in the future, changes that make In-Home Care more attractive now could either reduce costs by leading clients to choose lower cost services, or increase costs by making accepting assistance more attractive.

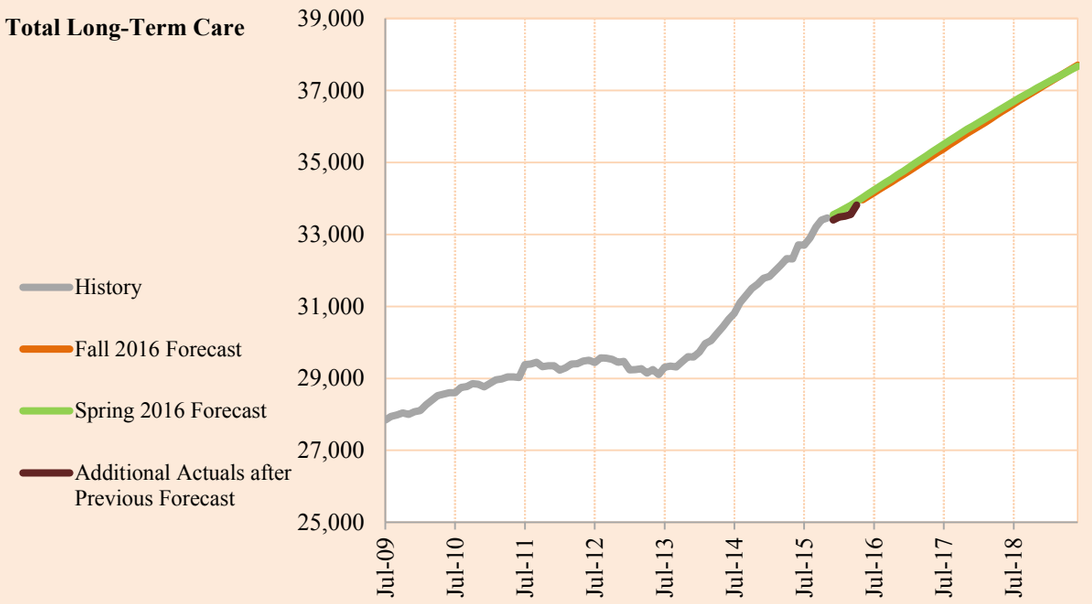
Oregon Demographic Shift – In addition to internal policy and program related changes, external changes such as demographic shifts in Oregon's population also

pose a risk to the forecast's accuracy over the longer term (for example, more seniors living longer, or the financial or physical health of those seniors). Oregon's population is aging, and elderly Oregonians are among the fastest growing segments of the state population. Oregonians with multiple chronic conditions in the 85 and older age group also risk depleting their resources, which will increase the likelihood they will become eligible for Long-Term Care programs.

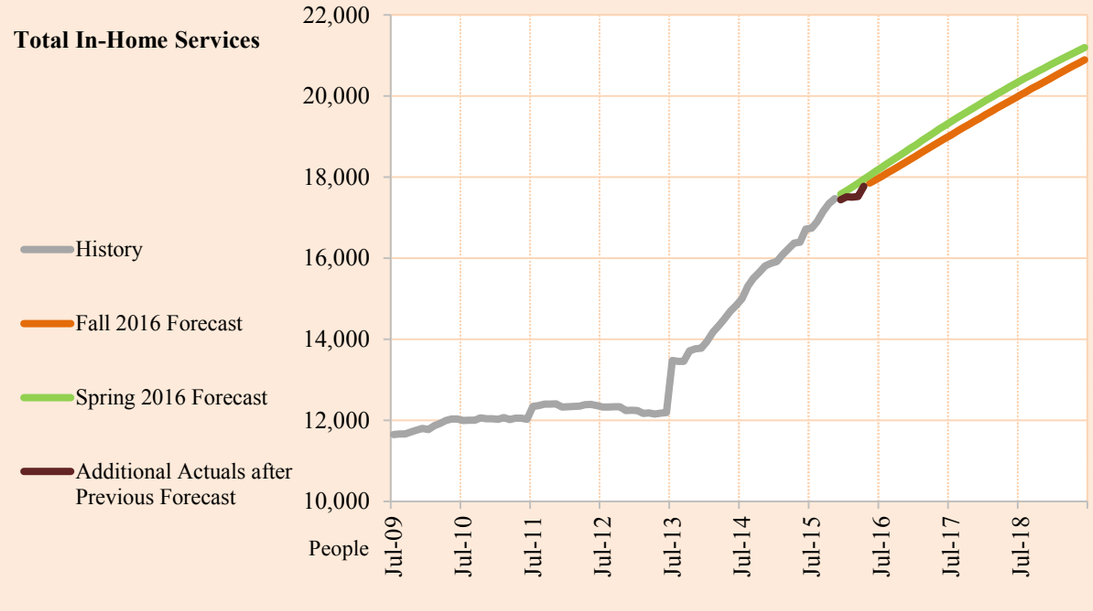
The long-term care caseload forecast has a shorter time horizon of two to three years, while the Demographic forecast has a longer time horizon of five to ten years. This presents a challenge to properly account for the impact of demographic shifts on the long-term care caseload. The OFRA (caseload forecast) is much more responsive to internal policy and program changes than the indirect and external effect of demographic shifts in a shorter time horizon. OFRA recognizes, however, the importance of indirect impacts of Oregon demographic changes, especially in elderly population, and regularly monitors it.

Oregon House Bill 2216 - Another factor that may impact LTC caseloads is Oregon HB 2216, passed in 2013, which calls for a statewide reduction in the Long-Term Care Nursing Facilities bed capacity.

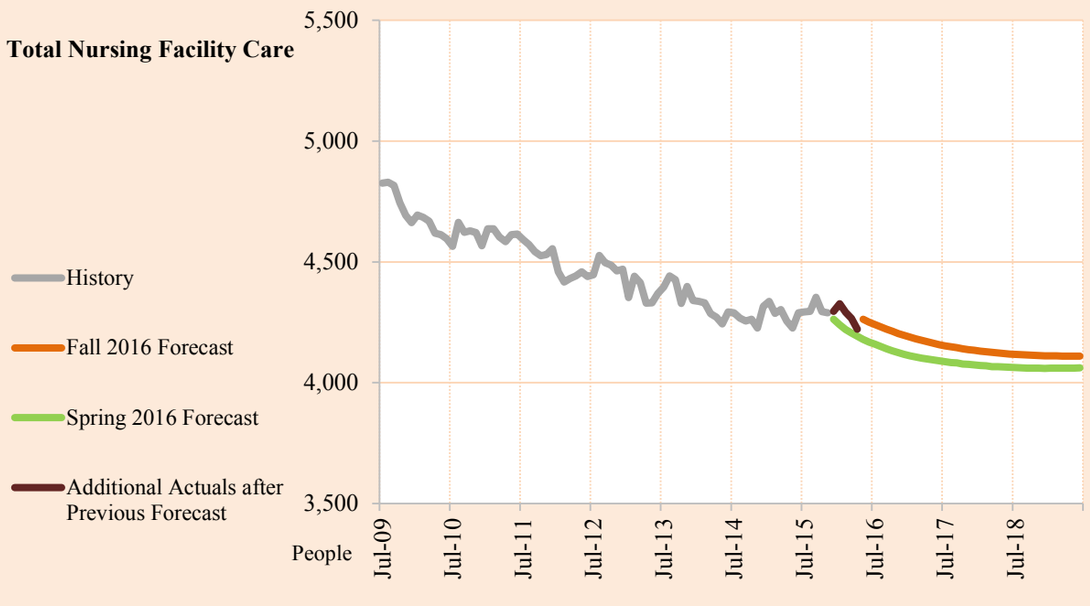
Total Long-Term Care



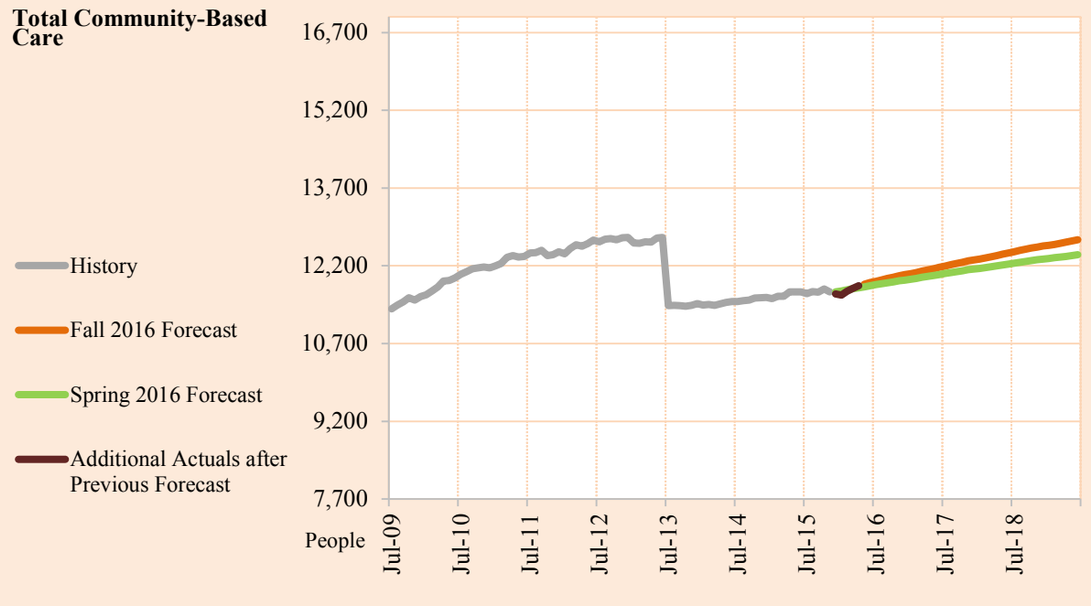
Total In-Home Services



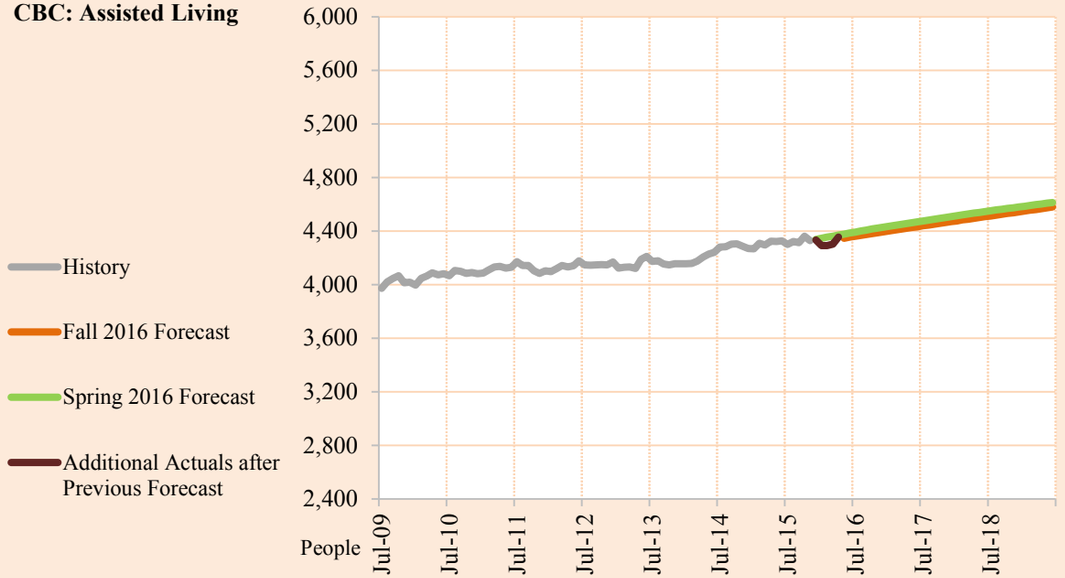
Total Nursing Facility Care



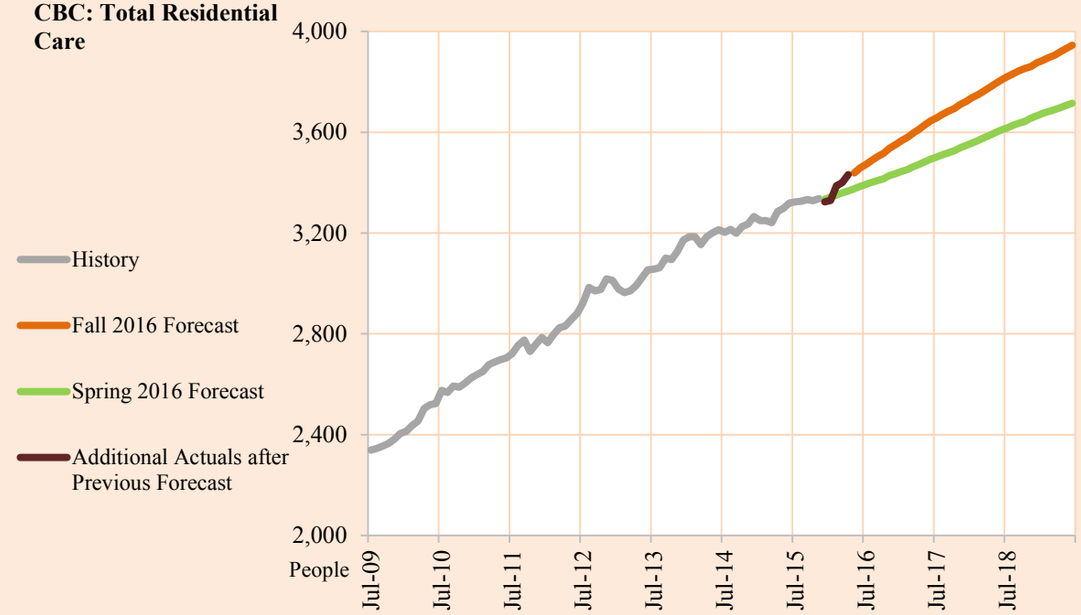
Total Community-Based Care



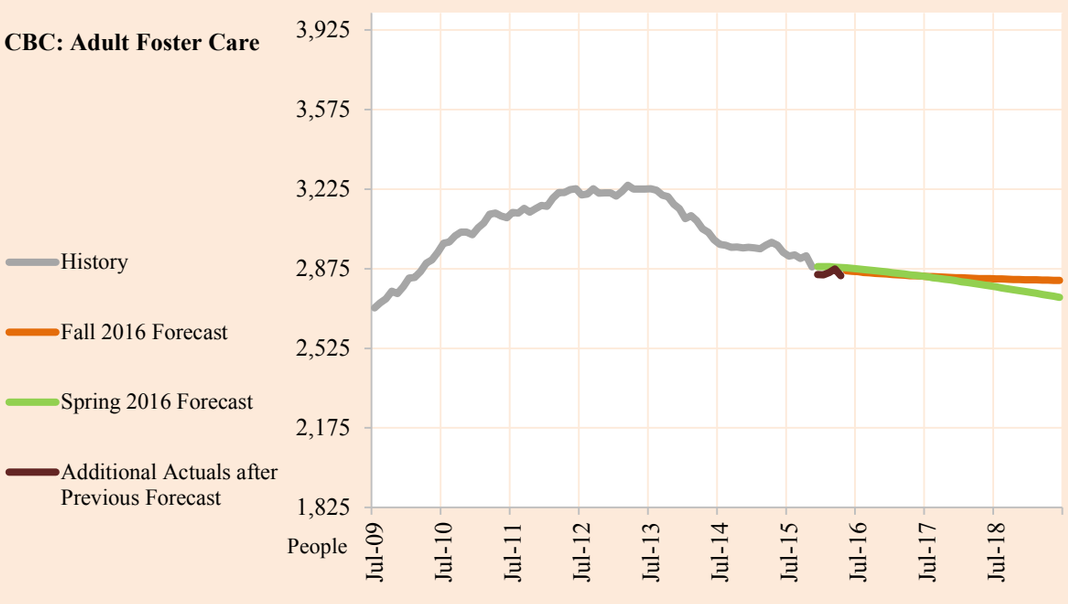
CBC: Assisted Living



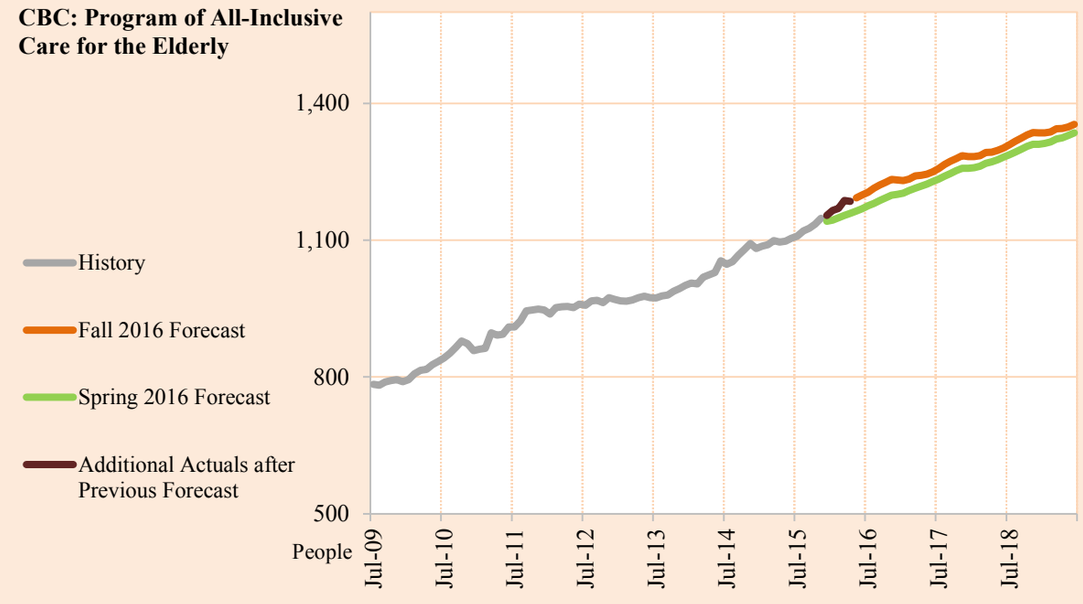
CBC: Total Residential Care



CBC: Adult Foster Care



CBC: Program of All-Inclusive Care for the Elderly



Aging and People with Disabilities Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
AGING AND PEOPLE WITH DISABILITIES								
In-Home Hourly without SPPC	12,360	12,775	415	3.4%	12,775	14,672	1,897	14.8%
In-Home Agency without SPPC	1,826	1,879	53	2.9%	1,879	2,131	252	13.4%
In-Home Live-In	1,474	922	-552	-37.4%	922	500	-422	-45.8%
In-Home Spousal Pay	103	67	-36	-35.0%	67	66	-1	-1.5%
Independent Choices	459	458	-1	-0.2%	458	587	129	28.2%
Specialized Living	199	198	-1	-0.5%	198	200	2	1.0%
In-Home K Plan Subtotal	**16,421**	**16,299**	**-122**	**-0.7%**	**16,299**	**18,156**	**1,857**	**11.4%**
In-Home Hourly with State Plan Personal Care	1,400	1,323	-77	-5.5%	1,323	1,451	128	9.7%
In-Home Agency with State Plan Personal Care	334	337	3	0.9%	337	375	38	11.3%
In-Home non-K Plan Subtotal	**1,734**	**1,660**	**-74**	**-4.3%**	**1,660**	**1,826**	**166**	**10.0%**
Total In-Home	**18,155**	**17,959**	**-196**	**-1.1%**	**17,959**	**19,982**	**2,023**	**11.3%**
Adult Foster Care	2,878	2,868	-10	-0.3%	2,868	2,831	-37	-1.3%
Assisted Living	4,389	4,361	-28	-0.6%	4,361	4,510	149	3.4%
Contract Residential Care	2,308	2,406	98	4.2%	2,406	2,727	321	13.3%
Regular Residential Care	1,086	1,057	-29	-2.7%	1,057	1,079	22	2.1%
Program of All-Inclusive Care for the Elderly (PACE)	1,173	1,194	21	1.8%	1,194	1,309	115	9.6%
Community-Based Care Subtotal	**11,834**	**11,886**	**52**	**0.4%**	**11,886**	**12,456**	**570**	**4.8%**
Basic Nursing Facility Care	3,556	3,571	15	0.4%	3,571	3,459	-112	-3.1%
Complex Medical Add-On	528	575	47	8.9%	575	569	-6	-1.0%
Enhanced Care	55	54	0	0.0%	54	55	1	1.9%
Pediatric Care	45	41	0	0.0%	41	40	-1	-2.4%
Nursing Facilities Subtotal	**4,184**	**4,241**	**57**	**1.4%**	**4,241**	**4,123**	**-118**	**-2.8%**
Total Long-Term Care	**34,173**	**34,086**	**-87**	**-0.3%**	**34,086**	**36,561**	**2,475**	**7.3%**

Intellectual and Developmental Disabilities (I/DD)

Historically, Oregon provided I/DD services under a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. However, starting in July 2013 Oregon began offering services through the Community First Choice Option in 1915 (k) of the Social Security Act (referred to as the K Plan), and now most I/DD services are delivered under the K Plan. Implementation of K Plan required adjustments to program policies related to both eligibility and program delivery. As a result, more individuals with I/DD have chosen to enroll in Case Management and to request services.

Case Management Enrollment

This is an entry-level eligibility, evaluation, and coordination service available to all individuals determined to have intellectual and developmental disabilities, regardless of income level. In 2013-15 Case Management Enrollment averaged 22,459 and is projected to increase to 25,309 or by 12.7 percent in 2015-17. In 2017-19 Case Management biennial average caseload is projected to increase to 28,218 or by 11.5 percent. Enrollment is projected to grow rapidly until most I/DD individuals have enrolled. Research is underway to determine what might be the "natural limit," where caseload would plateau. Oregon's Office of Developmental Disabilities Services (ODDS) has contracted with Human Services Research Institute (HSRI) to estimate the youth and adult populations likely to seek I/DD services in Oregon through 2019. HSRI estimated demand for I/DD services by applying national prevalence estimates to Oregon's youth and adult populations.

The remaining caseload categories are divided into adult services, children services, and other services.

Adult Services

Brokerage Enrollment (BE) – Under K Plan, services must be provided to all eligible I/DD clients who wish to be served. In Oregon, adults with I/DD can obtain services through either of two channels: Brokerages or the Community Developmental Disability Programs (CDDPs). Brokerage demand was expected to grow at the historical rate until reaching the contractual limit of 7,805 brokerage slots – with subsequent growth diverted to the county CDDPs (where most clients would be served in Comprehensive In-Home Services (CIHS)). In reality, Brokerage Enrollment has remained under capacity, while CDDPs have been struggling to keep up with demand. The 2015-17 biennial average forecast for Brokerage Enrollment is 7,659, slightly lower from the Spring 2016 forecast. The forecast for 2017-19 is 7,769, or 1.4 percent higher than 2015-17.

Comprehensive In-Home Services (CIHS) – Due to the K Plan requirement that all eligible clients be served, and the fact that Brokerage capacity is limited, CIHS caseload has grown dramatically since July 2014. While a significant rise was anticipated, the exact timing and magnitude has been difficult to project. CIHS caseload was 312 in mid-2013, 371 in mid-2014, and 1,084 in mid-2015. CIHS is forecast to grow dramatically in both 2015-17 and 2017-19, reaching 1,931 by mid-2017 and 2,482 by mid-2019. The 2015-17 biennial average forecast is 1,569 clients, and the 2017-19 biennial average forecast is 2,229 clients.

24-Hour Residential Care – The 2015-17 biennial average forecast is 2,804, slightly higher than the Spring 2016 forecast. The 2017-19 forecast for is 2,883, which represents a 2.8 percent increase over 2015-17.

Supported Living – The 2015-17 biennial average forecast is 700, which is 2.1 percent lower than the Fall 2015 forecast. The 2017-19 forecast is the same as 2015-17.

I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately 15 percent of the caseload. The 2015-17 biennial average forecast is 3,169 clients, slightly higher from the Spring 2016 forecast. The 2017-19 forecast is 3,267, which represents a 3.1 percent increase over 2015-17.

Stabilization and Crisis Unit – The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 10.1 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 99 for both 2015-17 and 2017-19.

Children Services

In-Home Support for Children (IHSC) – This caseload started growing rapidly in late 2013 as K Plan was implemented. While a rapid and significant rise was anticipated, the exact timing and magnitude has been difficult to project. The caseload was 187 clients in mid-2013; 872 clients in mid-2014; and 2,008 in mid-2015. In-Home Support for Children is forecasted to grow dramatically in both 2015-17 and 2017-19, reaching 3,193 by mid-2017 and 3,681 by mid-2019. The 2015-17 biennial average forecast is 2,696 clients, and the 2017-19 biennial average forecast is 3,484 clients.

Growth in this caseload is primarily due to implementation of the Community First Choice Option (K Plan), which allows individuals eligible for the Oregon Health Plan to receive In-Home services if they have an extended need for assistance with Activities of Daily Living. In addition, the income criteria used for children no longer considers family resources. The forecasted growth for this caseload incorporates assumptions about the historical pattern for children entering Case Management and the percentage of children enrolled in Case Management who will apply for services. However, the K Plan is a significant change and our assumptions may not be correct. For this and other reasons, this caseload was especially complex to forecast and the risk of error is high. For additional information, see the "Risks and Assumptions" section below.

Children Intensive In-Home Services (CIIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. This caseload is limited by capacity and is expected to remain at the level of 412 for both 2015-17 and in 2017-19.

Other Services

Employment and Day Support Services – In order to better reflect recent I/DD program changes, the definition of employment services has been revised. The new definition is broader, including all of the services previously counted as well as new services offered under Employment First and Plan of Care.

Based on the old definition (called Employment and Attendant Care Services), caseload averaged 4,166 in 2013-15. The new, more inclusive definition (renamed Employment and Day Support Services) is different enough that comparison to prior forecasts would be misleading.

This forecast projects moderate growth from 2015-17 to 2017-19, reflecting stabilization of the changes being implemented, including an increased focus on early job preparation for qualifying high school students. It is anticipated that these students will graduate from high school with their employment training and/or employment already in place. Using the new caseload definition, the 2015-17 biennial average is 6,304 and the 2017-19 biennial average is 6,425, which represents a 1.9 percent increase over 2015-17.

Transportation – Historically, this caseload included only services paid with state funds, not those using local match funding. In order to provide a more complete picture, the definition of services counted in the Transportation caseload has been expanded to include all of the services previously counted, plus transportation services provided under Plan of Care (e.g. transit passes and non-medical community transportation).

Using the old definition, the 2013-15 Transportation caseload averaged 1,818. The new, more inclusive definition is different enough that comparison to prior forecasts would be misleading.

This forecast projects moderate growth from 2015-17 to 2017-19, reflecting stabilization of the changes being implemented by I/DD employment services biennial average is 6,433, which represents a 3.3 percent increase over 2015-17.

Risks and Assumptions

There are a variety of additional factors that create risks for all I/DD caseload forecasts.

Although the K Plan started in July 2013, initial work began slowly at first and work accelerated in 2014 with most CDDPs experiencing higher caseloads and more requests for services than previous to July 2013. The increase in requests for services and higher caseloads caused some delays in access to service. Many of the CDDPs have recently hired new staff as a result of funding based on the workload model. With additional staff added, this may result in quicker entry of new individuals with I/DD. All of these practical operational changes mean that new service use patterns are not yet stable and may continue to fluctuate for some time. In addition, the estimate may be low if many families who have children with I/DD had never chosen to enroll their children in Case Management.

The increase in people requesting I/DD services has created capacity challenges for CDDPs and their provider networks. To receive funded services, enrollees' Medicaid eligibility must be established, a level of care and assessment completed as well as an Individual Support Plan developed.

The caseloads most directly impacted by K Plan implementation are those where the individual lives in their own home or with family members; specifically Comprehensive In-Home Services (for adults) and the In-Home Support for Children.

Comprehensive In-Home Services – Adults can be served through two channels – Brokerages or CDDPs. However, since the brokerages are near capacity, most caseload growth is occurring in the CDDP service known as Comprehensive In-Home Services. Growth in adult caseloads generally comes from children who age into adult services, or previously unserved adults who are newly interested. Since this caseload is growing rapidly and without precedent, the forecast is highly sensitive to the assumptions used to produce it, and the risk of error is higher than usual.

Furthermore, it should be noted that since Brokerage capacity is contractually constrained, contracting changes (e.g., increasing the number of contracted slots, or shifting unutilized seats to brokerages with waiting lists) could shift this growth from Comprehensive In-Home Services back to Brokerage Enrollment.

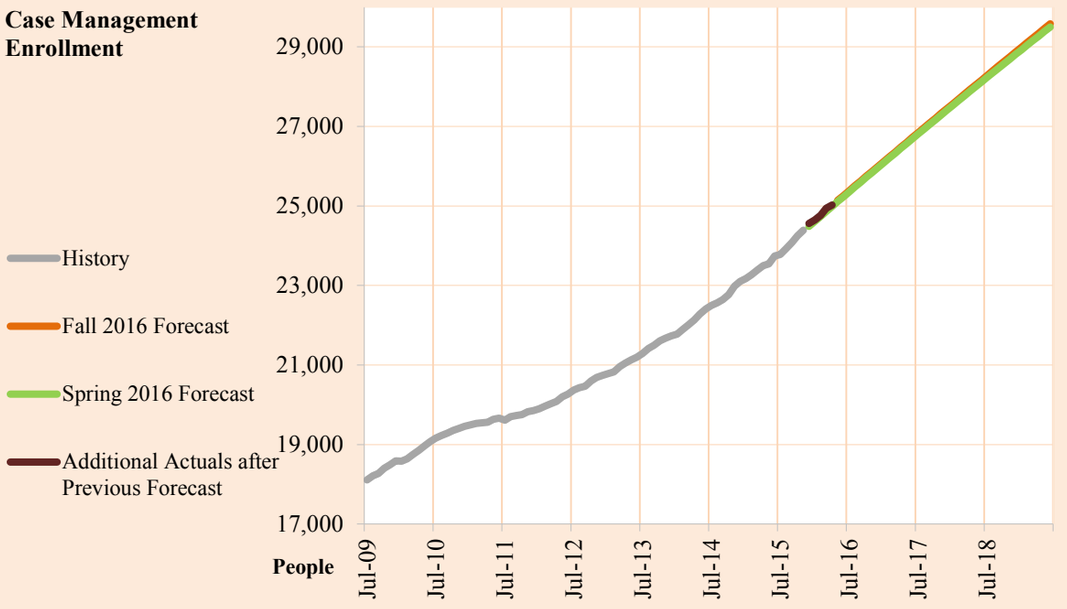
In-Home Support for Children – the K Plan implementation expanded the availability of services for many children. Prior to the implementation of the K Plan children were only able to receive limited in-home services and could only access additional services if they met crisis criteria. A child may now access significant in-home support without meeting crisis criteria if they are eligible for I/DD services and Medicaid. As a result, a significantly larger number of children may now access in-home services. Also, under Oregon's comprehensive waiver, additional children are now eligible for Medicaid services based solely on having a disability (meeting SSI standards), while not accounting for family financial resources. This may also increase the number of children who are able to access in-home services through the K Plan.

Summary of the key assumptions and steps used to project the In-Home Support for Children caseload

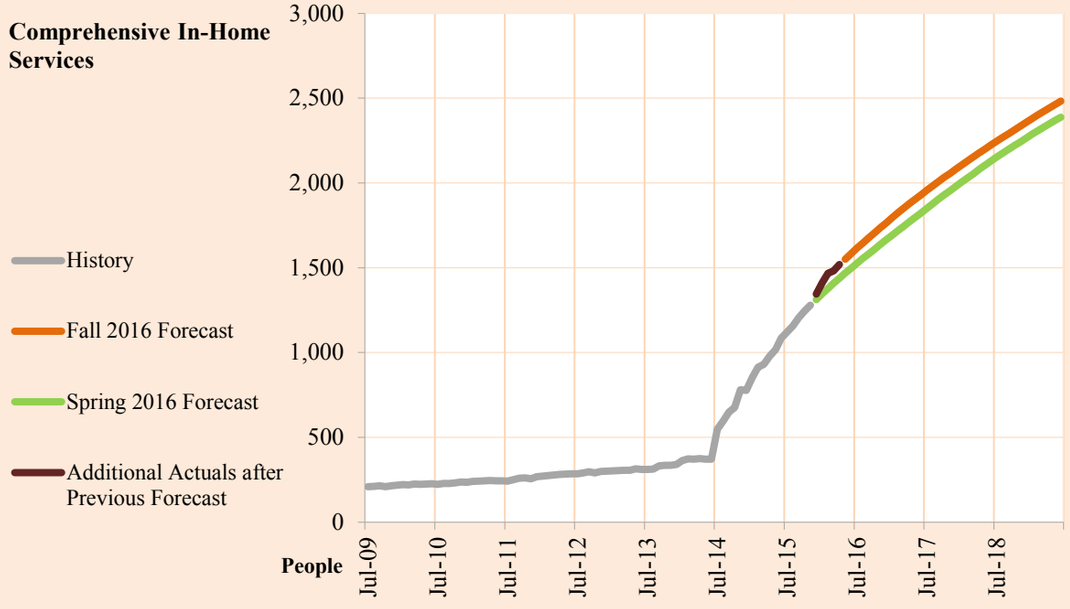
- Case Management enrollees under 18 years of age and not receiving additional I/DD services were used as the basis for estimating new entrants to this caseload.
- Next, the growth projected for Case Management was applied to this caseload as well.
- Then the percentage of children in Case Management and not receiving additional services was gradually reduced from 44 percent to 20 percent over four years.

These assumptions were discussed and debated by the I/DD Caseload Forecast Advisory Committee; then the forecaster made final changes based on personal judgment.

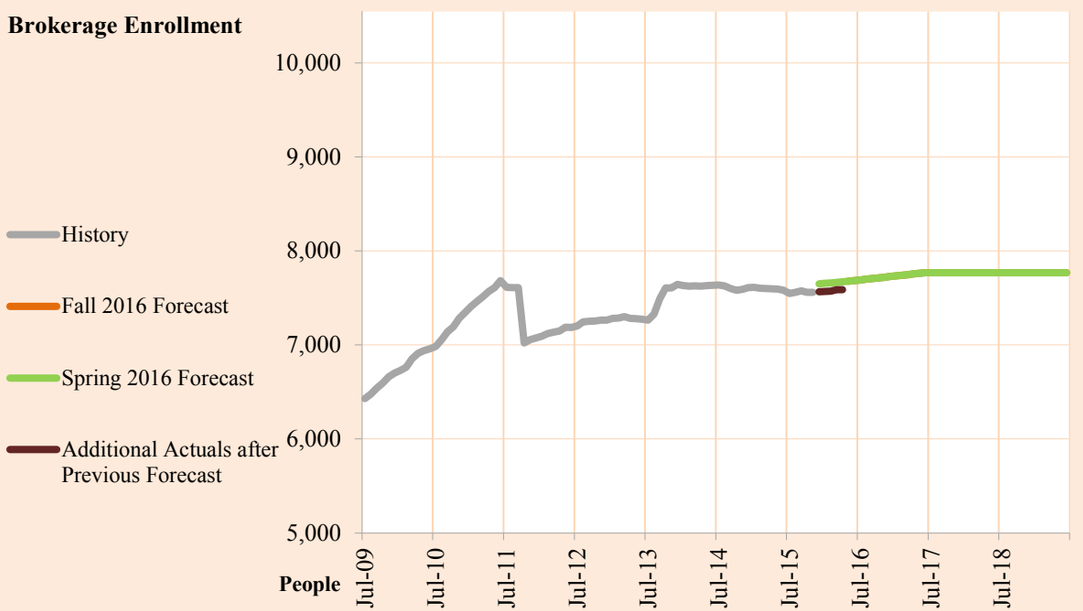
Case Management Enrollment



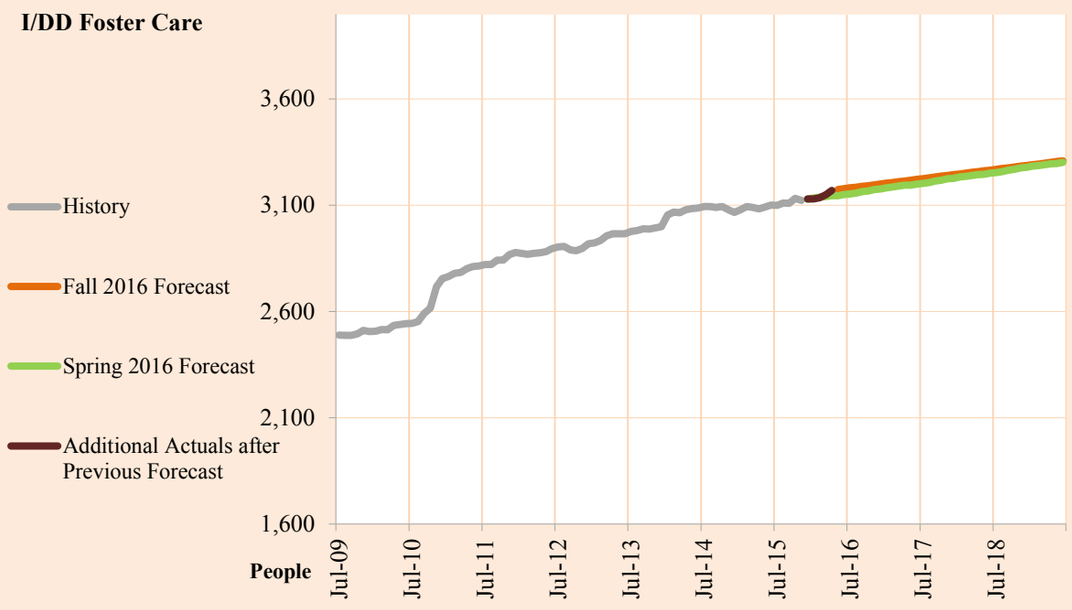
Comprehensive In-Home Services



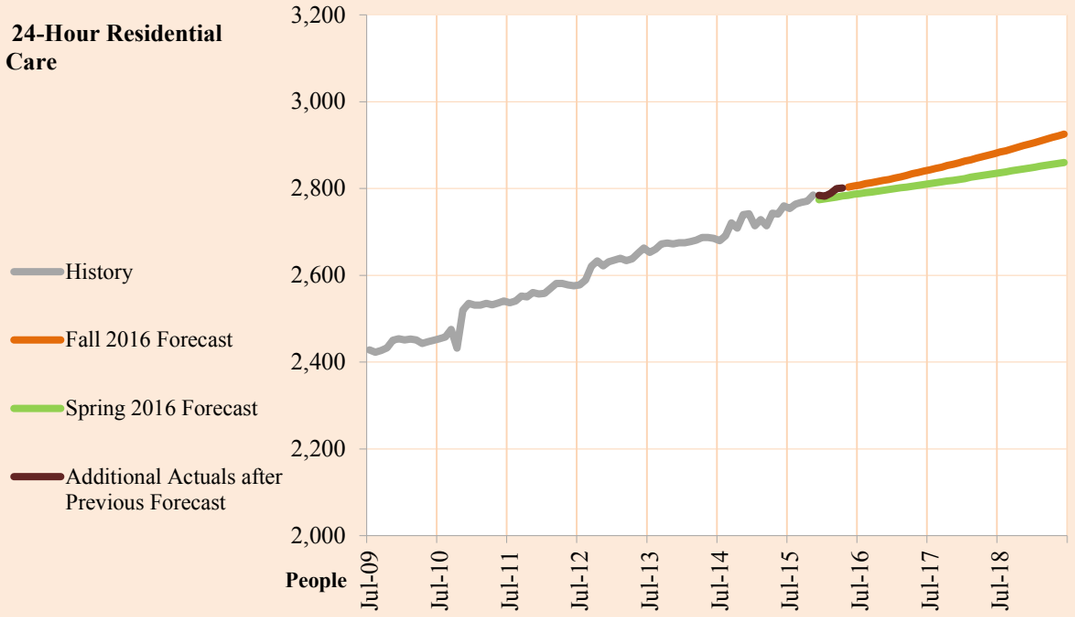
Brokerage Enrollment



I/DD Foster Care



24-Hour Residential Care



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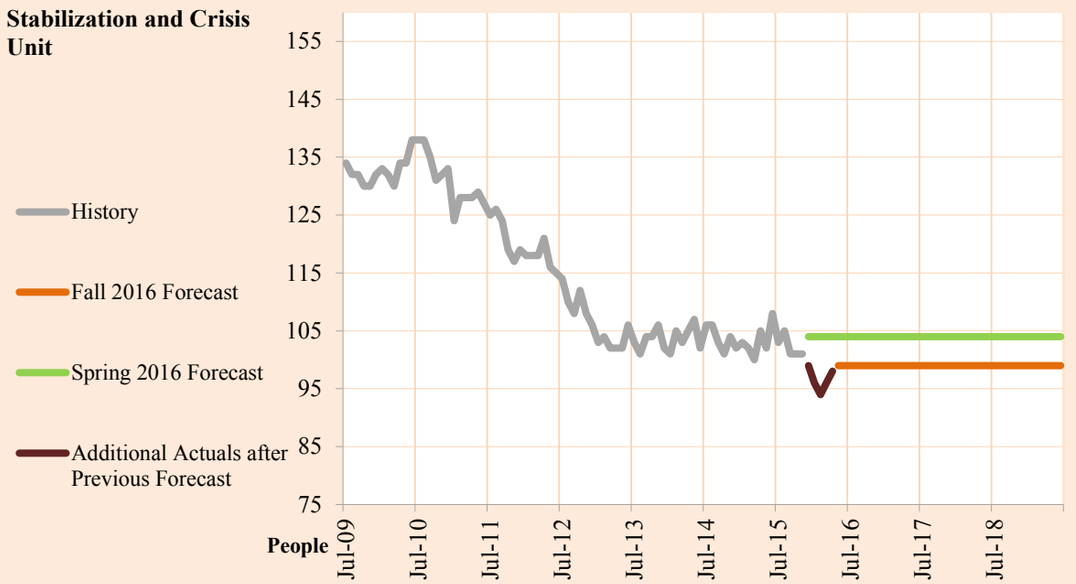

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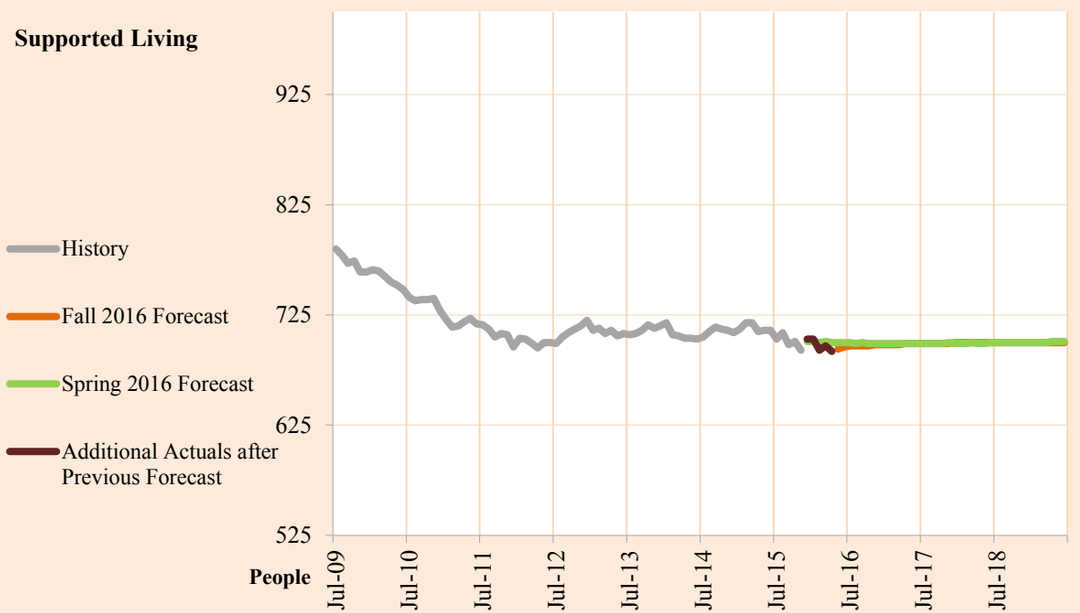
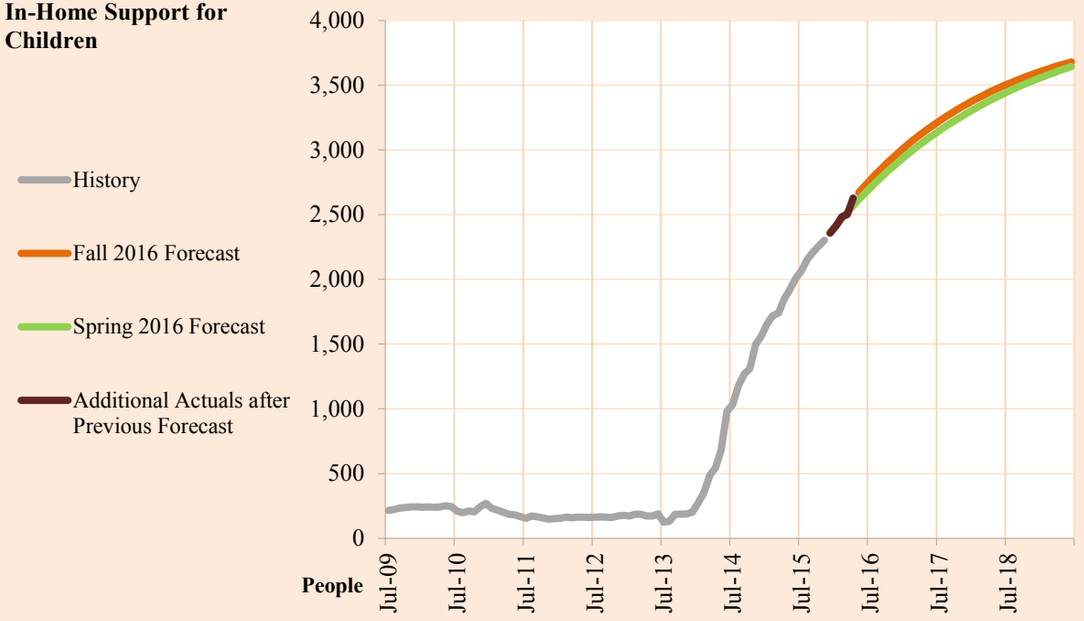
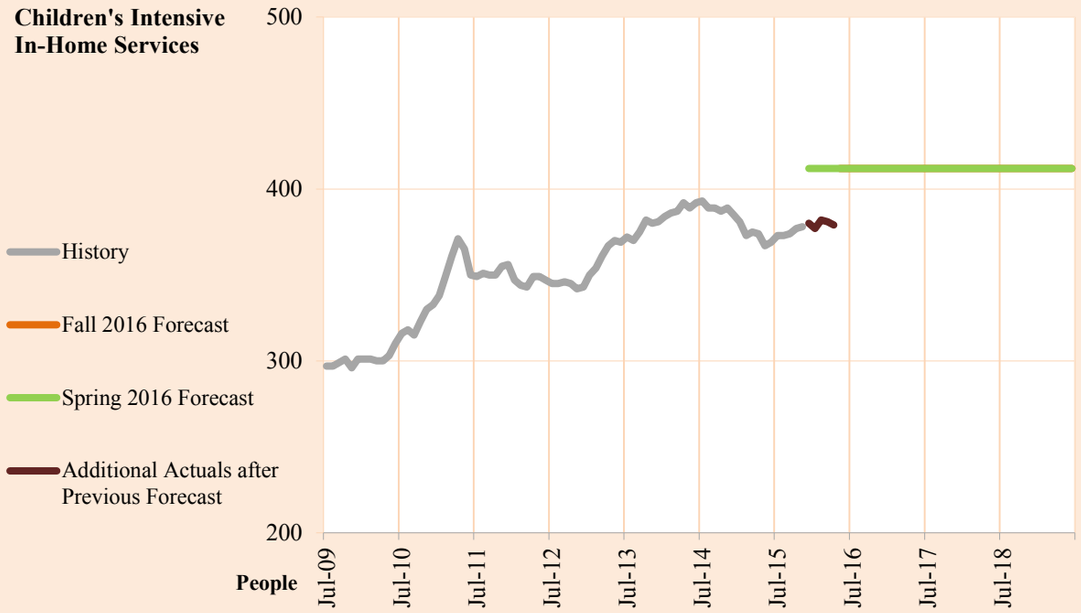


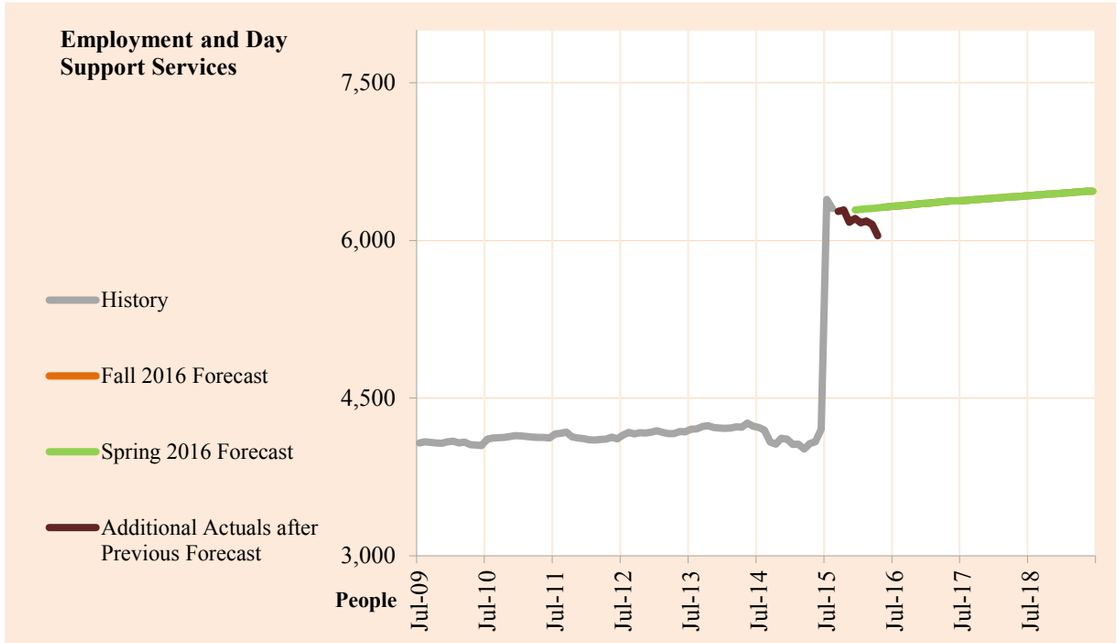
In-Home Support for Children



Children's Residential Care

Children's Intensive In-Home Services

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6,000
4,500
3,000
People
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
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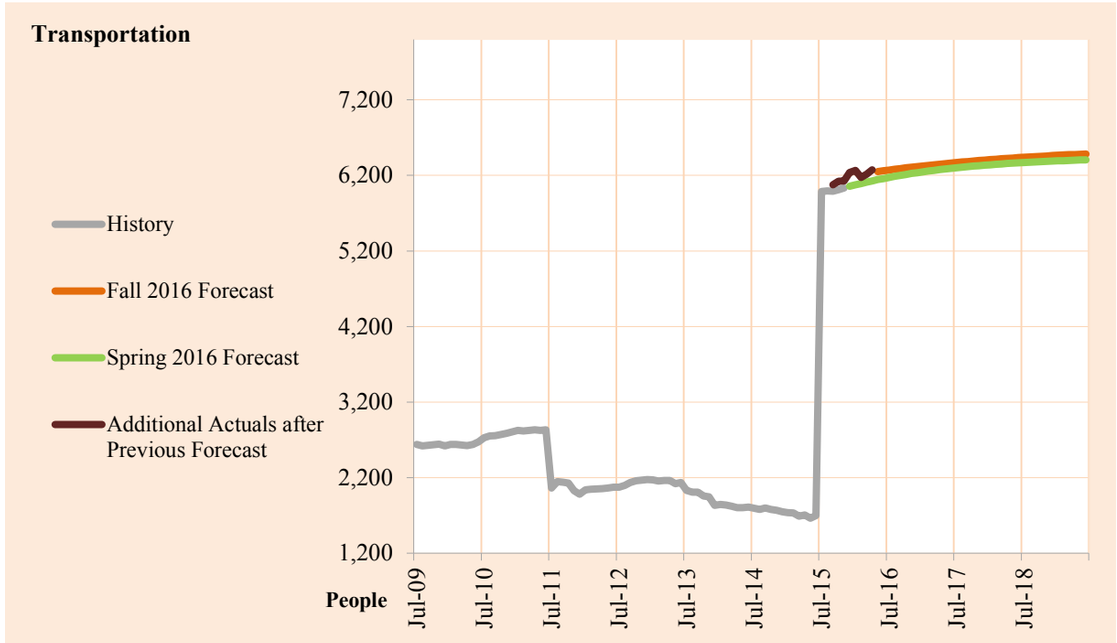
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18


Transportation
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6,200
5,200
4,200
3,200
2,200
1,200
People
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
Jul-09
Jul-10
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES								
Total Case Management Enrollment [1]	**25,281**	**25,309**	**28**	**0.1%**	**25,309**	**28,218**	**2,909**	**11.5%**
Adult								
Brokerage Enrollment	7,676	7,659	-17	-0.2%	7,659	7,769	110	1.4%
Comprehensive In-Home Services [2]	1,499	1,569	70	4.7%	1,569	2,229	660	42.1%
I/DD Foster Care [3]	3,154	3,169	15	0.5%	3,169	3,267	98	3.1%
24 hrs Residential Care	2,787	2,804	0	0.6%	2,804	2,883	79	2.8%
Supported Living	700	698	-2	-0.3%	698	700	2	0.3%
Stabilization and Crisis Unit [3]	104	99	0	-4.8%	99	99	0	0.0%
Children								
In-Home Support for Children [2]	2,654	2,696	42	1.6%	2,696	3,484	788	29.2%
Children Intensive In-Home Services	404	398	-6	-1.5%	398	412	14	3.5%
Children Residential Care	163	162	-1	-0.6%	162	166	4	2.5%
Total I/DD Services	**19,141**	**19,254**	**113**	**0.6%**	**19,254**	**21,009**	**1,755**	**9.1%**
Other I/DD Services								
Employment & Day Support Activities	6,302	6,304	2	0.0%	6,304	6,425	121	1.9%
Transportation	6,151	6,230	79	1.3%	6,230	6,433	203	3.3%

1. Some clients enrolled in Case Management do not receive any additional I/DD services.
2. Caseloads for both Comprehensive In-Home Services and In-Home Support for Children are rising significantly due to implementation of K Plan.
3. Foster Care and the Stabilization and Crisis Unit serve both adults and children: (I/DD FC - 83% / 17%; SACU - 89% / 11% respectively).

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 2016 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Medical Assistance								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	4.2%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	0.6%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	1.1%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	6.5%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	**1,048,498**	**1,043,045**	**-5,453**	**-0.5%**	**1,043,045**	**982,661**	**-60,384**	**-5.8%**
Other Medical Assistance Total	73,016	73,765	749	1.0%	73,765	74,384	619	0.8%
Total Medical Assistance	**1,121,514**	**1,116,810**	**-4,704**	**-0.4%**	**1,116,810**	**1,057,045**	**-59,765**	**-5.4%**
Mental Health [1]								
Under Commitment								
Total Forensic Care	828	859	31	3.7%	859	861	2	0.2%
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	45,425	45,645	220	0.5%	45,645	47,523	1,878	4.1%

1. Numbers reported represent adults only.

Health Systems Medicaid (HSM)

Since 2008, the primary drivers of the Medicaid caseload growth were:

- The most recent recession (December 2007 through an official ending date of June 2009).
- Implementation of the Oregon Healthy Kids Initiative in July 2009.
- Implementation of Patient Protection and Affordable Care Act (ACA) in January of 2014.

Taken together these three factors drove the total Medicaid caseload from approximately 408,000 clients prior to the recession to about 1,009,000 clients in January 2014, for a net increase of 601,000 clients or 147 percent. As of April 2016, the Medicaid caseload was 1,162,147 and the preliminary estimate for July 2016 is 1,117,367. For the past few years, the average caseloads were higher due to some delays in planned redeterminations, but since the redetermination work resumed in February 2016 the caseloads have been consistently declining. In general, the caseloads will continue to decline thru the forecast horizon as long as the economy remains in the current state and there are no further delays in the planned redeterminations.

ACA Adults – Since the redeterminations resumed in March 2016, the ACA Adult caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 410,731 clients on this caseload, down by roughly 38,000 compared to March 2016 count of 448,823. The caseload is expected to drop to 367,582 by the end of 2015-17 biennium and will account for about 36.9 percent of the total OHP caseload. The caseload is expected to continue declining at a slower pace through 2017-19 biennium as well.

Parent/Caretaker Relative – Although the improving economy puts downward pressure on this caseload, the inflow from ACA Adults, as a result of redeterminations, caused the caseload to grow. The most recent preliminary estimate for July 2016 shows 74,689 clients on this caseload, up by 6,604 compared to March 2016 count of 68,085. However, the current forecast does not project inflow to continue at that pace. The caseload is expected to drop to 70,608 by the end of 2015-17 biennium and will account for about 7.1 percent of the total OHP caseload. Similar to the previous caseload, this caseload is also expected to continue declining through 2017-19 biennium.

Pregnant Women – As of April 2016 there were 17,786 women on this caseload. The caseload has been declining steadily in the past few months as redeterminations were resumed. The caseload is expected to drop to 13,912 by the end of 2015-17 biennium and will account for 1.4 percent of the total OHP Plus caseload.

Children's Medicaid – Since redeterminations resumed in March 2016, this caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 337,543 clients on this caseload, down by 23,731 compared to March 2016 count of 361,274. The forecast predicts a small period of growth for this caseload this winter, when fewer redeterminations are planned and higher inflow of new clients is expected due to open enrollment. Overall, the caseload is expected to stay flat for the forecast horizon. By the end of 2015-17 biennium there will be 337,796 clients on this caseload and it will account for about 33.9 percent of the total OHP caseload.

Children's Health Insurance Program (CHIP) – As of April 2016 there were 63,280 children on this caseload. The caseload has been declining steadily in the past few months as redeterminations were resumed. The caseload is expected to drop to 58,892 by the end of 2015-17 biennium and will account for 5.9 percent of the total OHP Plus caseload.

Foster, Substitute Care & Adoption Assistance – As of April 2016 there were 19,576 children on this caseload. This caseload is growing and will continue to grow slowly through the forecast horizon. By the end of 2015-17 biennium there will be 20,004 clients on this caseload and it will account for 2.0 percent of the total OHP caseload.

Aid to the Blind and Disabled (ABAD) – As of April 2016 there were 81,387 clients on this caseload. Historically this caseload grew steadily. The ACA reform had a profound impact on this caseload. First, the availability of health insurance to low income adults (ACA Adults caseload) and, second, the availability of K-Plan (access to long term care without having to obtain a federal designation of disability) negatively impacted the demand for this caseload. Despite the declining trend immediately following the ACA implementation, there was always a consensus among the experts that the caseload will start growing again although at a more moderate growth rate. The most recent data proves that point. The caseload is expected to grow to 83,213 by the end of 2015-17 biennium and will account for 8.3 percent of the total OHP Plus caseload.

Old Age Assistance (OAA) – There were 41,768 clients on this caseload as of April 2016. The caseload is projected to grow steadily through the foreseeable future. This caseload is driven by population dynamics as well as economic conditions. Oregon's elderly population is projected to increase by roughly 4 percent per year. The caseload is expected to be 44,618 by the end of 2015-17 biennium and will account for 4.5 percent of the total OHP Plus caseload.

Other Medical Assistance Programs

Citizen-Alien Waived Emergent Medical - Regular (CAWEMR) – Since the redeterminations resumed in March 2016, this caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 43,861 clients on this caseload, down by 7,561 compared to the March 2016 count of 51,422. The caseload is expected to grow slightly to 44,849 by the end of 2015-17 biennium and will account for about 61.5 percent of Other Medicaid caseload.

Qualified Medicare Beneficiary (QMB) – There were 23,921 clients on this caseload as of April 2016. This caseload is expected to be 25,715 by the end of 2015-17 biennium and will account for about 35.3 percent of Other Medicaid caseload. This caseload has grown consistently since January of 2009 and is expected to continue growing through the forecast horizon.

Breast and Cervical Cancer Treatment Program (BCCTP) – There were 362 clients on this caseload as of April 2016. This caseload is expected to be 286 by the end of 2015-17 biennium and will account for about 0.4 percent of Other Medicaid caseload. This caseload is forecast to continue declining since ACA has reduced the number of uninsured adults who might qualify for the program.

Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance – There were 6,468 clients on this caseload as of April 2016. This caseload is expected to grow through the foreseeable future, and is expected to be 6,714 by the end of 2015-17 biennium.

Medicare Part-B Premium Assistance – There were 116,938 clients on this caseload as of April 2016. This caseload is projected to continue growing steadily, similar to the OAA and QMB caseloads. It is expected to be 124,297 by the end of 2015-17 biennium. Twenty-eight percent of those receiving Medicare Part-BA assistance are in OAA caseload; 27 percent are in ABAD; 20 percent are in QMB; and most of the remaining 25 percent are not in any of the forecasted Medicaid caseloads.

Risks and Assumptions

Implementation of the ACA continues to create uncertainty and forecast risk. The biggest known risks for the current forecast are:

- Deferred redeterminations.
- Next phase of Oregon Eligibility (ONE) system implementation.
- Volatility of historical data.

The first major risk arises from temporary changes made to eligibility redetermination practices. Since the implementation of ACA, the scheduled redeterminations have been delayed a few times:

- Oct-2013 thru Sep-2014, scheduled redeterminations were delayed in order to focus resources on ACA reform and the inflow of newly eligible adults and children.

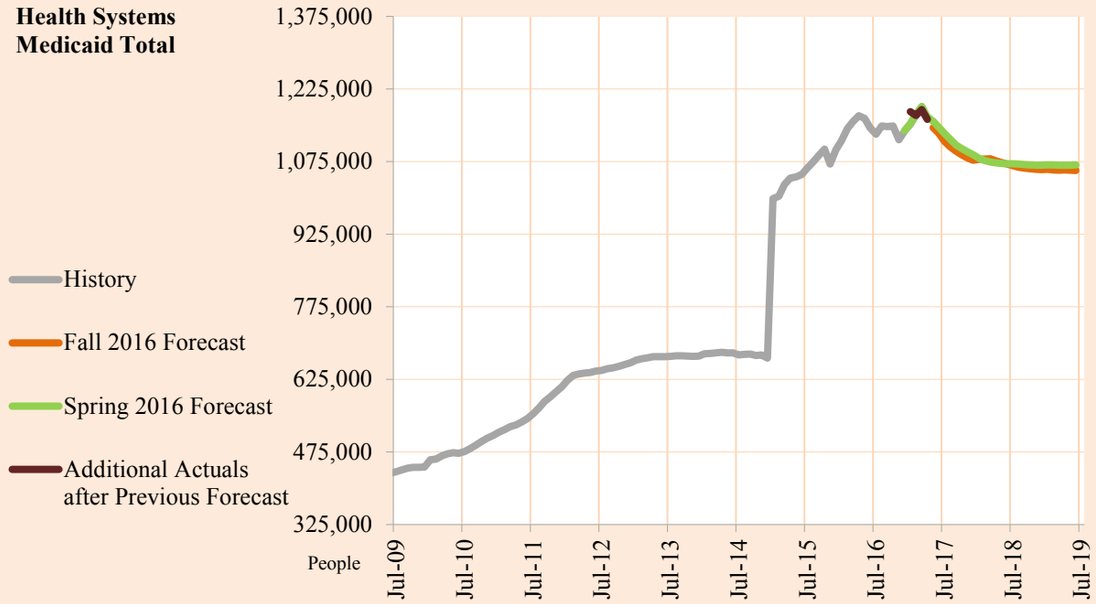
- Dec-2014 thru Mar-2015, scheduled redeterminations were delayed due to issues with Cover Oregon system and consequent challenges with the upcoming open enrollment period.
- Dec-2015 thru Feb-2016, scheduled redeterminations were delayed in order to focus resources on the transition to Oregon's new eligibility system – ONE.

As of March 2016, the scheduled redeterminations have been resumed and the transition to ONE is on schedule. There will be a brief slowing of redeterminations this Fall as OHA moves forward with the next phase of ONE implementation. To the extent possible, the Fall 2016 forecast incorporates the impact and consequences of anticipated changes to redeterminations. However, because operational details can change, this remains a major risk to our current forecast.

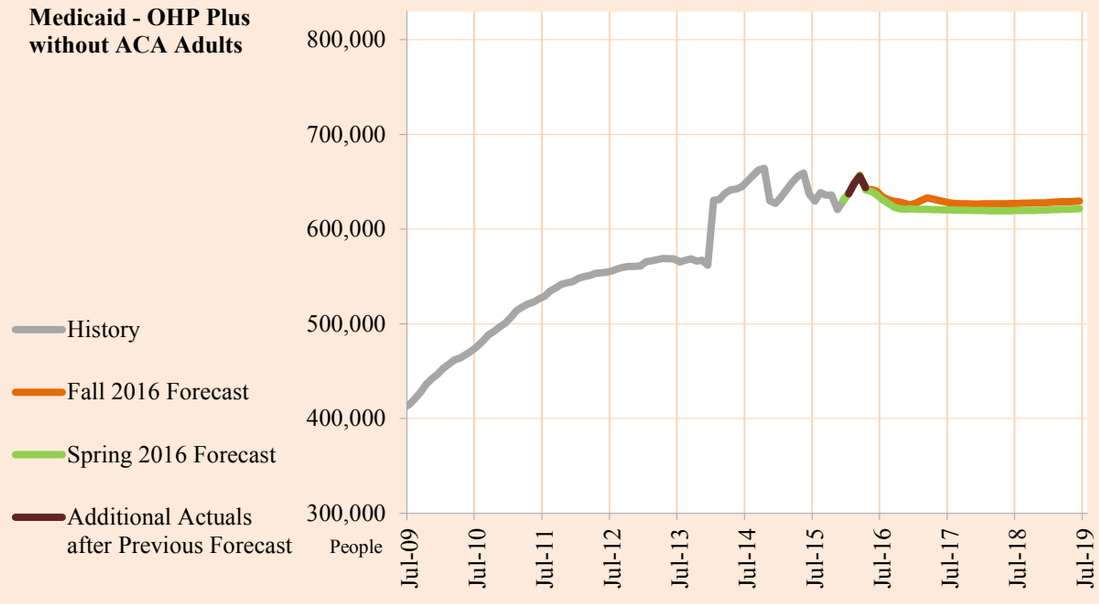
The second major risk is associated with the last phase of the ONE system implementation. In this phase OHA intends to fully launch ONE and make it directly available to Oregonians so they can access the application process themselves. So far, the implementation of ONE overall has been going smoothly, but nevertheless, system changes are tricky and there could be technical setbacks that could in turn cause delays in redeterminations and other issues.

The third major risk is associated with volatility of post-ACA data, which results in wide confidence intervals and could result in high forecast errors. The delays in redeterminations resulted in periods of caseload growth and consequent decline, which makes it very challenging to detect the true trends. Additionally, this had some profound consequences on all of the underlying model components – survival curves (used to predict leavers), new client flow, and transfer rates between caseloads. As the migration to ONE is complete (in early 2017) and there are more delays and disruptions to the ongoing renewal processes, the data will start to improve, however it might take an additional year until new patterns are established.

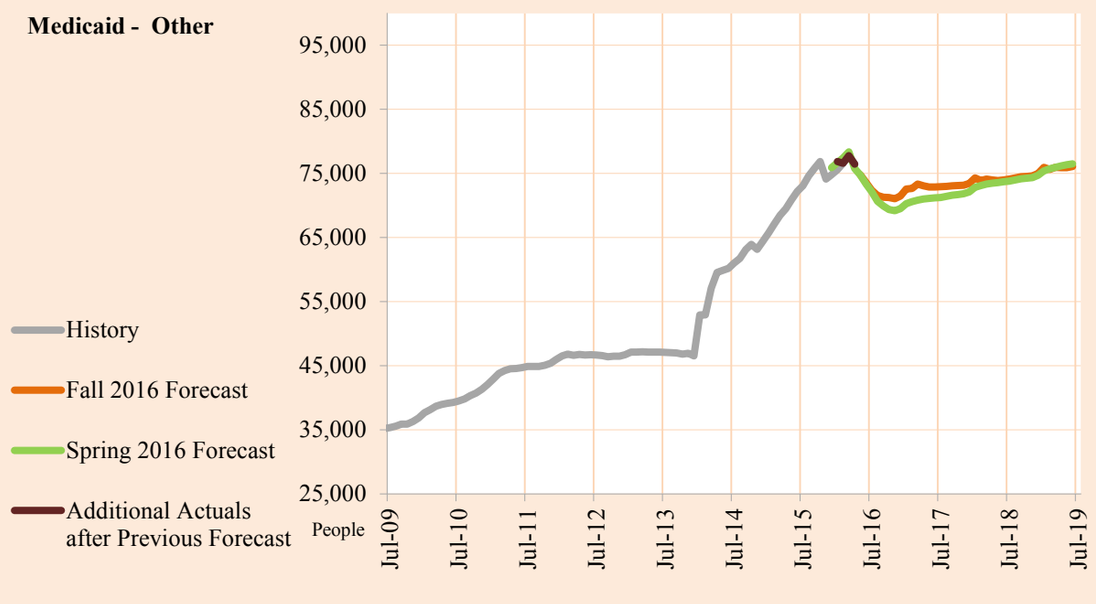
Health Systems Medicaid Total



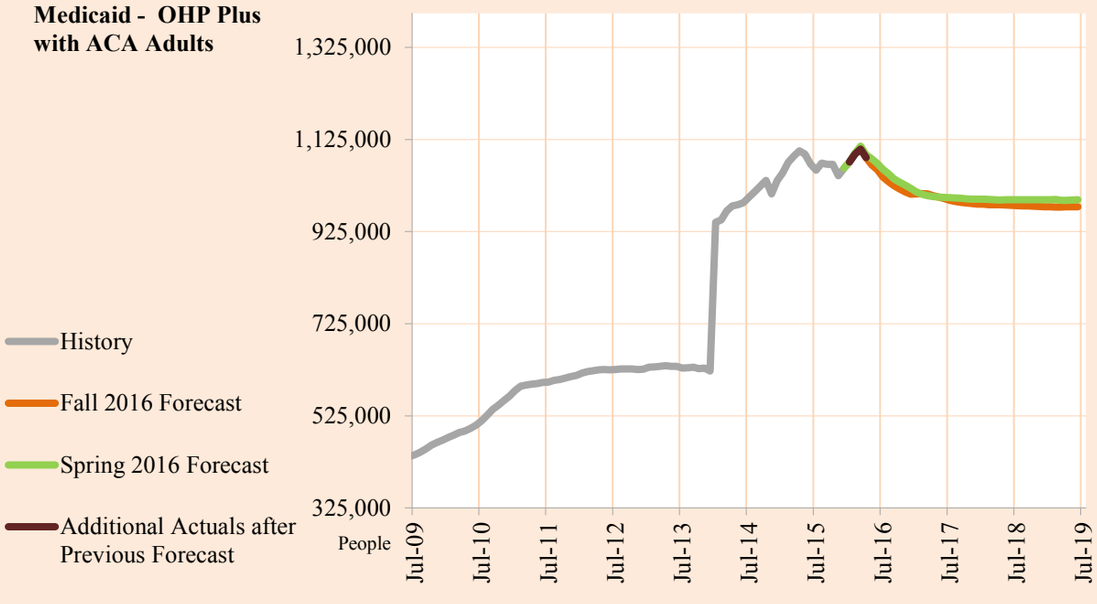
Medicaid - OHP Plus without ACA Adults



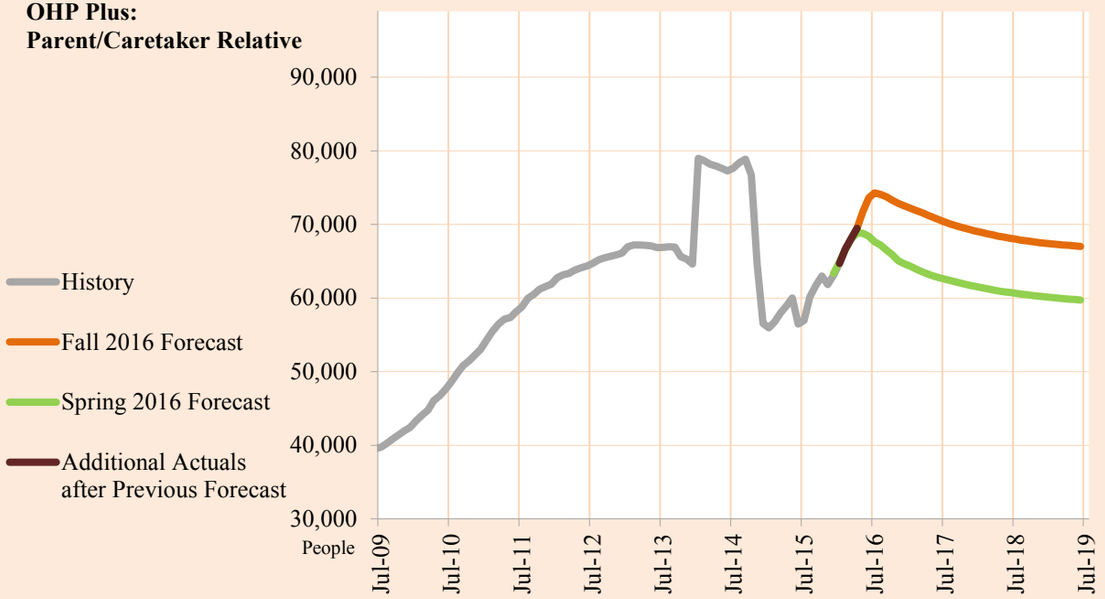
Medicaid - Other



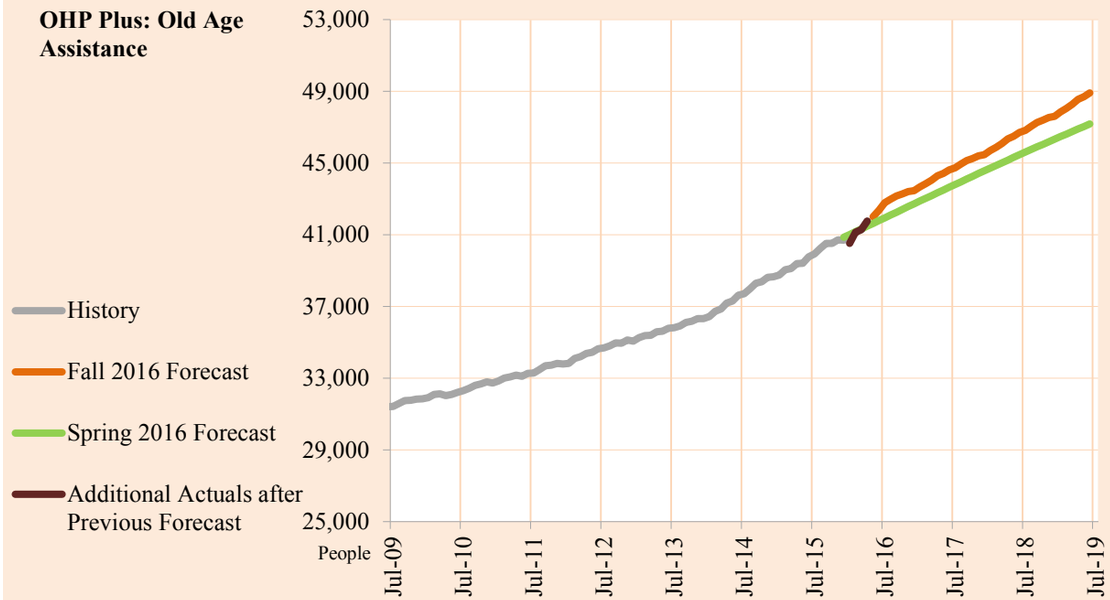
Medicaid - OHP Plus with ACA Adults



OHP Plus: Parent/Caretaker Relative

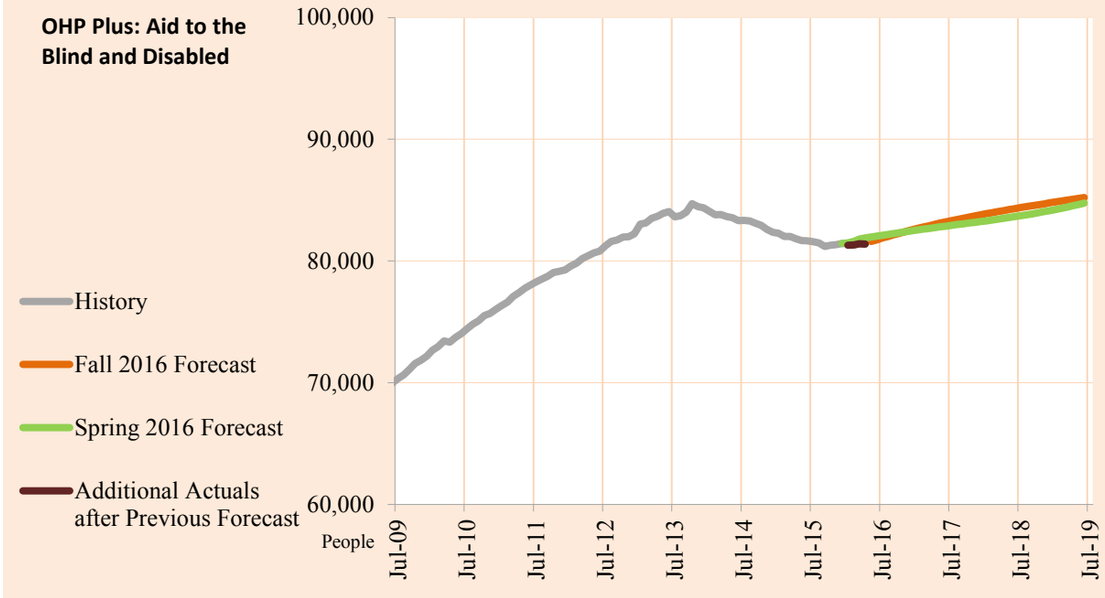


OHP Plus: Old Age Assistance

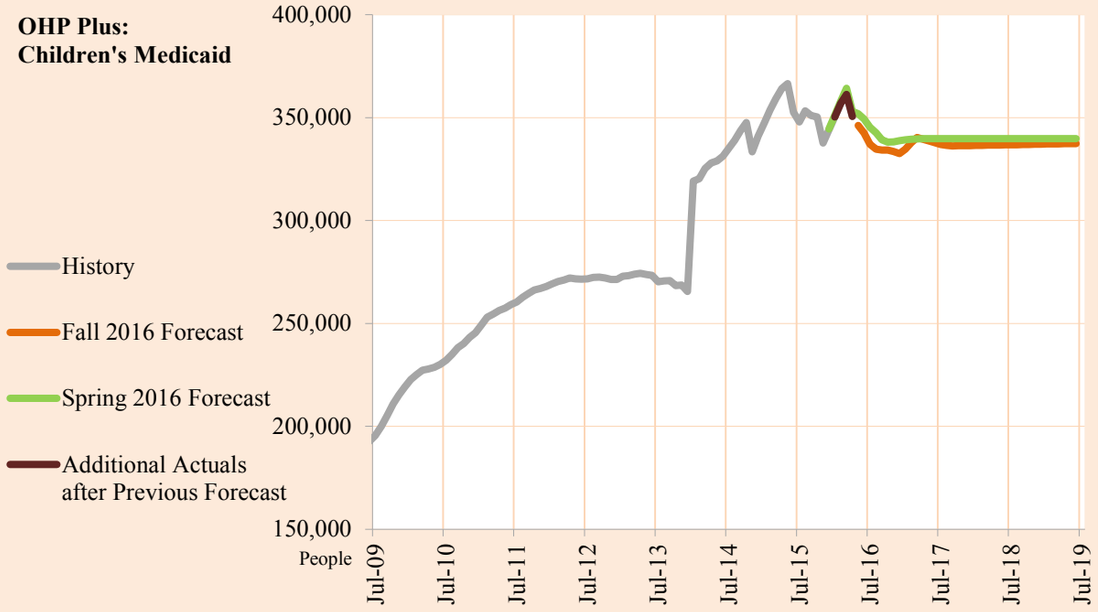


OHP Plus: Pregnant Woman Program

OHP Plus: Aid to the Blind and Disabled

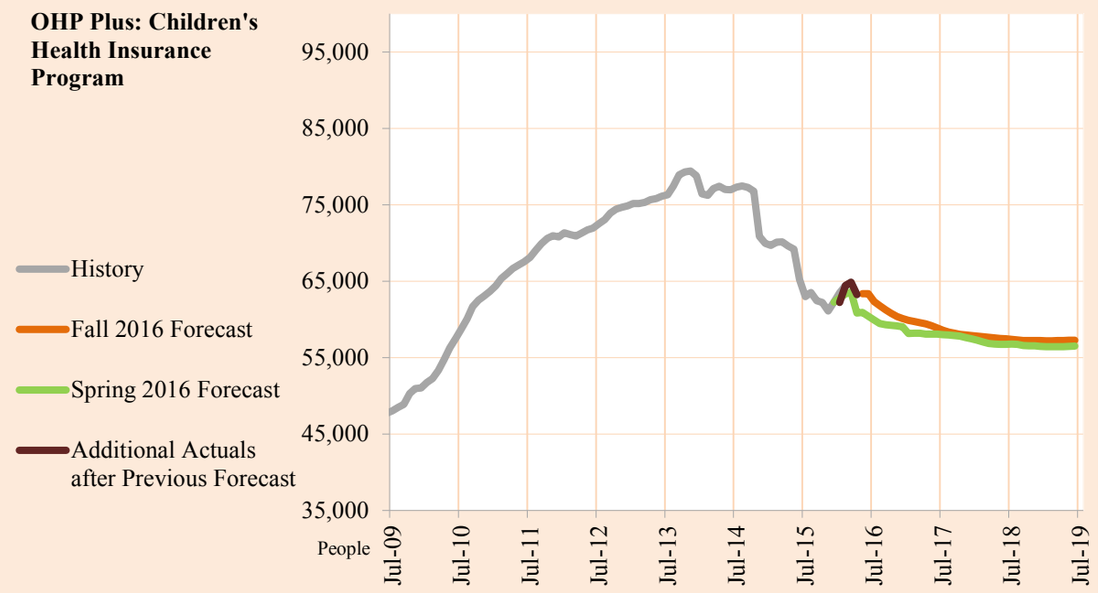


OHP Plus: Children's Medicaid

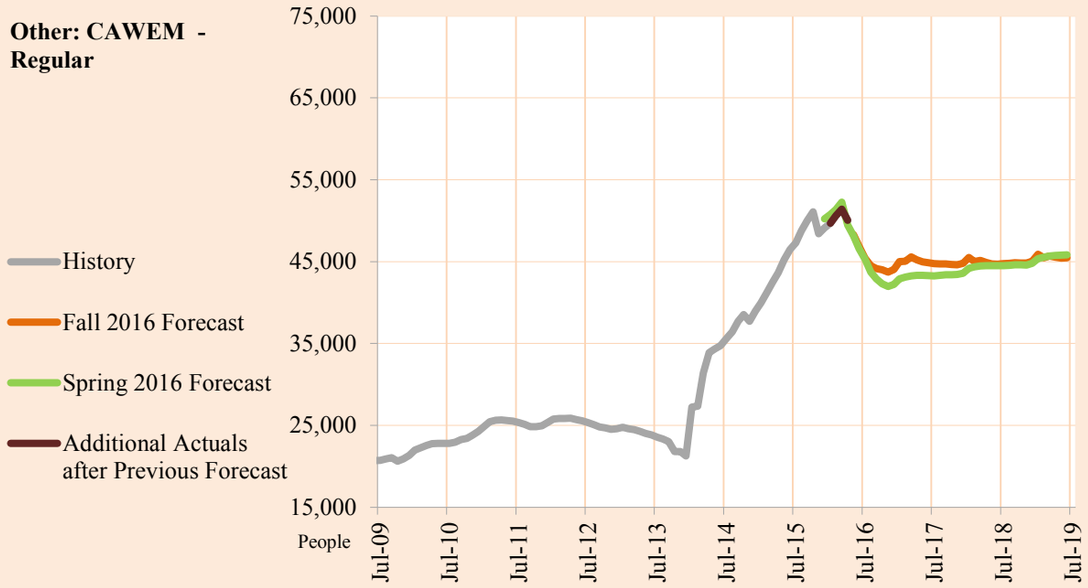


OHP Plus: Foster, Substitute Care and Adoption Assistance

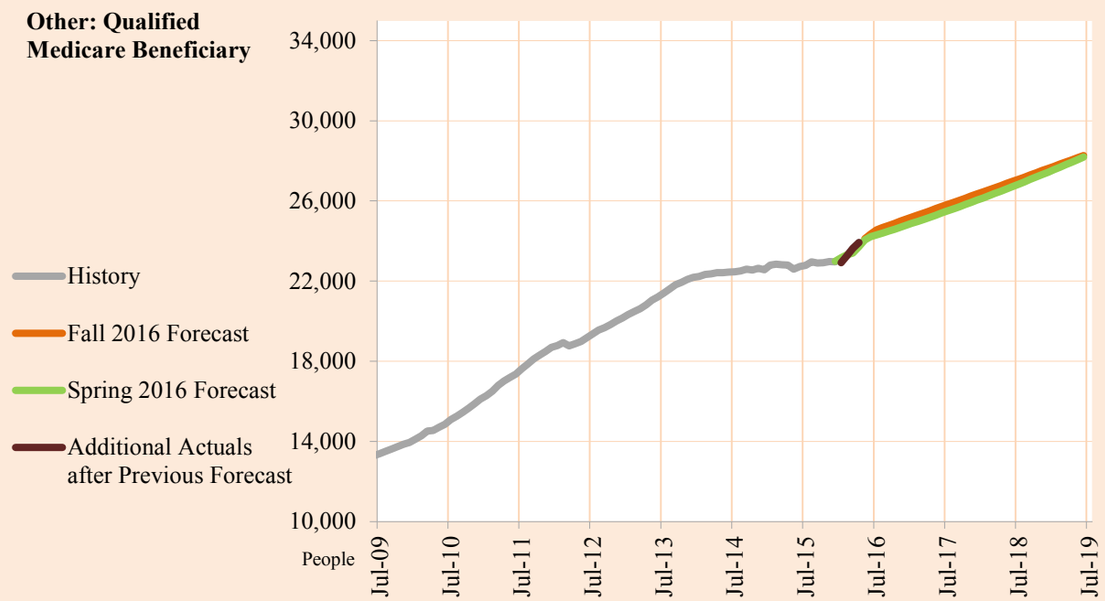
OHP Plus: Children's Health Insurance Program



Other: CAWEM - Regular

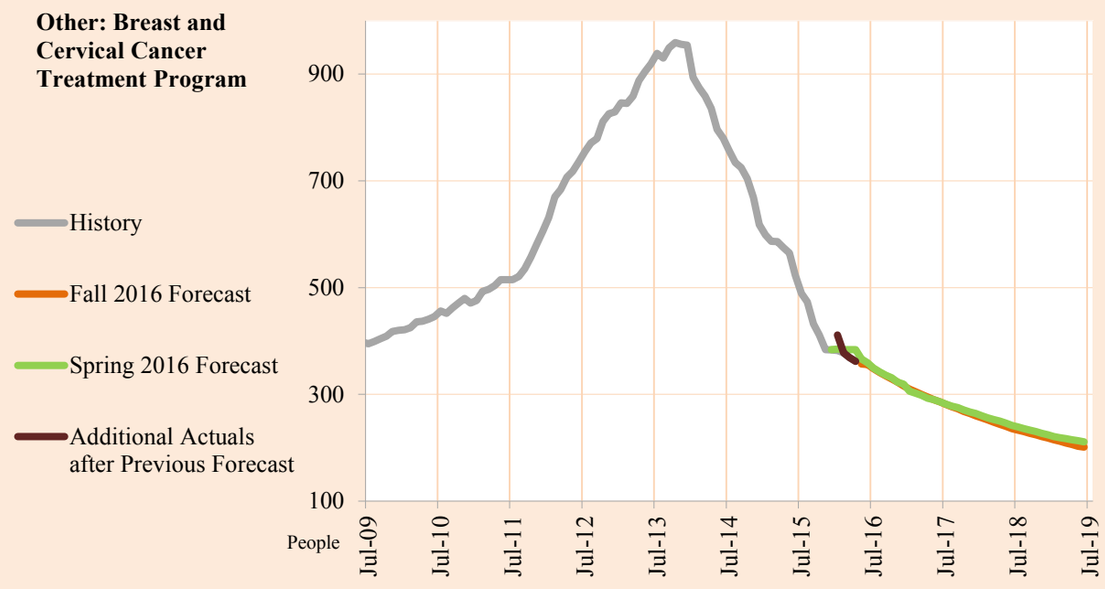


Other: Qualified Medicare Beneficiary

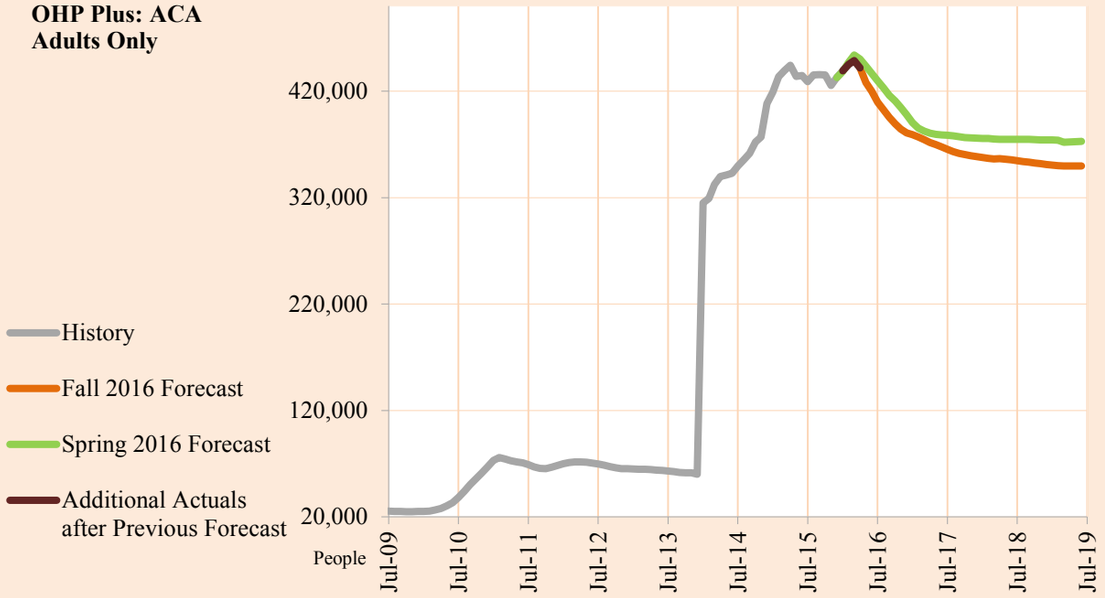


Other: CAWEM - Prenatal

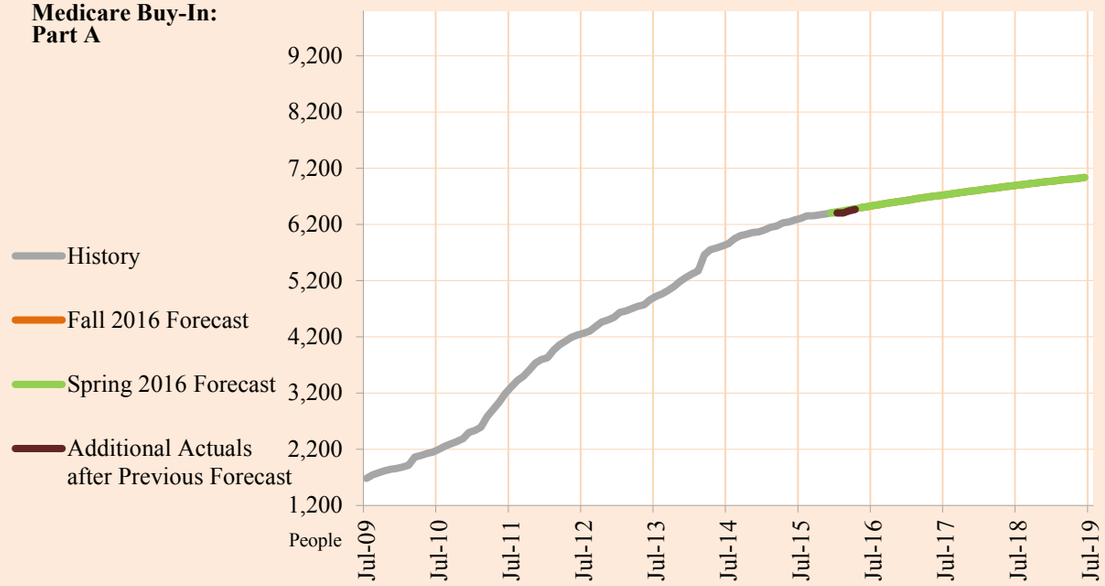
Other: Breast and Cervical Cancer Treatment Program



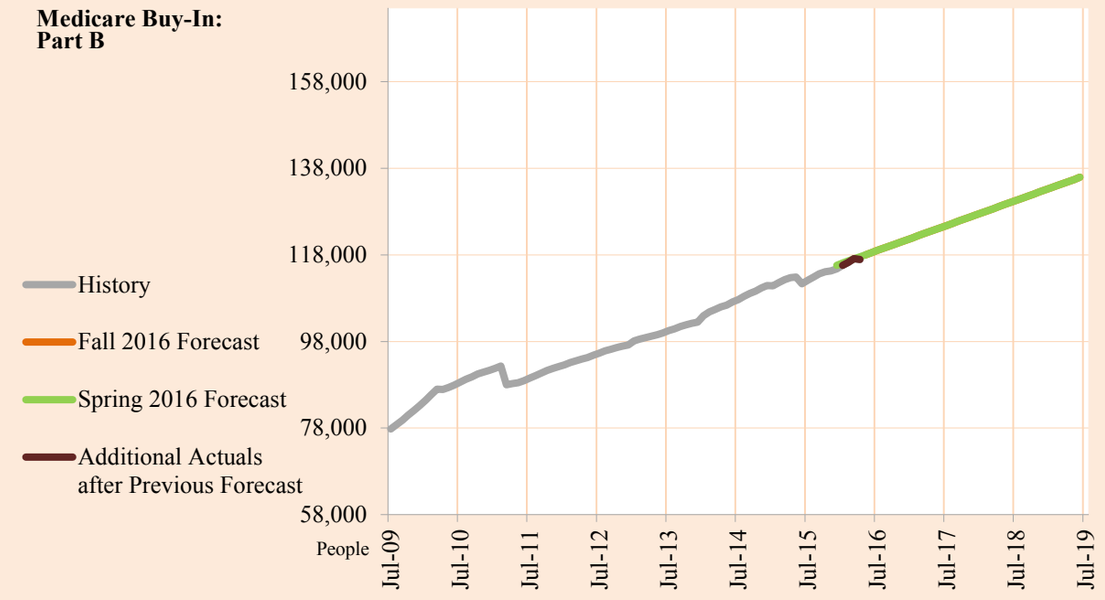
OHP Plus: ACA Adults Only



Medicare Buy-In: Part A



Medicare Buy-In: Part B



Health Systems Medicaid Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
MEDICAL ASSISTANCE								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	0.6%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	1.1%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	6.5%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	4.2%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	**1,048,498**	**1,043,045**	**-5,453**	**-0.5%**	**1,043,045**	**982,661**	**-60,384**	**-5.8%**
Other Medical Assistance								
Breast & Cervical Cancer Treatment Program	359	356	-3	-0.8%	356	237	-119	-33.4%
Citizen-Alien Waived Emergent Medical - Prenatal	2,257	2,168	-89	-3.9%	2,168	2,075	-93	-4.3%
Citizen-Alien Waived Emergent Medical - Regular	46,339	47,007	668	1.4%	47,007	45,036	-1,971	-4.2%
Qualified Medicare Beneficiary	24,061	24,234	173	0.7%	24,234	27,036	2,802	11.6%
Other Subtotal	**73,016**	**73,765**	749	1.0%	**73,765**	**74,384**	**619**	**0.8%**
Total Medical Assistance	**1,121,514**	**1,116,810**	**-4,704**	**-0.4%**	**1,116,810**	**1,057,045**	**-59,765**	**-5.4%**
Medicare Part A	6,522	6,518	-4	-0.1%	6,518	6,888	370	5.7%
Medicare Part B	118,626	118,532	-94	-0.1%	118,532	130,332	11,800	10.0%

Mental Health (MH)

This forecast includes adults who are receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Mental Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires Mandated populations, including criminally and civilly committed patients, to receive mental health services. There are three Mandated populations: (1) Aid and Assist, served at the State Hospital; (2) Guilty Except for Insanity (GEI), served at the State Hospital and in the community; and (3) Civilly Committed, also served at both the State Hospital and in the community. The Non-Mandated populations include two groups: (1) Previously Committed individuals, served mostly in the community; and (2) Never Committed individuals, also served mostly in the community. Due to data system changes, the Civilly Committed, Previously Committed, and Never Committed populations were not forecast during the Fall 2015 forecast cycle. As service providers have become more consistent in their use of the Measures and Outcomes Tracking System (MOTS), data for these populations have continued to be refined.

Mandated mental health services are provided through community programs, including residential care, and the Oregon State Hospital system. Non-Mandated services are primarily provided in community outpatient settings. Community programs provide outpatient services including intervention, therapy, case management, crisis, and pre-commitment services. The State Hospitals provide 24-hour supervised care to people with the most severe mental health disorders, including people who have been found guilty except for insanity.

Total Mandated Mental Health Services

The mandated caseload encompasses the committed caseload (Aid and Assist, GEI, and Civilly Committed clients). The 2015-17 biennial average forecast is 1,834 clients. The 2017-19 biennial average is 1,782 clients, which is 2.8 percent lower than the 2015-17 biennial average. As with all MH categories forecasted in this report, the Mandated population includes only adults.

Total Forensic Mental Health Services

The forensic caseload encompasses the Aid and Assist and GEI clients. The 2015-17 biennial average forecast is 859 clients. The 2017-19 biennial average is 861 clients, which is 0.2 percent higher than the 2015-17 biennial average.

Aid and Assist – This caseload exhibited steady growth throughout 2013, 2014, 2015 and into 2016. Aid and Assist currently counts only clients served at the State Hospital. As MH moves toward mobile forensic evaluation teams, Aid and Assist in the State Hospital will likely decrease, but the timing is unknown. The total number served may continue to increase, but we will be unable to forecast that number unless community Aid and Assist data are also tracked and available for analysis. The 2015-17 biennial average forecast is 260 clients. The 2017-19 biennial average is 271 clients, which is 4.2 percent higher than the 2015-17 biennial average forecast.

Guilty Except for Insanity (GEI) – These clients are under the jurisdiction of the Psychiatric Security Review Board and State Hospital Review Panel. Nationally, violent crimes are down despite population growth. For the past several years the Total GEI caseload in Oregon has steadily declined. The 2015-17 biennial average forecast is 599. The 2017-19 biennial average is 590, which is 1.5 percent lower than the 2015-17 biennial average forecast.

Civil Commitments – This caseload has been subject to several data system changes, rendering conclusions about caseload trends variable. For the past two years the caseload has been declining. This may be due in part to the expansion of Medicaid. It is also possible that new investments are helping to reduce this caseload. The 2015-17 biennial average forecast is 975 clients. The 2017-19 biennial average is 921 clients, which is 5.5 percent lower than the 2015-17 biennial average.

Previously Committed – This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000.

About 80 percent of these clients are served in non-residential settings, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings. The 2015-17 biennial average forecast is 2,567 clients. The 2017-19 biennial average is 2,543 clients, which is 0.9 percent lower than the 2015-17 biennial average.

Never Committed – This caseload captures clients receiving mental health services that have not been civilly or criminally committed since the year 2000. More than 99 percent of these clients are served in non-residential settings. The 2015-17 biennial average forecast is 41,244 clients. The 2017-19 biennial average is 43,198 clients, which is 4.7 percent higher than the 2015-17 biennial average.

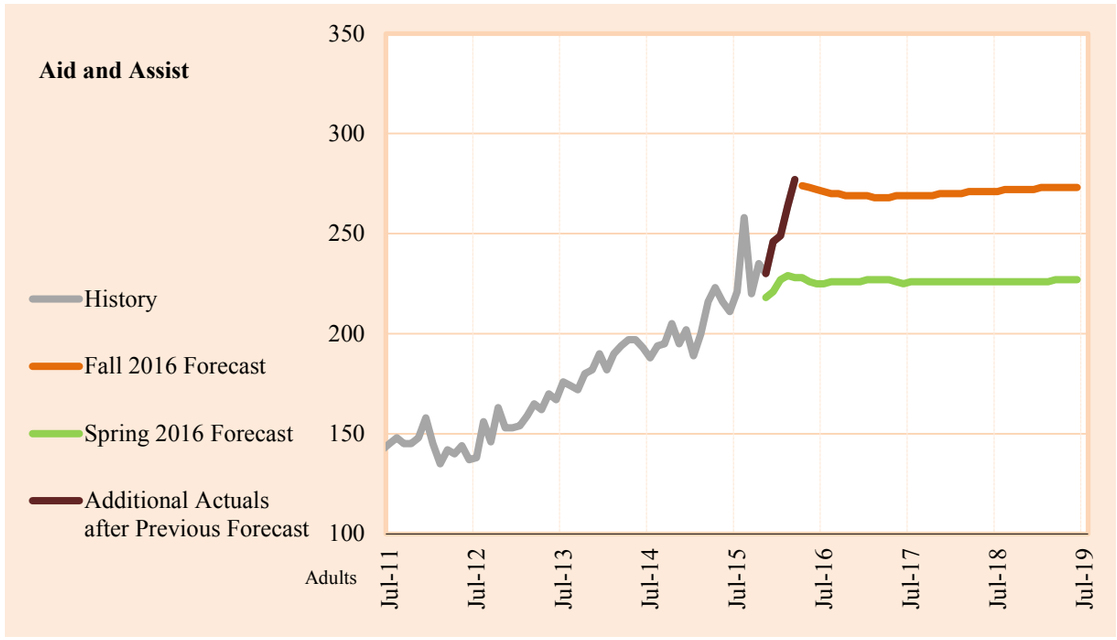
Risks and Assumptions

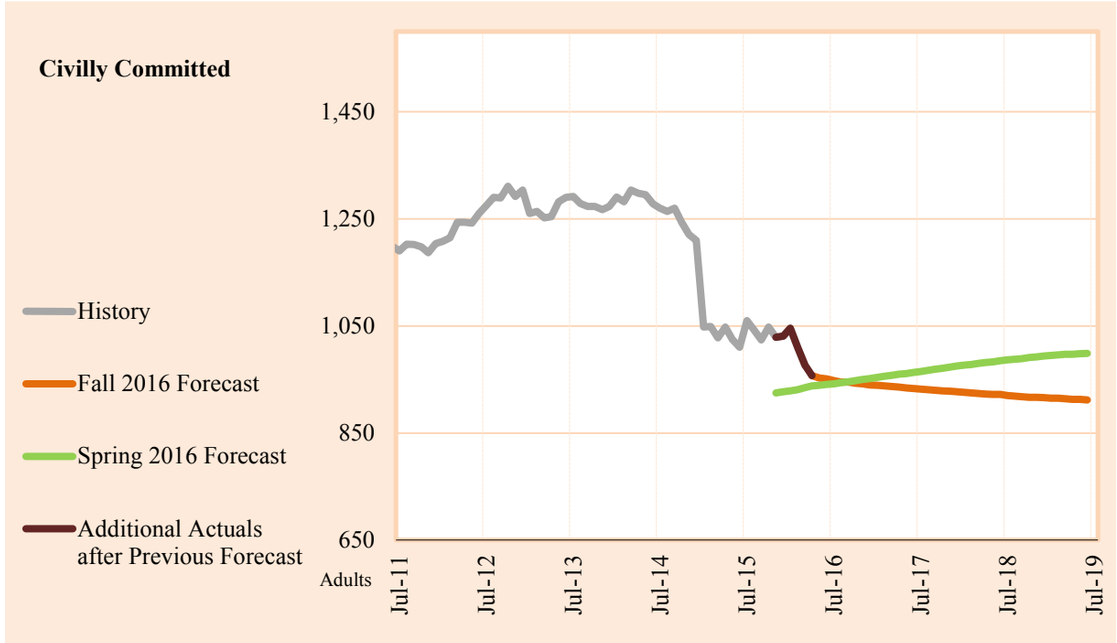
The Aid and Assist caseload may be impacted by community level efforts to keep people out of the State Hospital. In particular, misdemeanor admissions have decreased in Marion County, and this may spread to other counties. Additionally, program leadership is promoting the idea that Aid and Assist can be provided locally, not just at the Oregon State Hospital. Resource development is under way, and funding is going to high-utilizing areas. To the extent this idea gains traction, caseload would under count the actual number served since data are not currently available for Aid and Assist clients served outside the State Hospital.

The Aid and Assist caseload is subject to variation at the county level. For example, differences in police training as well as local judges can affect the Aid and Assist caseload at the Oregon State Hospital.

The Guilty Except for Insanity caseload is subject to review by the Psychiatric Security Review Board and/or the State Hospital Review Panel. When clients are released by the Board/Panel prior to their end of jurisdiction date, the caseload is driven down. Based on end of jurisdiction date alone, January and March of 2017 are expected to have above normal numbers ending jurisdiction.

A major risk to the Civilly Committed caseload is related to the timeliness of reporting. Provider input delays, especially concerning civil commitment data, can lead to artificially low caseload numbers.


Aid and Assist
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
350
300
250
200
150
100
Adults
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19


Civilly Committed
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
1,450
1,250
1,050
850
650
Adults
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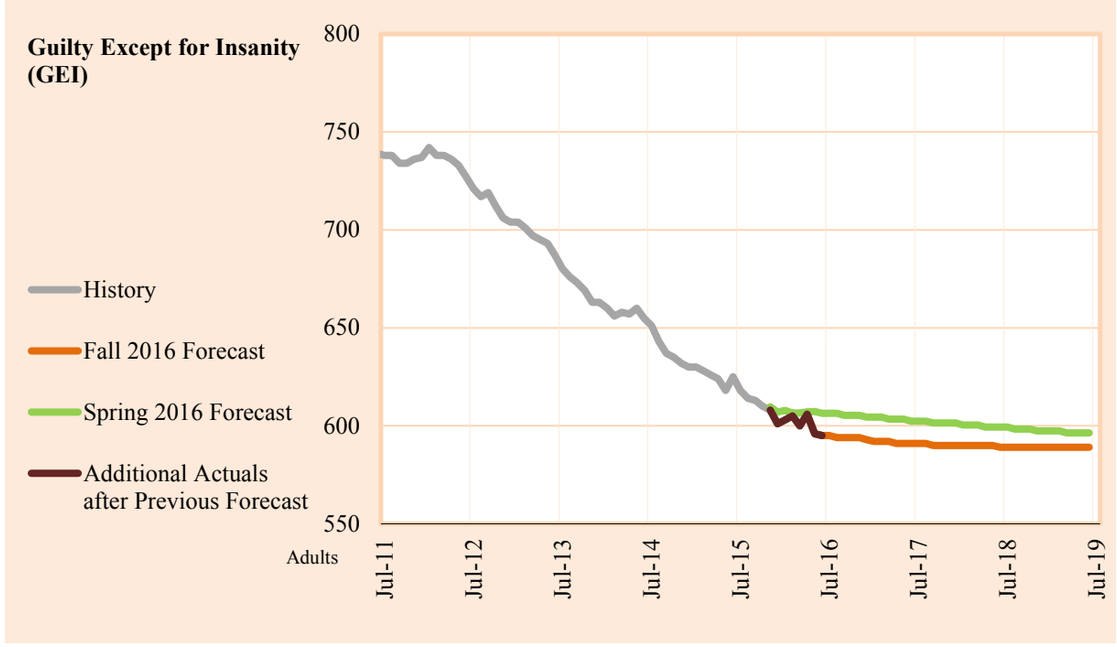
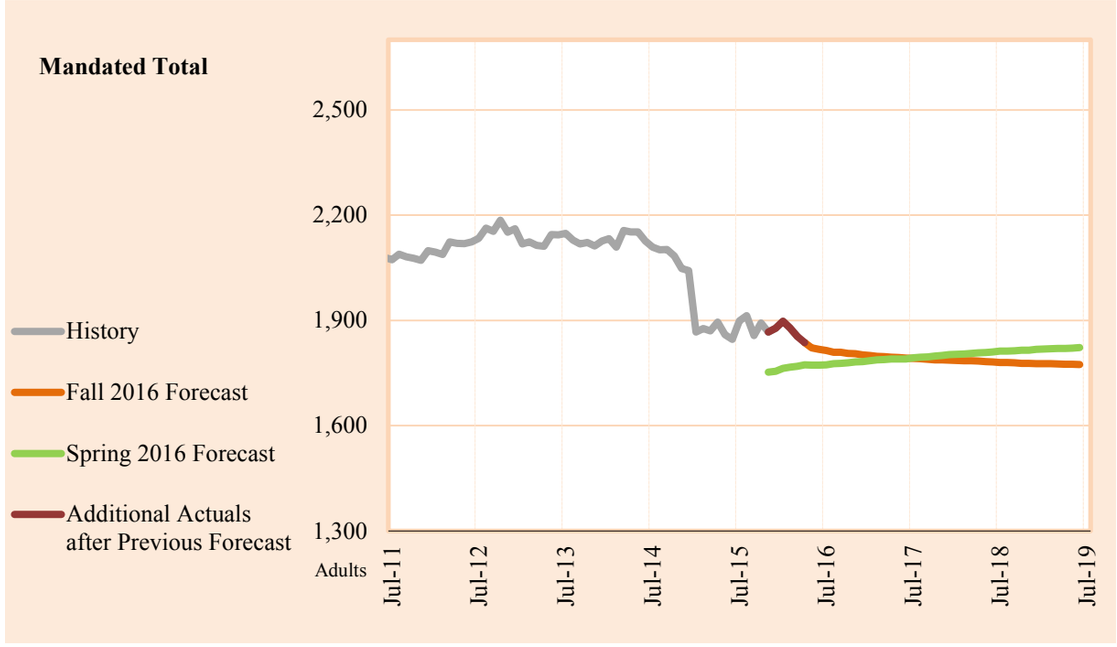
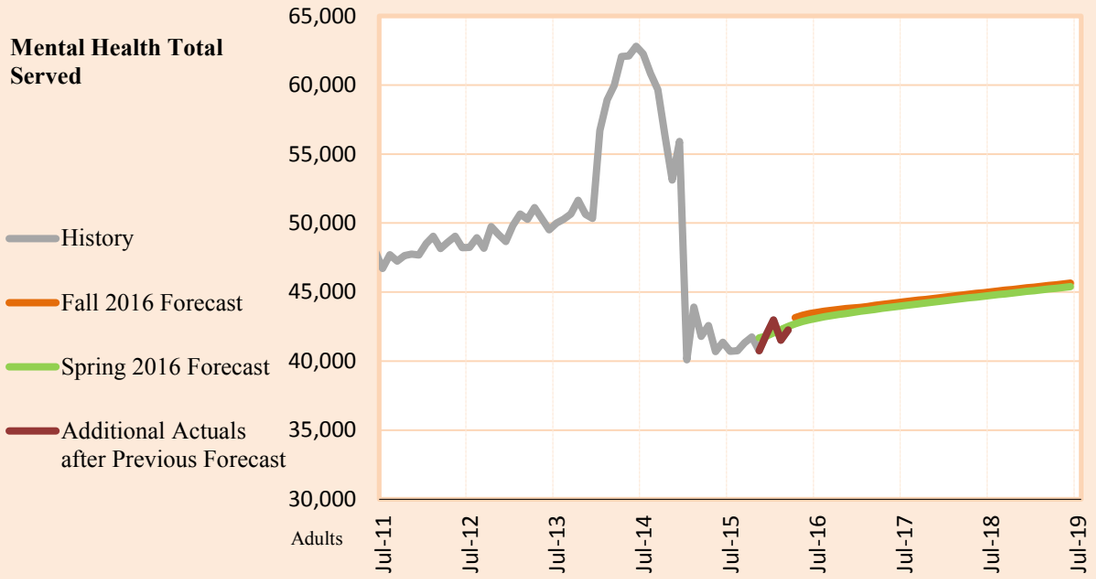
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

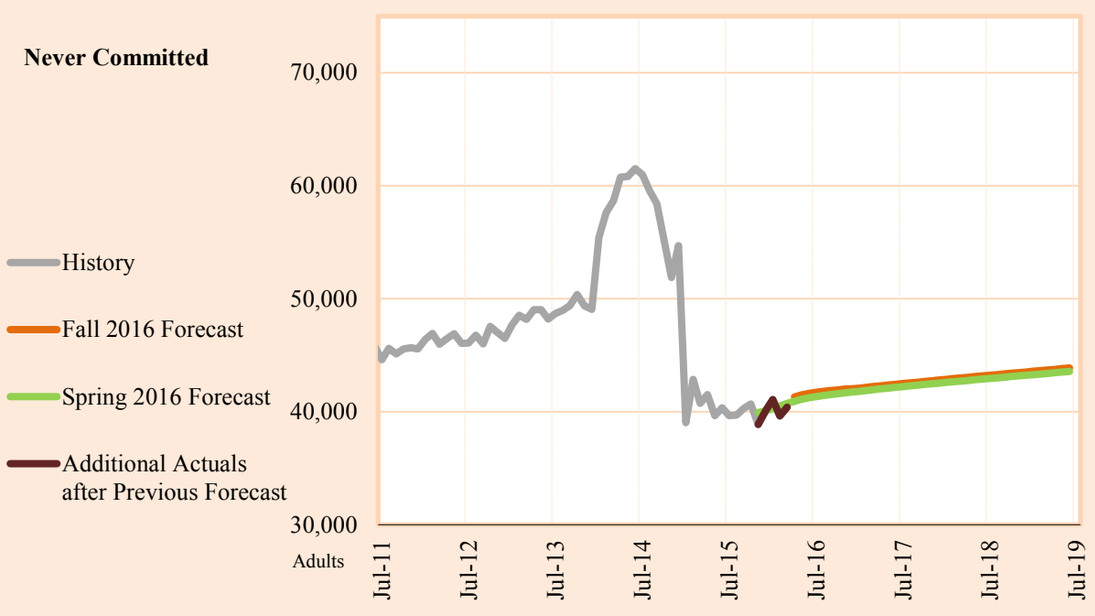

Guilty Except for Insanity (GEI)
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
800
750
700
650
600
550
Adults
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19


Mandated Total
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
2,500
2,200
1,900
1,600
1,300
Adults
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

Mental Health Total Served



Never Committed



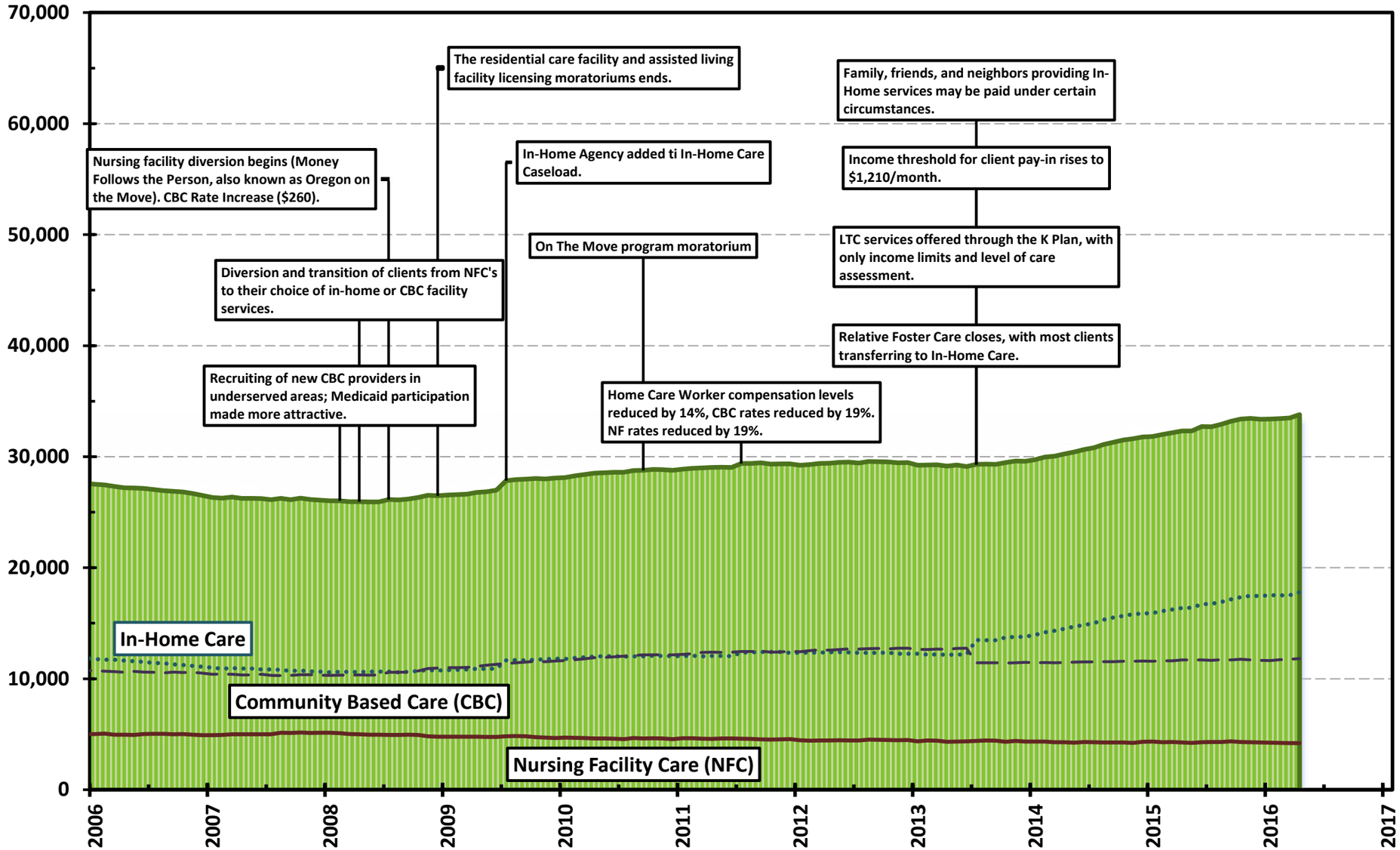
Mental Health Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
MENTAL HEALTH [1]								
Under Commitment								
Aid and Assist	221	260	39	17.6%	260	271	11	4.2%
Guilty Except for Insanity (GEI)	607	599	-8	-1.3%	599	590	-9	-1.5%
Total Forensic Care	**828**	**859**	**31**	**3.7%**	**859**	**861**	**2**	**0.2%**
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	**45,425**	**45,645**	**220**	**0.5%**	**45,645**	**47,523**	**1,878**	**4.1%**

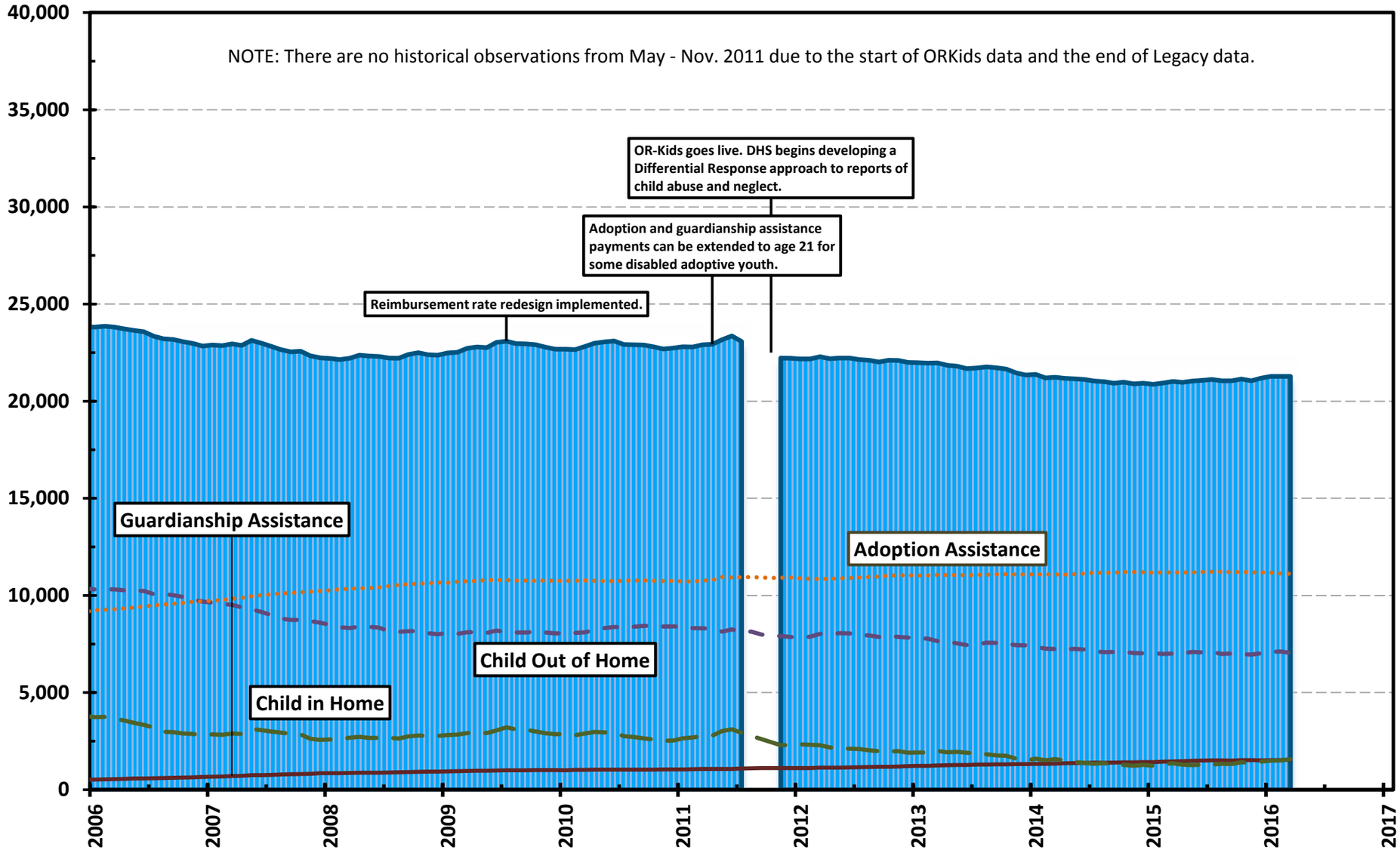
1. Numbers reported represent adults only.

Appendix I
DHS Caseload History & Definitions

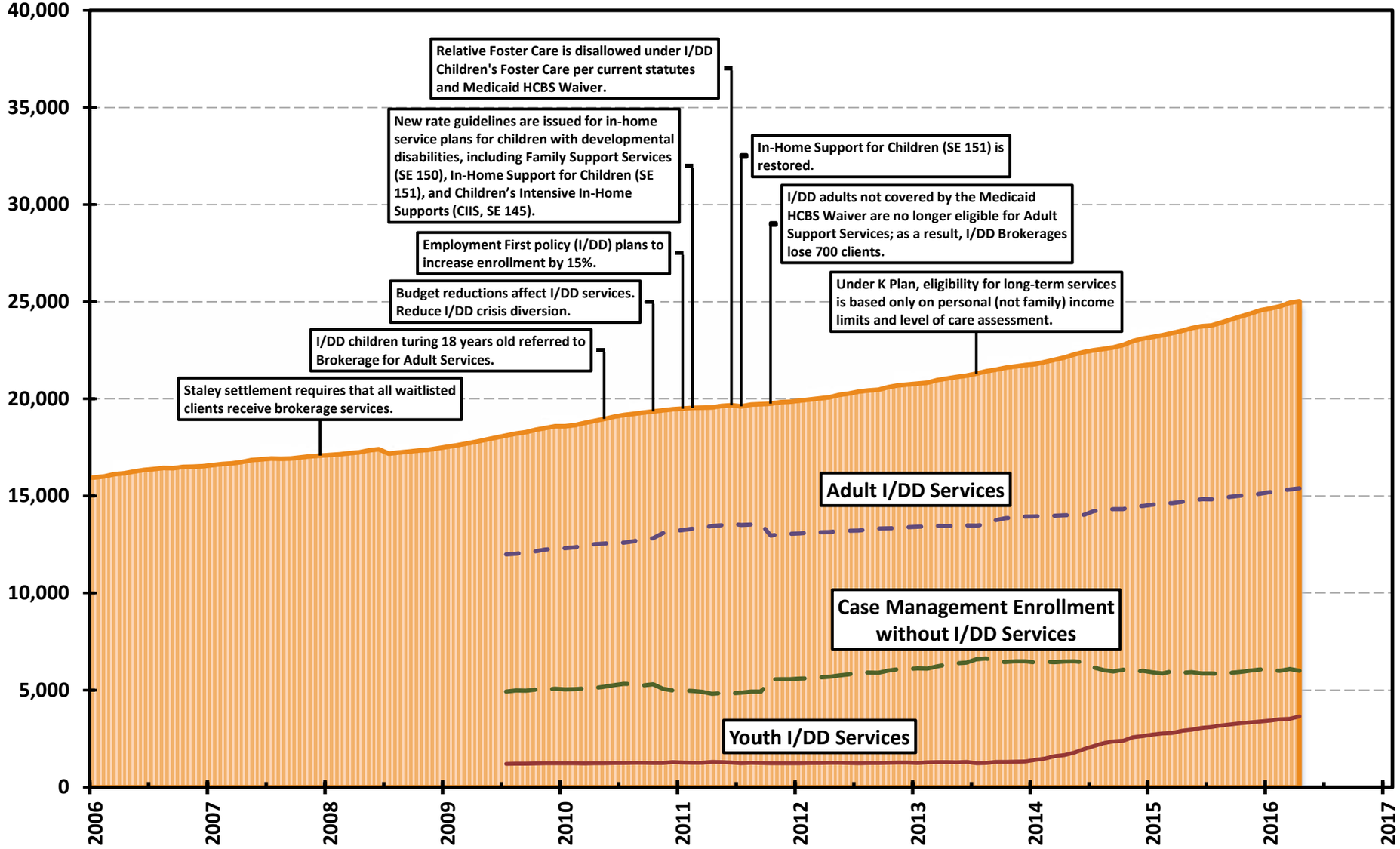
Aging and People with Disabilities (APD) Caseload



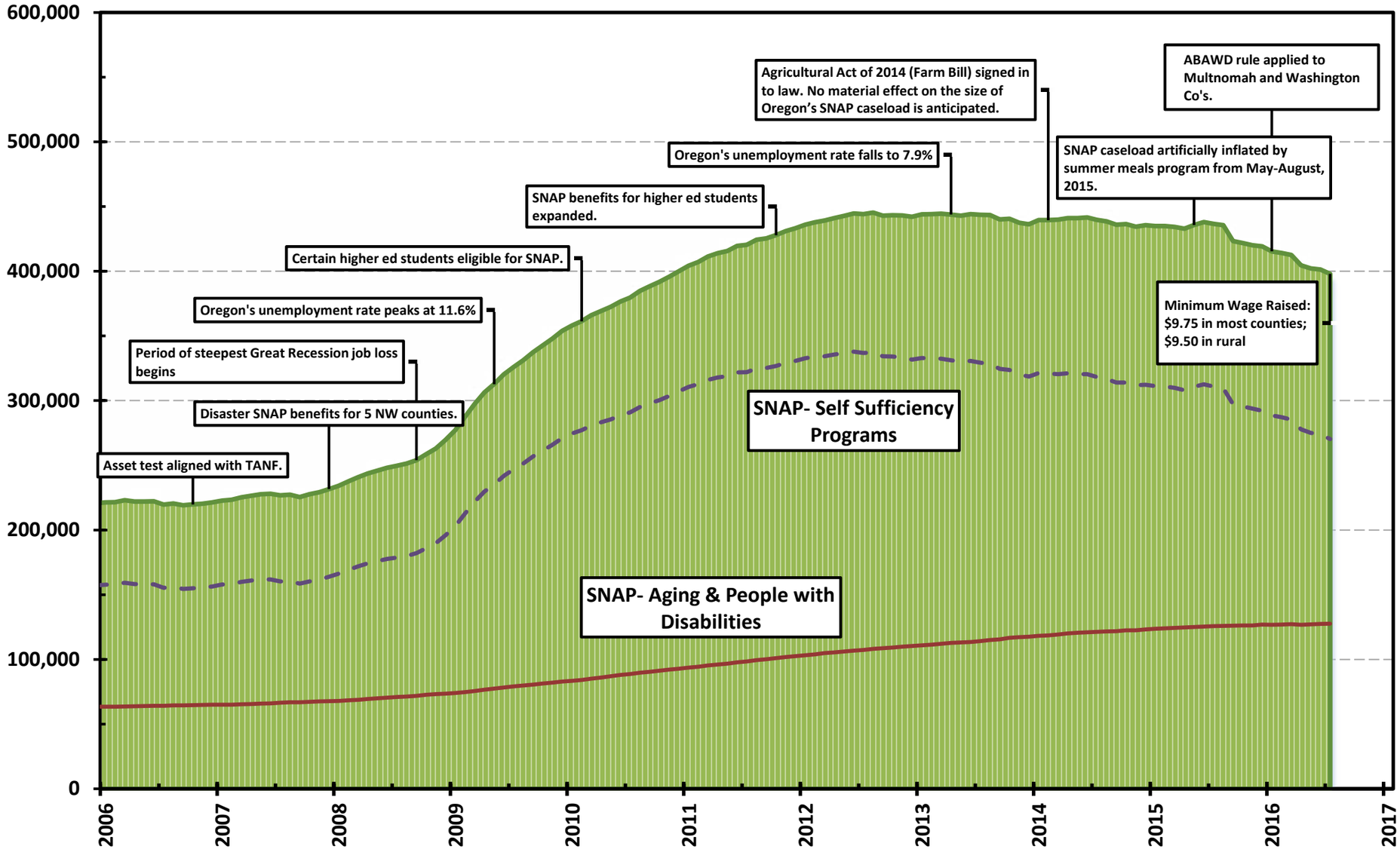
Child Welfare (CW) Caseload



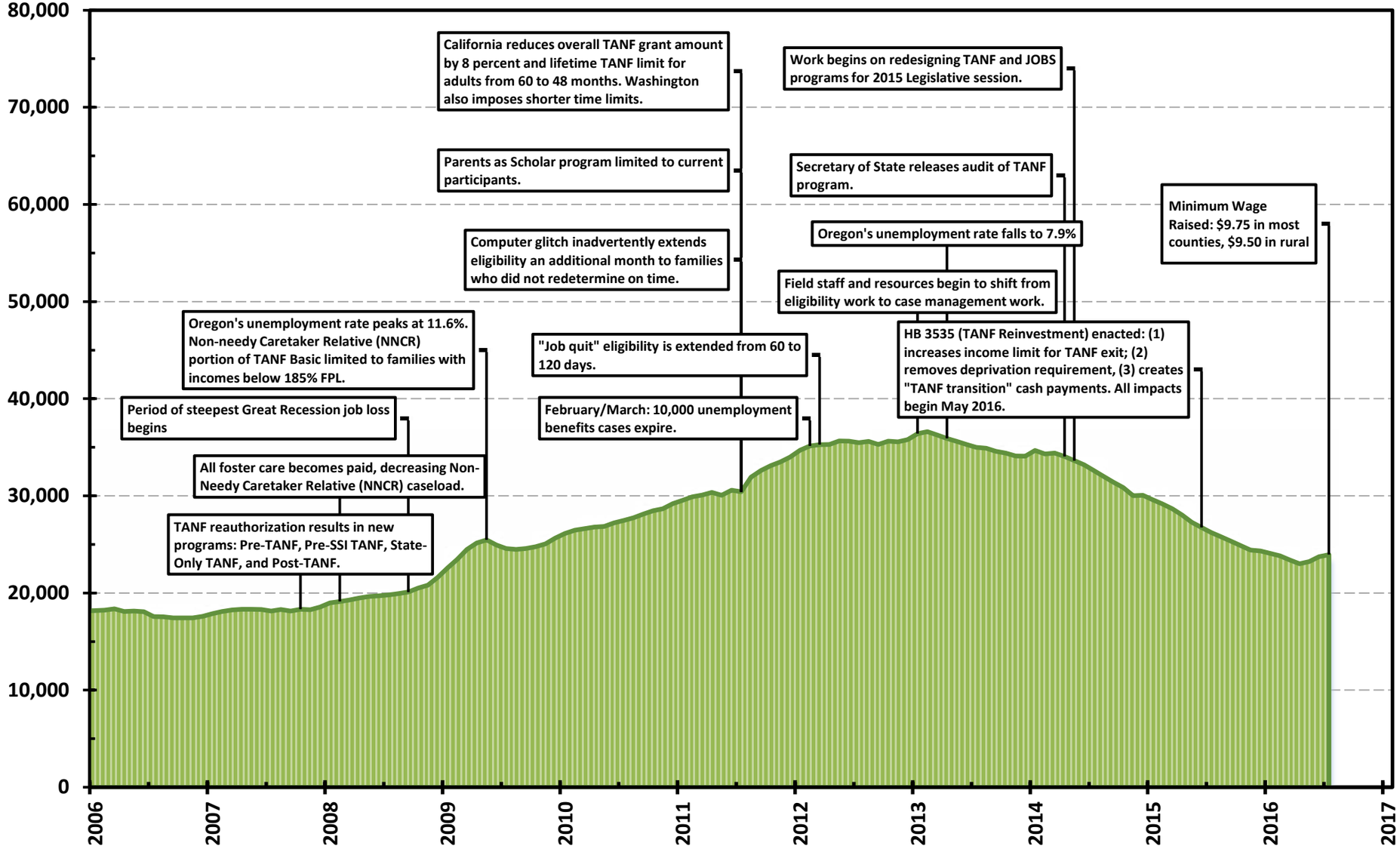
Intellectual & Developmental Disabilities (I/DD): Case Management Enrollment



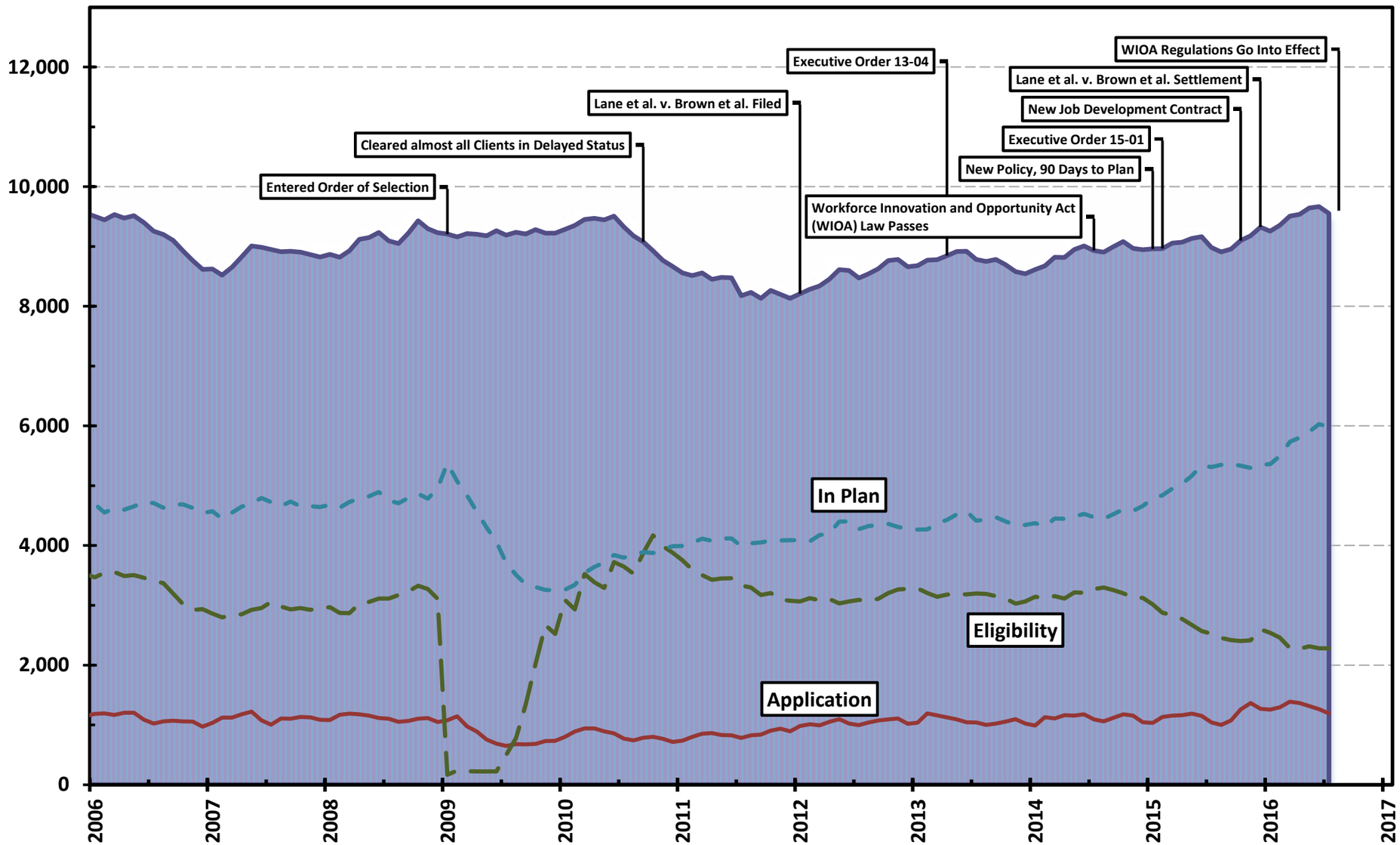
Self Sufficiency Programs (SSP):
Supplemental Nutrition Assistance Program (SNAP) Caseload



Self Sufficiency Programs:
Temporary Assistance for Needy Families (TANF) Caseload



Vocational Rehabilitation



DHS CASELOAD DEFINITIONS

Federal Poverty Level (FPL)

"The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL."

2016 Poverty Guidelines for Oregon

Person in family/ household	Poverty Guideline
1	$11,880
2	$16,020
3	$20,160
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6	$32,580
7	$36,730
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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. To qualify, clients must meet financial and non-financial requirements which vary depending on whether the individual will be covered under K Plan or the HCBS Waiver.

Historically, Oregon's LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver (under the Omnibus Budget Reconciliation Act of 1981), which allows the State to provide home and community-based care alternatives to institutional care such as nursing facilities.

Starting in July 2013, using a new option available under the Patient Protection and Affordable Care Act of 2010 (ACA), Oregon began offering services primarily through the Social Security Act's 1915 (k) Community First Choice Option (referred to as K Plan).

The LTC caseloads are grouped into three major categories: In-Home, Community-Based Care, and Nursing Facilities.

In-Home Programs

In-Home programs provide personal 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.

In-Home Agency

In-Home Agency is an alternative way to purchase in-home care. Under this program, clients contract with an agency for the services they need, and those services are delivered in the client's own home by an employee of the agency. Screening and scheduling are often simpler when working with an agency.

Live-In

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 clients who choose to have their paid care provided by their spouse. Spouses are paid for the services they provide.

Independent Choices

Independent Choices allows clients more control in the way they receive their in-home services. Under this program, clients decide for themselves which services they will purchase, but are also required to keep financial records of the services they've purchased.

Specialized Living

Specialized Living provides care in a home-like setting 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 be served in other Community-Based Care facilities.

State Plan Personal Care (Non-K Plan Medicaid Services)

State Plan Personal Care services are available to people who are eligible for Medicaid, but not eligible for waivered services. Services supplement the individual's own personal abilities and resources, but are limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Community Based Care (CBC)

Community-Based Care caseload includes clients receiving services in licensed, community-based residential settings. Services include assistance with ADLs, medication oversight, and social activities. Services can also include nursing and behavioral supports to meet complex needs.

Assisted Living Facilities

Assisted Living Facilities are licensed 24-hour care settings serving six or more residents that provide private apartments and focus on resident independence and choice.

Adult Foster Care

Adult Foster Care provides long-term care in home-like settings licensed for five or fewer unrelated people. These facilities are open to clients who are not related to the care provider.

Residential Care Facilities

Residential Care Facilities (Regular or Contract) are licensed 24-hour care settings serving six or more residents. These facilities range in size from six beds to over 100. “Contract” facilities are licensed to provide specialized Alzheimer care.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated Medicare/Medicaid program providing all-inclusive care. 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 facilities licensed and regulated by DHS. Nursing facilities provide clients with skilled nursing services, housing, related services and ongoing assistance with activities of daily living.

Basic Care

Basic Care clients need comprehensive, 24-hour care for assistance with ADLs and ongoing nursing care due to either age or physical disability.

Complex Medical Add-On

Complex Medical Add-On clients have medical conditions that require additional nursing services and staff assistance beyond Basic Care.

Enhanced Care

Enhanced Care clients have difficult to manage behavioral issues such as self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, or problematic medication needs that require special care in Nursing Facilities. Some of these clients are also served in community-based care facilities.

Pediatric Care

Pediatric Care clients are children under 21 who receive nursing care in pediatric nursing facility units.

Child Welfare (CW)

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 is counted only once during a month. For children participating in more than one CW program within a month, they are counted in the program highest on the list below:

Adoption Assistance

Adoption Assistance coordinates and supervises adoption for children in foster care who cannot 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.

Intellectual and Developmental Disabilities (I/DD)

Intellectual and Developmental Disabilities programs provide support to qualified adults and children with intellectual and developmental disabilities through a combination of case management and services. Intellectual and Developmental disabilities include intellectual disabilities, 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 include foster homes or residential group home settings.

The forecasted Intellectual and Developmental Disabilities programs are counts of individual clients receiving a program's services within the month. Clients can receive services from more than one program in the same month (for example, from both a residential and a support program).

Case Management Enrollment

Case Management Enrollment provides entry-level eligibility evaluation and coordination services.

The other caseloads are grouped into three broad categories: adult services, children services, and other services.

Adult services

Brokerage Enrollment

Brokerage Enrollment provides planning and coordination of services that allow clients to live in their own home or in their family's home.

24-Hour Residential Care

24-Hour Residential Care provides 24-hour supervised care, training and support services delivered in neighborhood homes.

Supported Living

Supported Living provides individualized support services to clients in their own home based on their Individual Support Plan.

Comprehensive In-Home Services

Comprehensive In-Home Services help individuals aged 18 years or older with intellectual and developmental disabilities to continue to live in their homes.

I/DD Foster Care

Foster Care provides 24-hour care, supervision, provision of room and board, and assistance with activities of daily living for both adults and children (approximately 84 percent and 16 percent respectively).

Stabilization and Crisis Unit

Stabilization and Crisis Unit (previously called State Operated Community Programs) offers safety net services and support to the most vulnerable, intensive, medically and behaviorally challenged I/DD clients when no other community based option is available to them. The program serves both adults and children (approximately 88 percent and 12 percent respectively).

Children's services

In-Home Support for Children

In-Home Support for Children provides services to individuals under the age of 18 in the family home.

Children Intensive In-Home Services

Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their own 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 in neighborhood homes other than the family home or foster care.

Other I/DD services

Employment and Day Support Activities

The caseload previously known as Employment and Day Support has been redefined and given a new title. Employment and Attendant Care Services are out-of-home employment or community training services and related supports provided to individuals 14 or older, to improve the individual's productivity, independence and integration in the community. Examples of services covered within this caseload include: discovery, employment path services, initial and on-going job coaching, individual and small group employment support, and certain types of attendant care.

Transportation

Transportation services have been redefined to include all non-medical transportation services including services provided under Plan of Care (e.g. transit passes and non-medical community transportation).

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 October 1, 2008, the new name for the federal Food Stamp Program is the Supplemental Nutrition Assistance Program (SNAP). Oregon began using the new name on January 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), however most recipients qualify below 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 benefits amounts.

Temporary Assistance for 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 40 percent of FPL) to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, and pursuing treatment for drug abuse or mental health as needed. As of April 2016 proof of deprivation (death, absence, incapacity, or unemployment of a parent) will no longer be a requirement of TANF enrollment.

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.

TANF Employment Payments (EP) are available to those families exiting TANF due to employment. Transition payments are for three months only. TANF EP is currently authorized for the 2015-17 biennium.

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 family 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.

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 (40 percent of FPL; TA-DVS only considers income on hand that is available to meet emergency needs).

Vocational Rehabilitation (VR)

Vocational Rehabilitation Services assess, plan, and coordinate vocational rehabilitation services for people who have physical or mental disabilities and need assistance to obtain and retain employment that matches their skills, potential, and interest. Services are provided through local VR offices across the state. The program provides counseling, training, job placement, assistive technology, and extended services and supports.

VR services involve four stages, each of which are now being forecast:

Application

Clients in the Application stage have completed an application for VR services.

Eligibility

Clients in the Eligibility stage have been determined eligible for VR services and are developing a plan for employment.

In Plan

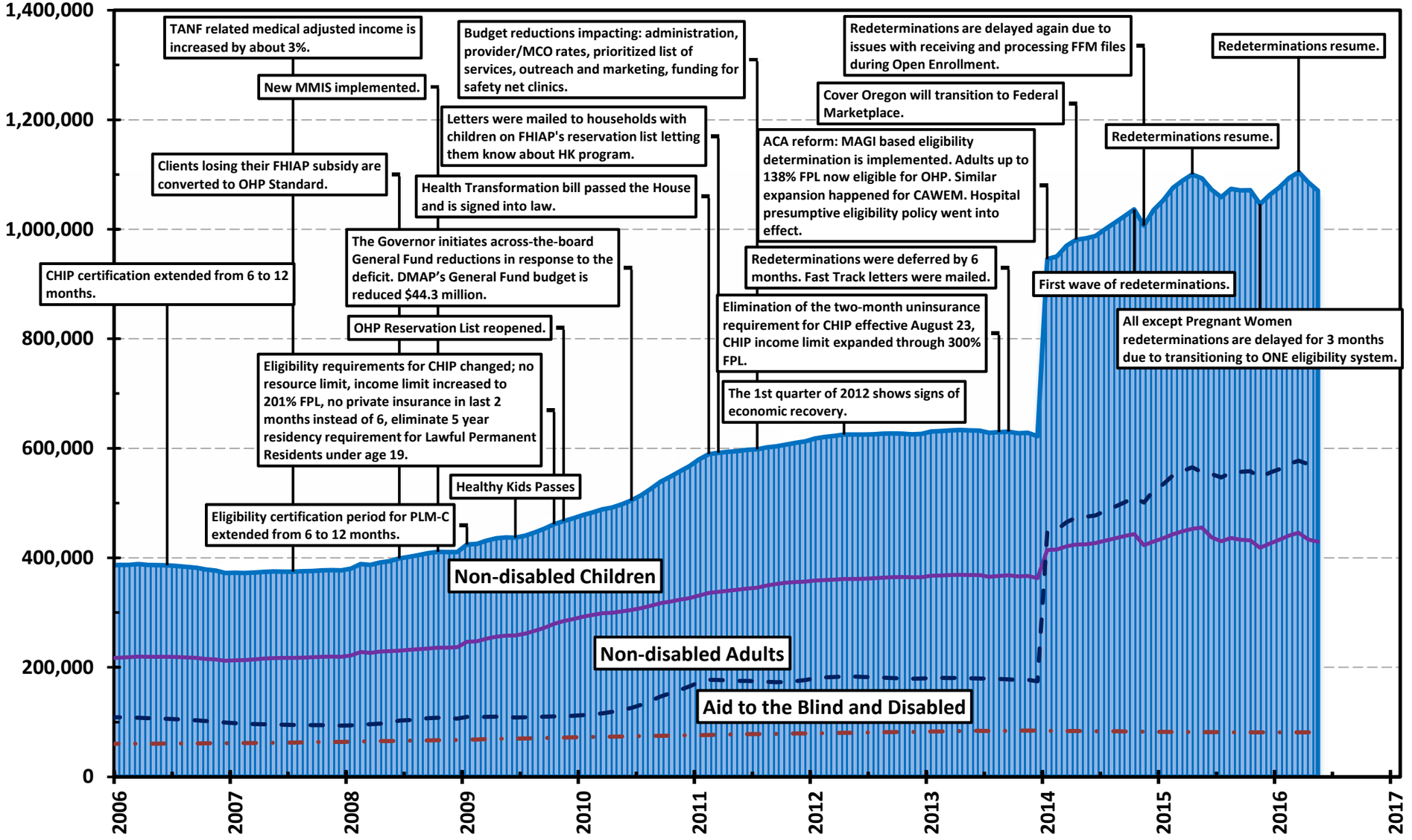
Clients who are In Plan are receiving VR services. After employment and if all is going well, a case is normally closed after 90 days.

Post-Employment Services

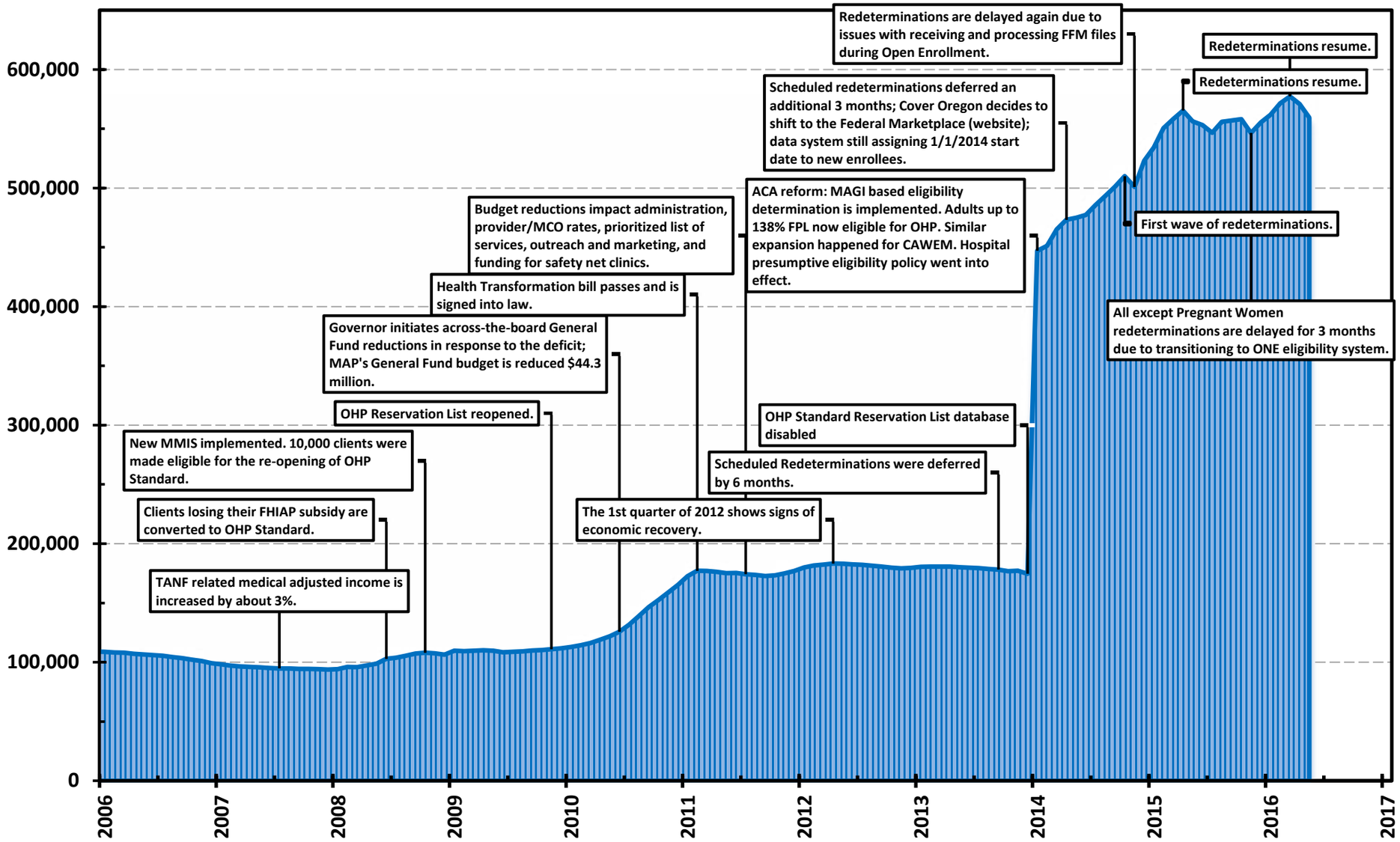
Clients can receive Post-Employment Services after employment if they need help keeping their job or advancing within it. Also, if they need assistance re-obtaining their job if it is lost.

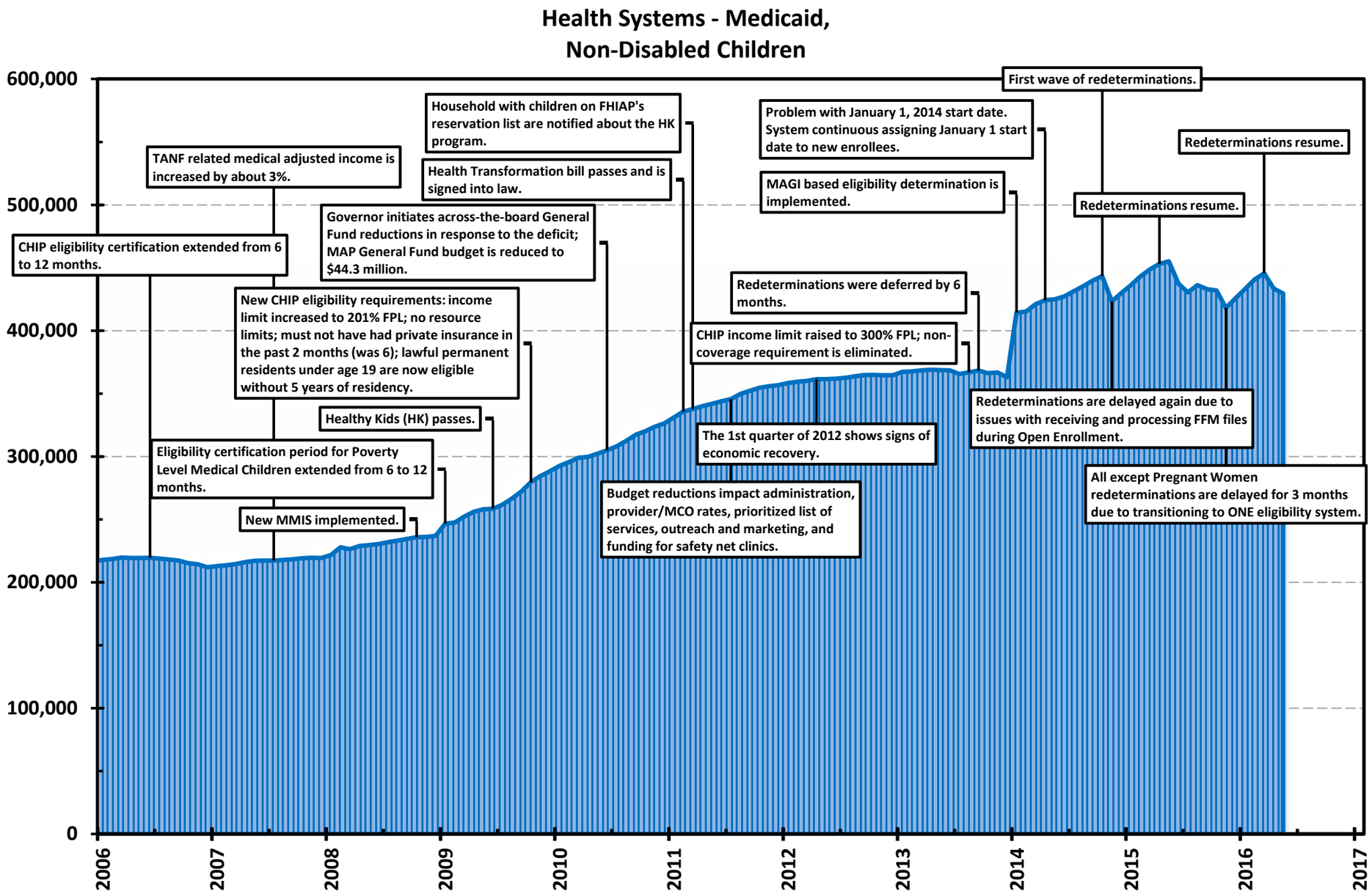
Appendix II
OHA Caseload History & Definitions

Health Systems - Medicaid,
Total Oregon Health Plan - Plus and Standard

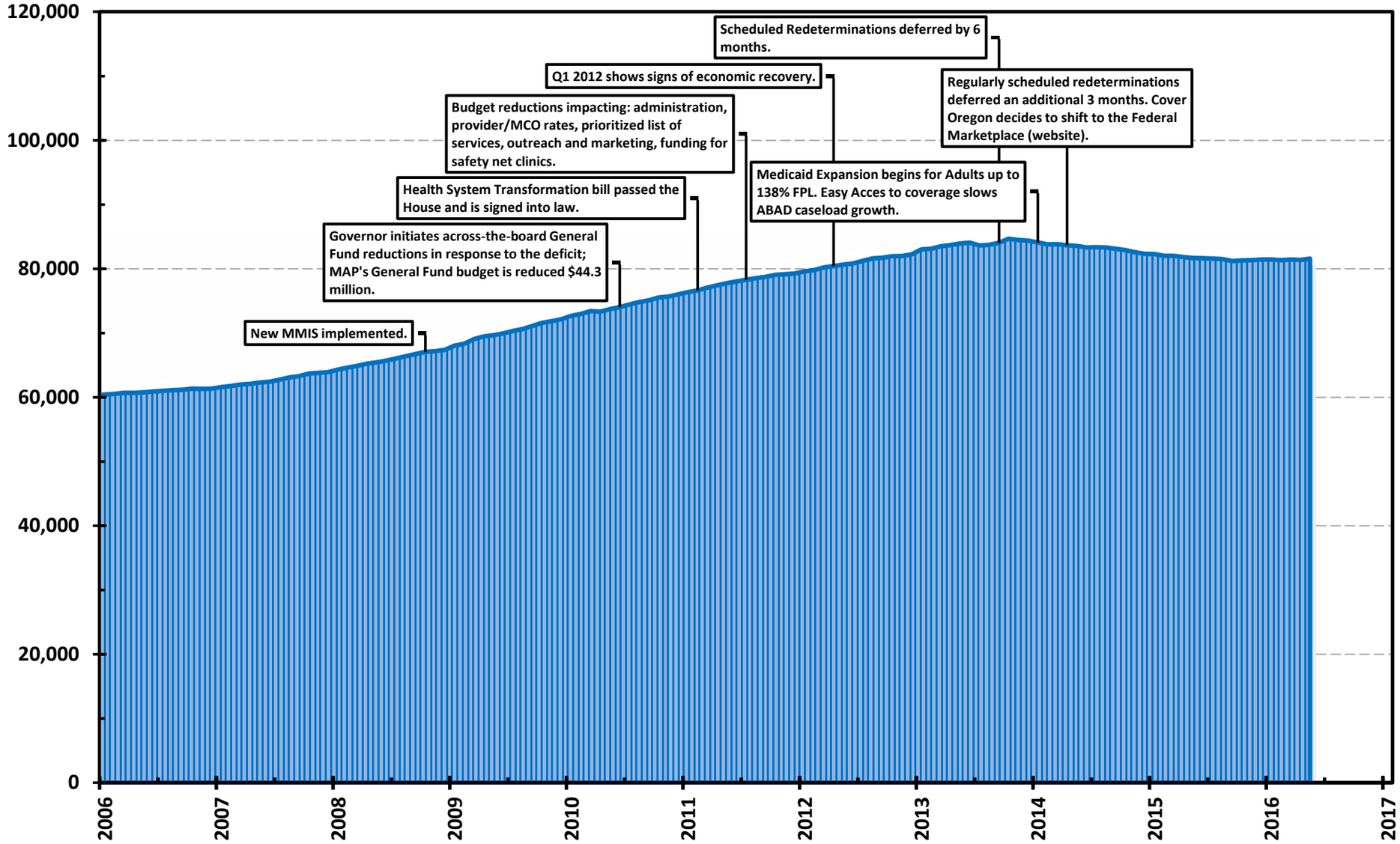


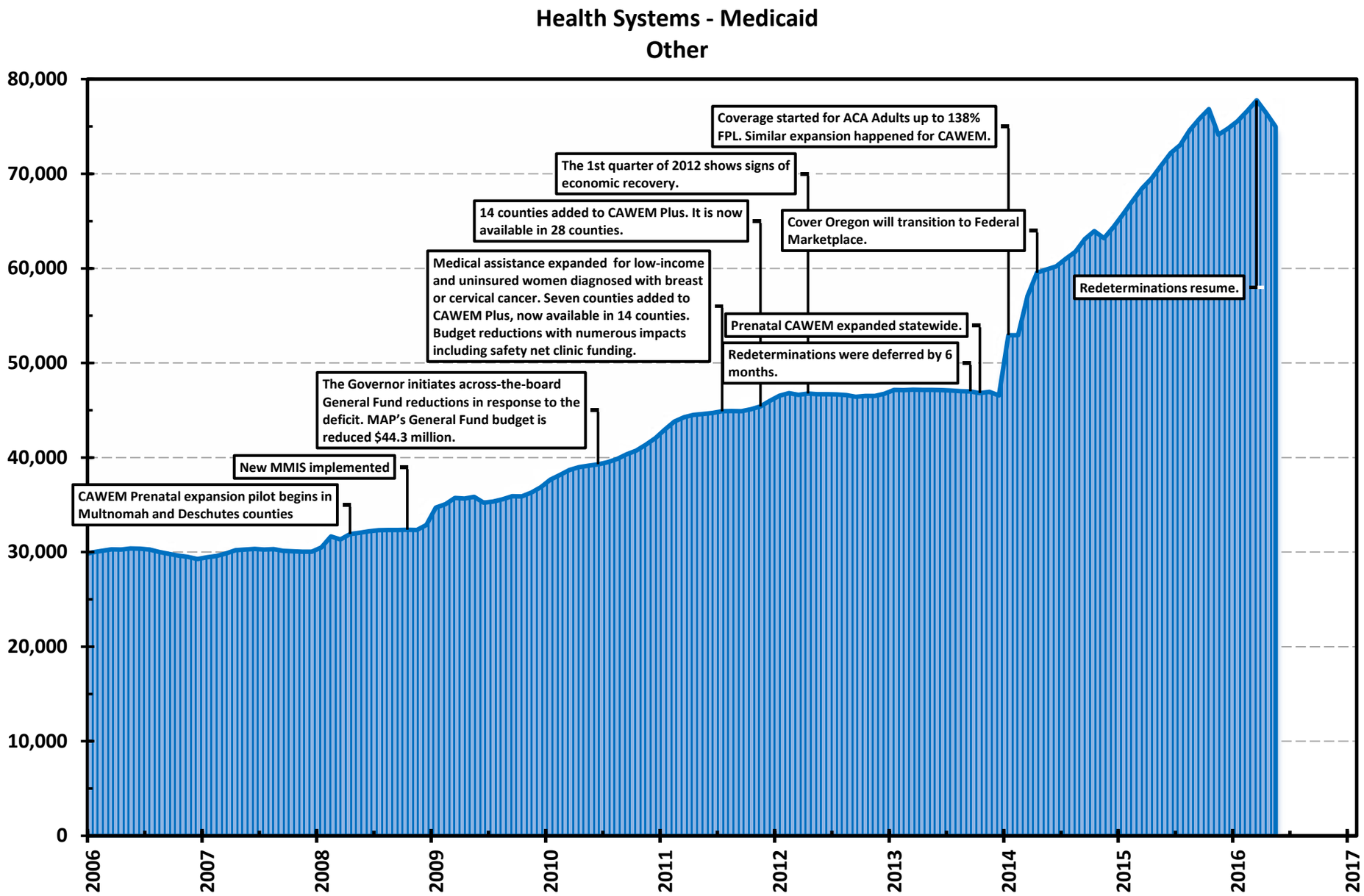
Health Systems - Medicaid, Non-Disabled Adults



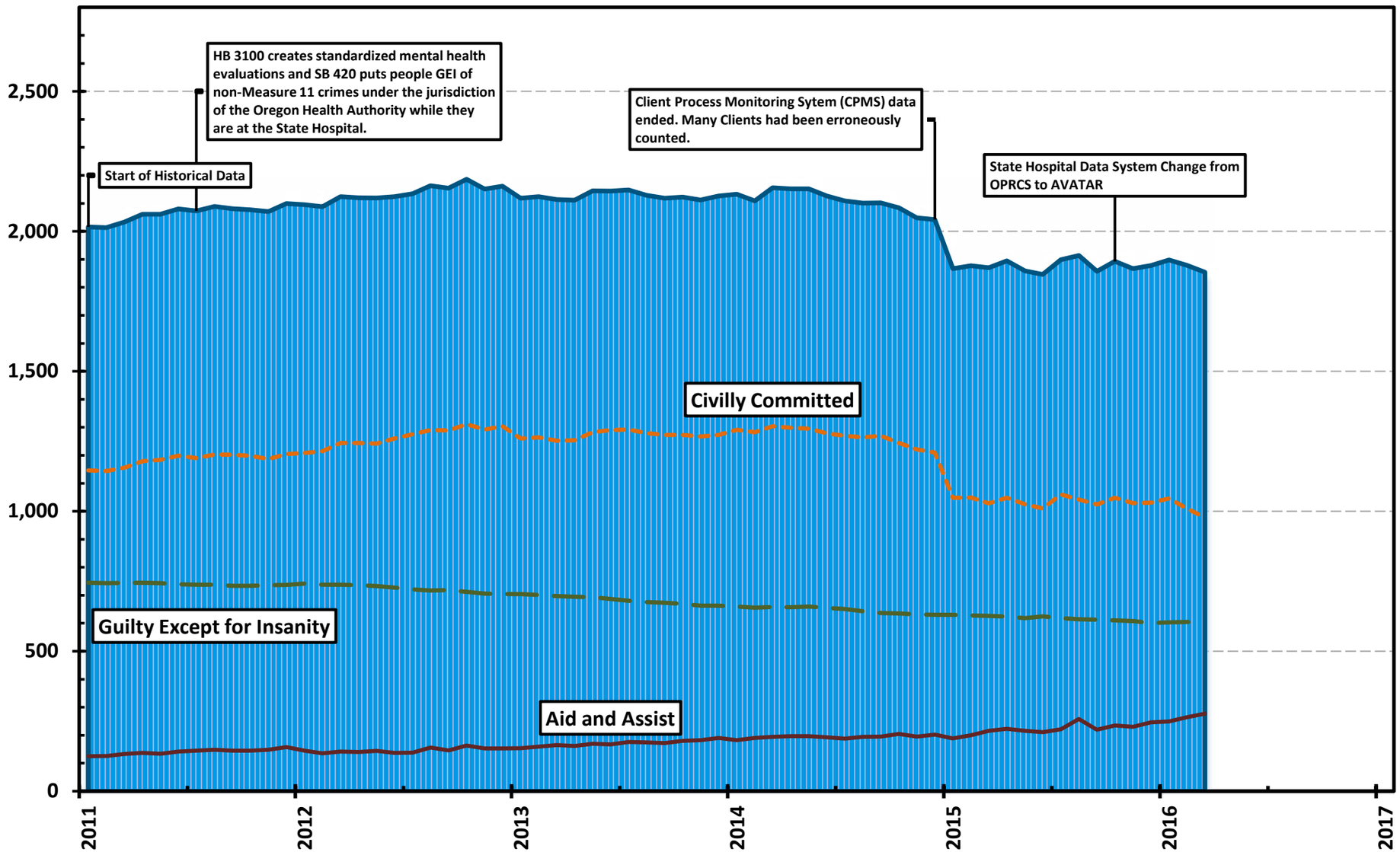

Health Systems - Medicaid,
Non-Disabled Children
600,000
500,000
400,000
300,000
200,000
100,000
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
First wave of redeterminations.
Household with children on FHIAP's reservation list are notified about the HK program.
Problem with January 1, 2014 start date. System continuous assigning January 1 start date to new enrollees.
Redeterminations resume.
TANF related medical adjusted income is increased by about 3%.
Health Transformation bill passes and is signed into law.
MAGI based eligibility determination is implemented.
Redeterminations resume.
Governor initiates across-the-board General Fund reductions in response to the deficit; MAP General Fund budget is reduced to $44.3 million.
CHIP eligibility certification extended from 6 to 12 months.
Redeterminations were deferred by 6 months.
New CHIP eligibility requirements: income limit increased to 201% FPL; no resource limits; must not have had private insurance in the past 2 months (was 6); lawful permanent residents under age 19 are now eligible without 5 years of residency.
CHIP income limit raised to 300% FPL; non-coverage requirement is eliminated.
Redeterminations are delayed again due to issues with receiving and processing FFM files during Open Enrollment.
Healthy Kids (HK) passes.
The 1st quarter of 2012 shows signs of economic recovery.
Eligibility certification period for Poverty Level Medical Children extended from 6 to 12 months.
Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.
All except Pregnant Women redeterminations are delayed for 3 months due to transitioning to ONE eligibility system.
New MMIS implemented.

Health Systems - Medicaid, Aid to the Blind and Disabled




Health Systems - Medicaid
Other
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
CAWEM Prenatal expansion pilot begins in Multnomah and Deschutes counties
New MMIS implemented
The Governor initiates across-the-board General Fund reductions in response to the deficit. MAP's General Fund budget is reduced $44.3 million.
Medical assistance expanded for low-income and uninsured women diagnosed with breast or cervical cancer. Seven counties added to CAWEM Plus, now available in 14 counties. Budget reductions with numerous impacts including safety net clinic funding.
14 counties added to CAWEM Plus. It is now available in 28 counties.
The 1st quarter of 2012 shows signs of economic recovery.
Coverage started for ACA Adults up to 138% FPL. Similar expansion happened for CAWEM.
Prenatal CAWEM expanded statewide.
Redeterminations were deferred by 6 months.
Cover Oregon will transition to Federal Marketplace.
Redeterminations resume.

Mental Health (MH):
Total Mandated Mental Health Caseload (Adults)



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7	$36,730
8	$40,890

Health Systems - Medicaid (HSM)

The Health Systems Division coordinates physical, oral, and behavioral health services funded by Medicaid.

Historically, Medicaid programs were 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 Medicaid – programs that provide medical benefits but are not considered part of OHP.

Starting in January 2014 there are only two major categories since OHP Standard was discontinued. At that time, all OHP Standard clients were moved to the new ACA Adults caseload group, where they became eligible for OHP Plus benefits.

OHP Plus Benefit Package

The OHP Plus package offers comprehensive health care services to adults and children who are eligible under Medicaid or CHIP rules. The new ACA Adults caseload also receives this benefit package.

ACA Adults

This is a new caseload which represents the expansion of Medicaid under the United States Federal Patient Protection and Affordable Care Act of 2010 (ACA). This caseload includes citizens 18 to 64 years old with incomes up to 138 percent of FPL, who are not pregnant or disabled. ACA Adults are currently divided into two subcategories: ACA Adults with Children, and ACA Adults without Children. In the future, the subcategories may be changed to age cohorts.

Pregnant Women

This is the new name for Poverty Level Medical Women (PLMW).

This program provides medical coverage to pregnant women with income levels up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth.

Parent/Caretaker Relative

This is a new caseload comprised of adults who would previously have been included in the Temporary Assistance for Needy Families caseloads (TANF Related Medical and TANF Extended). Parent/Caretaker Relative offers OHP Plus medical coverage to adults with children who have incomes not exceeding approximately 42 percent of Federal Poverty Level (FPL).

Temporary Assistance for Needy Families (TANF)

Clients from this caseload were transferred to two other caseloads: adults were transferred into Parent/Caretaker Relative caseload and children - into Children's Medicaid caseload.

Children's Medicaid

The Children's Medicaid offers OHP Plus medical coverage to children from birth through age 18 living in households with income from 0 to 133 percent of Federal Poverty Level (FPL). This is a new caseload comprised of children who would previously have been included in three other caseloads: children from the Poverty Level Medical Children caseload (PLMC), children from the TANF Medical caseloads (TANF-RM, TANF-EX), and children from lower income CHIP households.

Poverty Level Medical Children (PLMC)

This caseload has been renamed to Children's Medicaid and the income rules were widened to include children previously included in other caseloads.

Children's Health Insurance Program (CHIP)

This caseload has been redefined. This caseload now covers uninsured children from birth through age 18 living in households with income from 134 to 300 percent of FPL.

Previously, this caseload covered children from households with income from 100 to 200 percent of FPL.

Foster, Substitute Care and Adoption Assistance

Foster, Substitute Care and Adoption Assistance provides medical coverage through Medicaid for children in foster or substitute care and children whose adoptive families are receiving adoption assistance services. Clients are served up to age 21, with the possibility of extending coverage to age 26 depending on client eligibility.

Aid to the Blind and Disabled Program (ABAD)

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). The income limit is 100 percent of the SSI level (roughly 75 percent of FPL), unless the client also meets long-term care criteria, in which case the income limit rises to 300 percent of SSI (roughly 225 percent of FPL).

Old Age Assistance (OAA)

Old Age Assistance provides medical coverage through Medicaid for individuals who are age 65 or over and eligible for federal SSI.

OHP Standard Benefit Package (discontinued December 31, 2013)

This program has ended, with clients transferred to the new ACA Adults caseload. Prior to ACA, clients in OHP Standard were not eligible for traditional Medicaid programs. OHP Standard provided a reduced package of services compared to the OHP Plus program. OHP Standard also required participants to share some of the cost of their medical care through premiums and co-payments.

Other Medicaid (Non-OHP Benefit Packages)

Citizen/Alien Waived Emergent Medical (CAWEM)

Citizen/Alien Waived Emergent Medical is a program that covers emergent medical care for individuals who would qualify for Medicaid if they met the citizenship/residency requirements. The program has two subcategories:

- Regular (CAWEM CW) which provides only emergency medical care.
- Plus (CAWEM CX) which also covers all pre-natal medical services (plus up to 2 months postpartum).

Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. Clients in this caseload have incomes from 100 percent of SSI (roughly 75 percent of FPL) to 100 percent of FPL, and do not meet the criteria for medical covered long-term care services. OHA pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductible not exceeding the Department's fee schedule.

Breast and Cervical Cancer Treatment Program (BCCTP)

Historically, BCCTP provided medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Program administered by Public Health through county health departments and tribal health clinics. Effective January 1, 2012, women do not need to be enrolled for screening through the Breast and Cervical Cancer Program in order to access BCCTP. After determining eligibility, the client receives full OHP Plus benefits. Clients are eligible until reaching the age of 65, obtaining other coverage, or ending treatment. This program is available for both citizens and non-citizens/aliens.

Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance

Medicare Part A covers *inpatient services*, such as inpatient stays and emergency visits. It is free for Medicare eligible individuals except for those who don't have sufficient work history. Thus, **Medicare Part-A Premium Assistance Program** is a subsidiary program offered by HSM to help low-income individuals (under 100 percent of FPL) to pay for the premiums when free Medicare coverage is not available due to insufficient work history.

Medicare Part B Premium Assistance

Medicare Part B coverage is for outpatient services, such as routine check-ups and physical therapy. Medicare eligible individuals have an option to subscribe, but they are required to pay a premium. **Medicare Part B Premium Assistance Program** offered by HSM is a subsidiary program available to low-income individuals (under 133 percent of FPL) and it pays for the premiums.

Part A and Part B Premium Assistance caseloads are not mutually exclusive. For the most part, those who receive Part A premium assistance also receive Part B premium assistance. Likewise, Medicare Part A/Part B premium assistance caseloads are not grouped under OHP or Other caseloads, because most of the individuals with Part A/Part B premium assistance have already been counted in one of our traditional Medicaid caseloads (OAA, ABAD, and QMB). There is a segment that is not in the traditional Medicaid caseloads. They are in Specified Low Income Medicare Beneficiary (SLIMB) or Qualified Individual (QI) groups that we track, but do not forecast . Lastly, there is a slight discrepancy in counts between people on the Medicaid caseload who have Medicare, and those who receive premium assistance.

Mental Health (MH)

The Mental Health program provides prevention and treatment options for clients with mental illnesses.

The MH caseload forecast is the total number of adult clients receiving government paid mental health services per month. MH provides both Mandated and Non-Mandated mental health services, some of which are residential.

Total Mandated Population

Mandated caseloads include 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 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.

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 for psychiatric assessment and treatment until they are fit to stand trial. “Fitness to Proceed” means that the client is able to assist the attorney and stand trial.

Guilty Except for Insanity (GEI)

Clients in GEI caseloads have been found “guilty except for insanity” of a crime by a court. The GEI caseload includes clients who are under the jurisdiction of the Psychiatric Security Review Board as well as clients at the State Hospital who are under the jurisdiction of the State Hospital Review Panel. OHA 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.

Civil Commitment

This caseload includes individuals currently under commitment (although a proxy rule is currently being used to estimate the end date for clients’ mandated service). 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. They may be served at the State Hospital or in the community.

Previously Committed

The Previously Committed caseload includes people who were previously either civilly or criminally committed but whose commitment period has ended. These clients continue to receive individual services, counseling, training, and/or living supports. About 80 percent of these clients are served in non-residential settings.

Never Committed

The Never Committed caseload includes people who have never been either civilly or criminally committed but who are receiving mental health services either in the community or in a residential setting. About 99 percent of these clients are served in non-residential settings. Clients in the State Hospital are of a voluntary or voluntary by guardian status.

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 503-947-5185 or 503-378-2897 for TTY.

FALL 2016 DHS|OHA REGIONAL FORECASTS BY DISTRICT

Budget, Planning and Analysis
Office of Forecasting, Research and Analysis

DECEMBER 2016

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FALL 2016 DHS|OHA REGIONAL CASELOAD FORECAST

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, we hope 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 DHS service district, as well as district totals. The result is a forecast for all 36 Oregon counties for 15 different caseloads within the Oregon Department of Human Services and the Oregon Health Authority.

The results of the DHS and OHA statewide biennial forecasts are also included in this document in order to provide a contrast to the county and district forecast values. For more information, see the Fall 2016 DHS/OHA Caseload Forecast.

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 June 2019. This is especially true for counties with small populations where a modest increase in caseload represents a major percentage increase.

Changes to Forecasted Caseloads and Risks to Accuracy

Starting in January 2014, the Oregon Health Authority implemented several significant changes in how Medicaid is delivered due to the federal Patient Protection and Affordable Care Act of 2010 (ACA). The ACA mandates that eligibility for Medicaid caseloads be extended to higher income levels. As a result of this expansion, several programmatic changes occurred in Oregon Health Plan (OHP) Plus.

There are multiple unknowns at play when estimating participation in a new program and reformulating existing ones. Chief among them is the rate at which new clients will choose to take advantage of expanded eligibility. Another challenge is the fact that the historical patterns normally utilized for forecasting are disrupted and new patterns may take several years to emerge. The likelihood of forecast error, therefore, is larger than for established programs – particularly given the scale of change. Under these circumstances, error at the county level is magnified.

Changes in the economy are a persistent risk to the accuracy of all forecasted caseloads. The State of Oregon's Office of Economic Analysis has stopped using the term "full throttle growth" to describe the state of Oregon's economy. Employment is still expected to continue to grow in 2017, but in a less vigorous way than the previous two years. Growth is expected to moderate from mid-2017 through 2019 as baby-boomers retire. The influence of an expanding economy can in many ways be as difficult to predict as a recession. The economy of the Portland Metro area is expanding strongly, as it usually does in good times. In other parts of the state, expansion is more uneven. In some areas, expansion is modest at best. This is understandable given that different parts of the state have different economic and employment resources to draw on. These local differences add another level of risk to forecast accuracy at the county level.

Special Section

There is a two-part special section in this document that looks at the future of Long Term Care (LTC). The first section estimates the increase in LTC that will occur in the next 30 years based on demographics alone. The second half looks at variables other than demographics that can influence Long Term Care, such as average retirement income and the number of people age 50 and older on SNAP. The point of this section is not to create a Long Term forecast, but instead show how much demographics and other variables will influence LTC, especially in the next 15 years, when the number of seniors in Oregon will double.

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 follow the statewide trend could be distorted to match the expected statewide pattern. As patterns at the county level are better understood, forecasts will become more accurate.

Goodness-of-fit was determined for each program's forecast by summing 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 different 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, "American Community Survey" 5 year (2011-2015) estimates;
- The Oregon Employment Department's "Oregon Labor Market Information System," "Current Employment Statistics" and "Labor Force and Unemployment by Area" data, November, 2016;
- The Portland State University Population Research Center, "Population Estimates by Age Group (less than 18 Years, 18-64 Years, and 65 Years and Older)": July 1, 2013;
- Oregon Economic and Revenue Forecast December, 2016, Volume XXXVI, No.4.

The Furture of Long Term Care

Around the office we've been getting more and more questions about the impact of demographics on our caseloads – most especially the Long Term Care caseload. "Long Term Care" is the broad term for aid to people with rather severe disabilities that qualify them for nursing facility care. Not everyone finds a nursing home desirable, however. A lot of people in Long Term Care are receiving services in their own homes; others are in settings like adult foster care. When we get questions about the relationship between demographics and Long Term Care, it's always with the assumption that age-related disabilities drives the caseload. That requires a "yes, but…" kind of answer. First, a third of all people in Long Term Care are non-elderly – that is, they are under age 65 (see Table 1). So age-related disabilities only drives a portion of this caseload. Second, the number of people in care through the Department of Human Services is a portion of the overall number of people who receive Long Term Care. According to the Census Bureau, over 140,000 Oregonians reported "self-care difficulty."[1] Although that's an imperfect measure of the number of people who need Long Term Care, it is indicative of the fact that our agency provides services to the disabled and needy – a subset of a larger population.

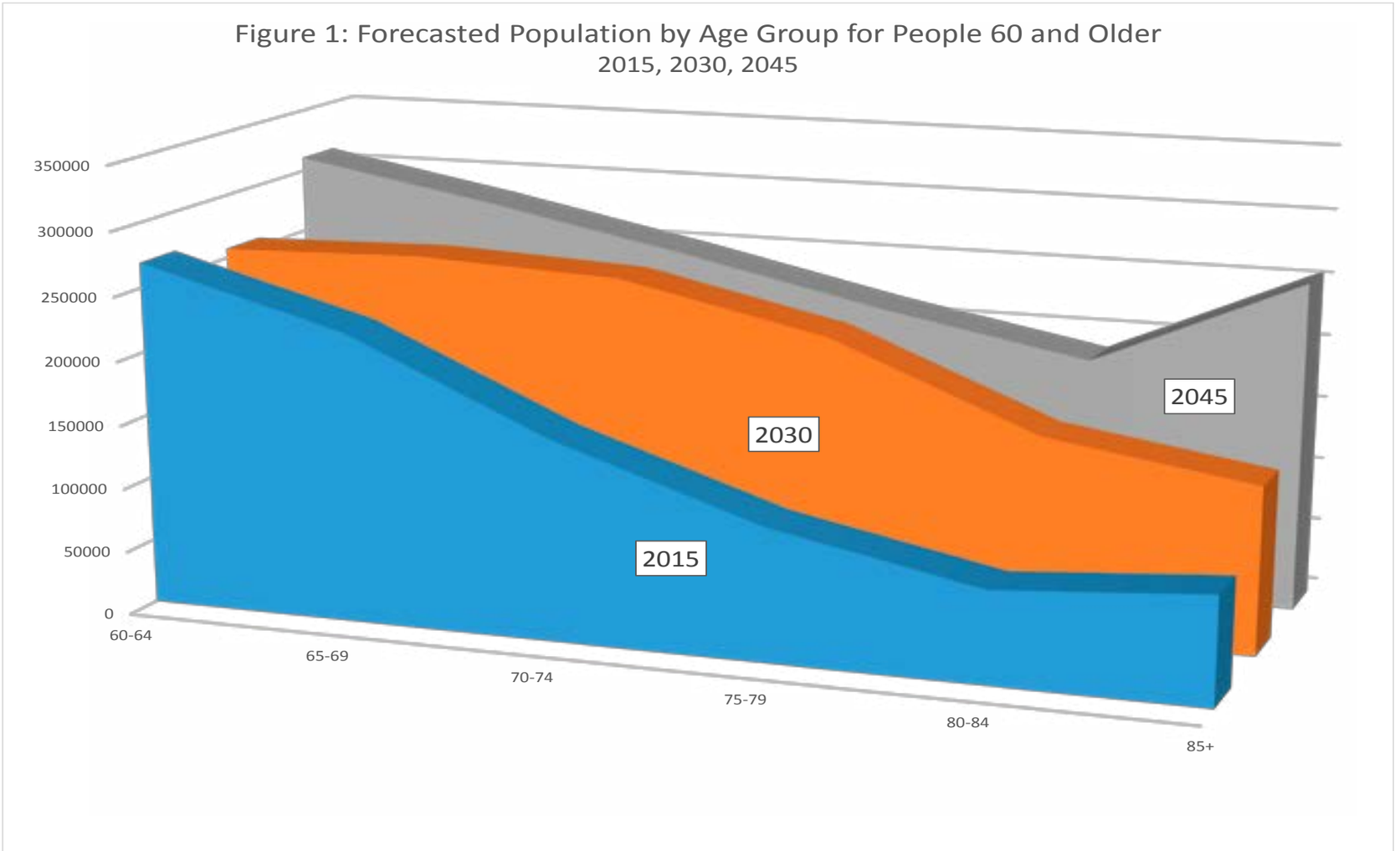
Table 1: Long Term Care Average Monthly Caseload, 2015

Age Group	Count	Percent
Under 50	3,383	10.2%
50-64	8,106	24.4%
65-74	7,817	23.5%
75-79	3,704	11.1%
80-84	3,629	10.9%
85+	6,646	20.0%
TOTAL	33,286	100.0%

The third thing to keep in mind is that there is no consensus as to the relative health of people who are currently moving toward old age. Some data suggests they will be healthier than ever before, others suggest they will be quite unhealthy. For example, baby boomers are 50% less likely to smoke than previous generations, while they are 55% more likely to have diabetes.[2]

Regardless of health status in their senior years, the fact remains that the number of seniors will grow a great deal in the next 15 years, to an unprecedented level. Figure 1 shows the forecasted demographic change for Oregonians over age 60 in 2015, 2030, and 2045, taken from the state demographer's official long term forecast.[3]

1. American Community Survey five year estimate, 2011-2015.
2. United Health Foundation, "America's Health Rankings, a call for action for individuals and their communities, 2016 report" http://cdnfiles.americashealthrankings.org/SiteFiles/PressReleases/Final%20Report-Seniors-2016-Edition.pdf
3. See "Oregon's Long Termcounty population forecast, 2010-2050" and other demographic information for Oregon at http://www.oregon.gov/das/OEA/Pages/forecastdemographic.aspx



What is most obvious about this graphic is the "bulge" of people between ages 60 and 80 that the state will experience in 2030. These are baby boomers entering old age and "near old age." This phenomenal rise will continue to influence the demographics fifteen years later, in 2045, as the baby boom cohort exits their 70s. The spike in people over 80 seen at the far right of the graph in 2045 is a testament both to the size of the baby-boom cohort and to the expected longevity of people in old age. These two things coupled together will in essence permanently increase the size of Oregon's Long Term Care population.

These increases won't happen overnight. Figure 1 shows change in 15 year increments Demographic changes like this build up over time. Figure 2 shows the steady increase in the population of Oregonians entering their senior years.

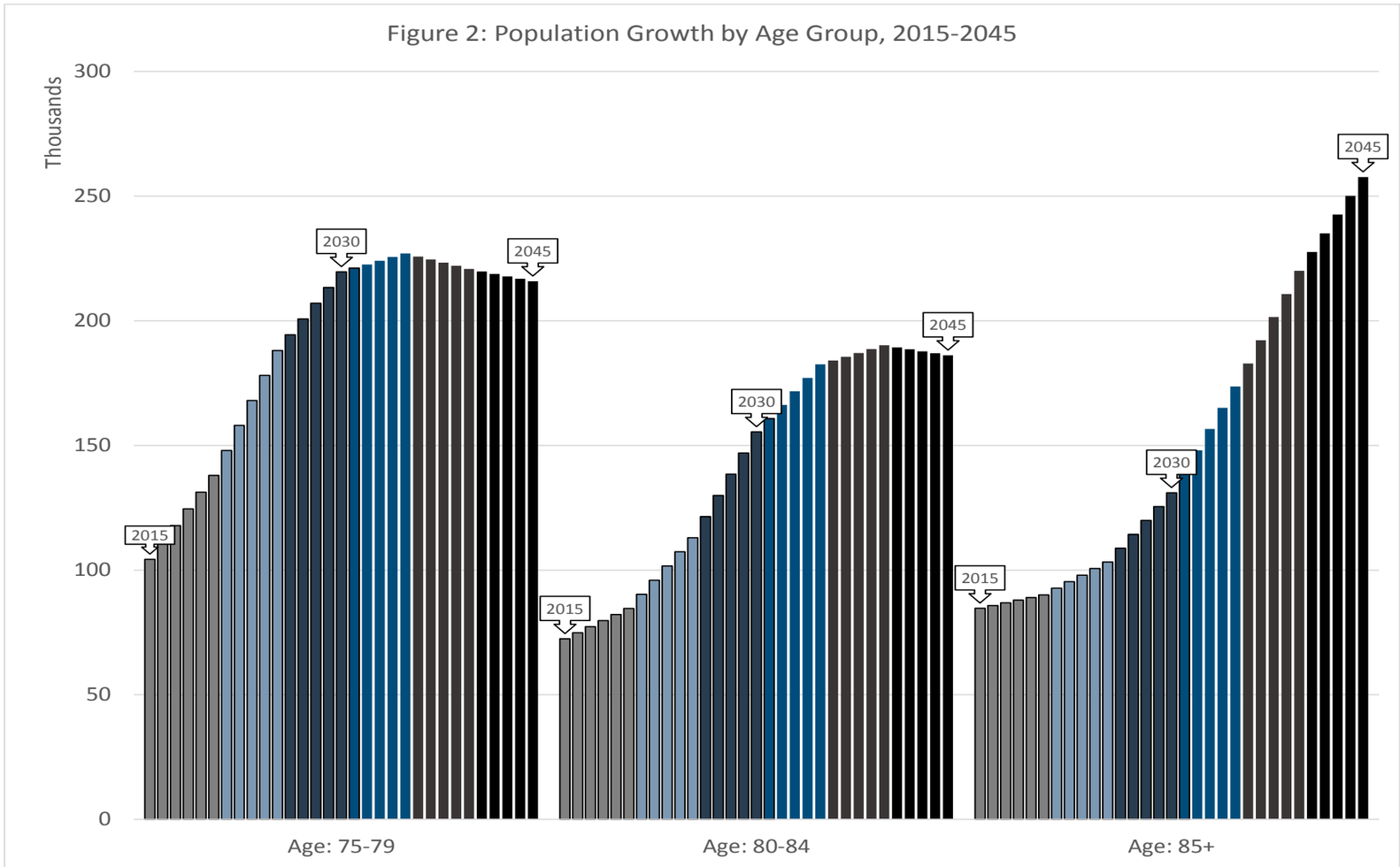


Figure 2 shows the steady growth of people between age 75 and 79, which will essentially double in size between 2015 and 2030. The same will happen for people between age 80 and 85, though on a smaller scale. By 2035, the increases for these two groups will plateau. Because we expect more and more Oregonians to live through this period of their lives, the 85 and older group will experience accelerated growth, especially after the year 2025. This growth will continue for the next 20 years.

This doubling of people in their senior years between now and 2030, and the looming challenges of caring for them as they become disabled, has been called "the 2030 problem" and is a problem for the whole country. How it looks in Oregon – based on what we know now – is the purpose of this special section.

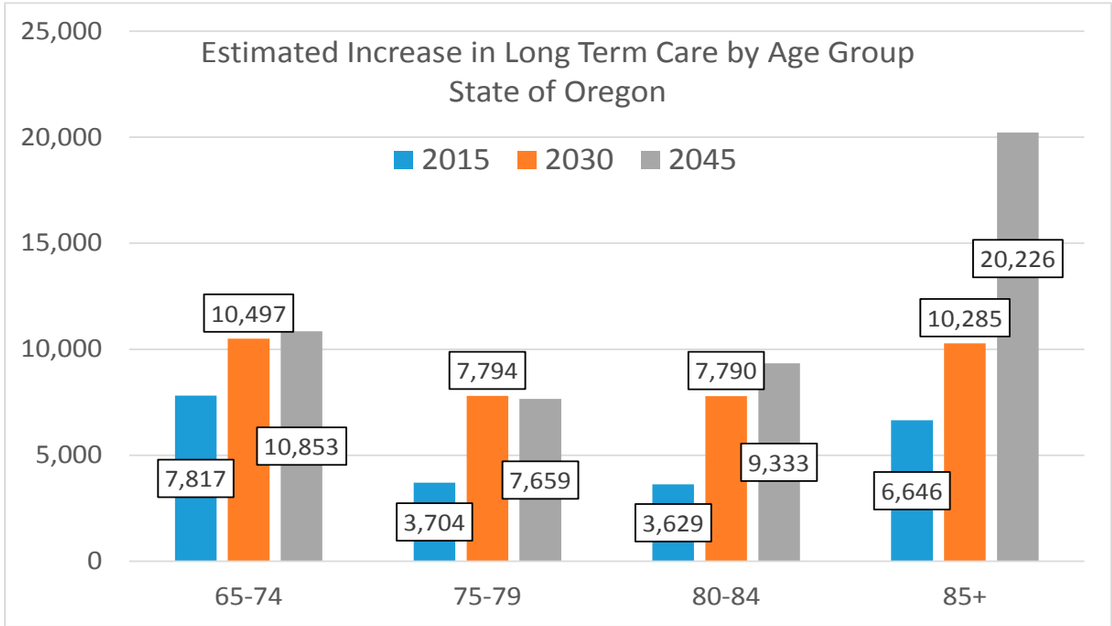
Long Term Forecasts for Long Term Care

The folly of engaging in Long Term forecasts is widely known – just look at the weather forecast. For short term forecasts, many of the variables that can influence the future are known and can be accounted for. Get farther out and everything becomes more unstable. In the world of Human Services, these issues are compounded. Public policy changes can influence the size of caseloads far more than demographics. Public policy isn't only just a matter of stated goals – what we may want to do based on our values or what we consider a priority – it's also a matter of money. What the economy does between now and 2045, and whether that will allow us the revenue to do the things we want to do for seniors in poverty is impossible to know. And that doesn't include the public policy and budget considerations of our federal partners. Still, it is important to show the scope of the "2030 problem,"[4] and one way to do that is by estimating (I won't even call it forecasting) the number of persons who will need Long Term Care as the number of seniors grows. It is also important to keep in mind that demographics in one part of the state are not the same as another part. So these estimates will be done at the county level.

The estimates presented here are based on the Long Term forecast of county population prepared by the Oregon Office of Economic Analysis in 2013. They assume that the proportion of the county (by age group) that are currently in long term care will remain the same, so that changes in long term care will be purely demographic-driven. This estimate only includes the persons we might expect to see in DHS-compensated Long Term Care, not the total population of persons in care (in other words, it doesn't include long term care that is privately paid). All the estimates are based on the average monthly caseload for each county in the year 2015.

Figure 3 shows the estimated increases in DHS Long Term Care by age group, isolating people age 65 and older. The total estimate (including all age groups) shows an increase in the caseload from 33,286 in 2015 to 48,329 in 2030. That's an increase of 45 percent. A large increase, but not the doubling that we're expecting of seniors overall.

4. See Knickman JR and Snell, EK (2002) The 2030 Problem: Caring for Aging Baby Boomers. Health Services Research, 37(4): 849-884.



The number of people in Long Term Care will double among people between age 75 and 84; but that's only a subset of all the people in Long Term Care. Because other age groups will grow much more slowly, the growth in LTC won't be as dramatic as the growth of seniors in Oregon overall. By 2045, the number of people in LTC is expected to reach 62,392 – almost doubling the number in 2015. Put another way, although the number of seniors will double in Oregon between 2015 and 2030, it will take an additional 15 years for the Long Term Care population to double.

On the following pages, county-based estimates are shown for the expansion of Long Term Care in 2030 and 2045, for people aged 65 and over. It does not include estimates for counties whose Long Term Care caseload never exceeds 100 cases. Very small counts are even more prone to inaccuracy than the ones presented, so I shied away from producing them. The map also includes the percent increase in long term care (overall, regardless of age) from 2015 to 2030.

For more information on the regional forecast, contact:

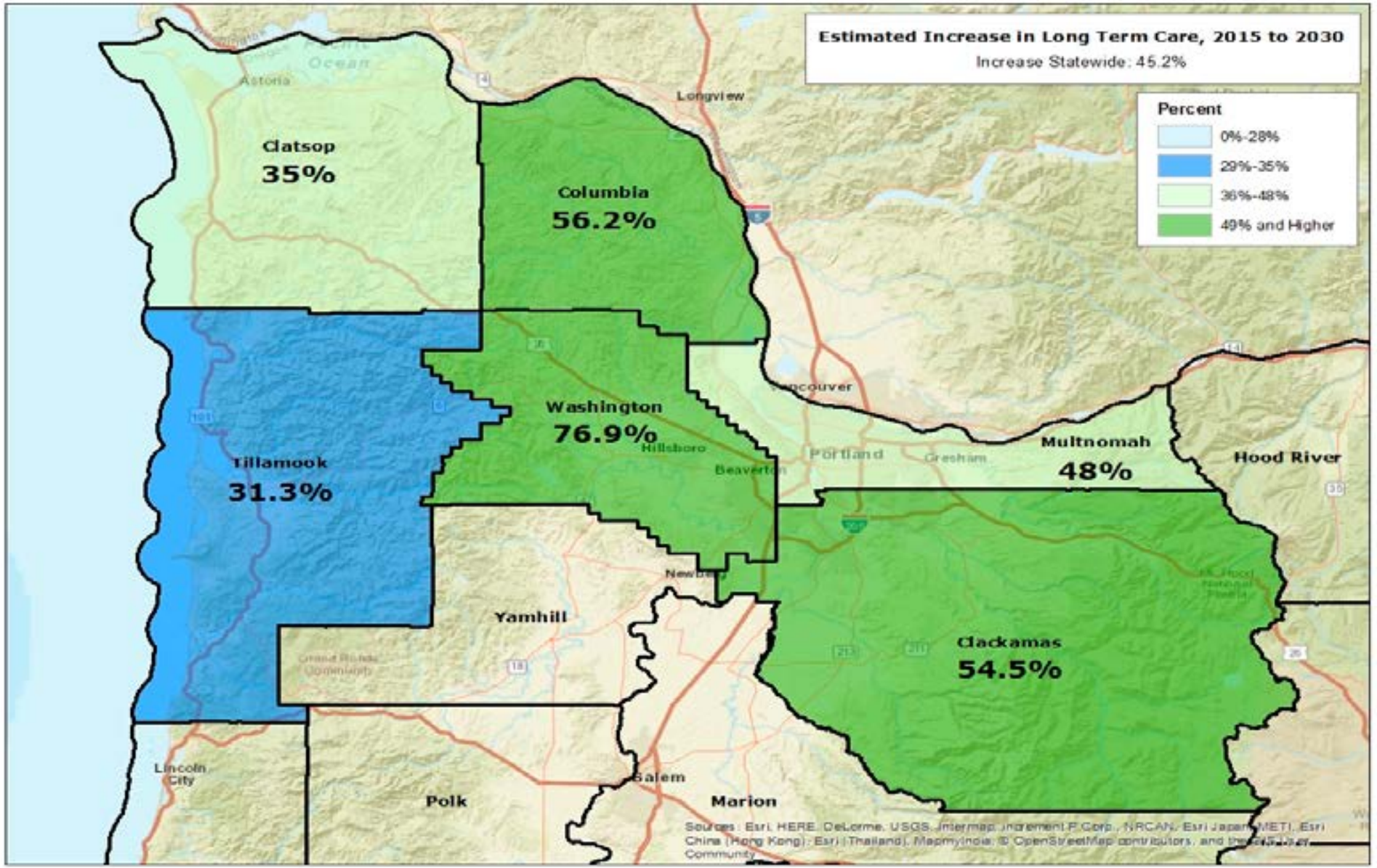
Gregory Tooman

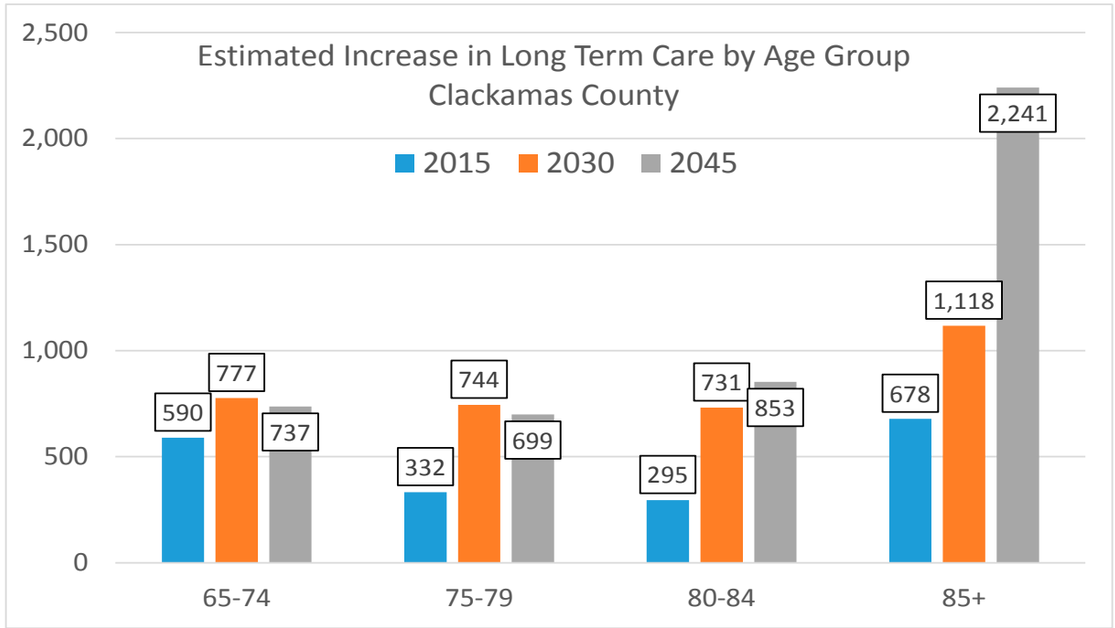
Regional Forecaster

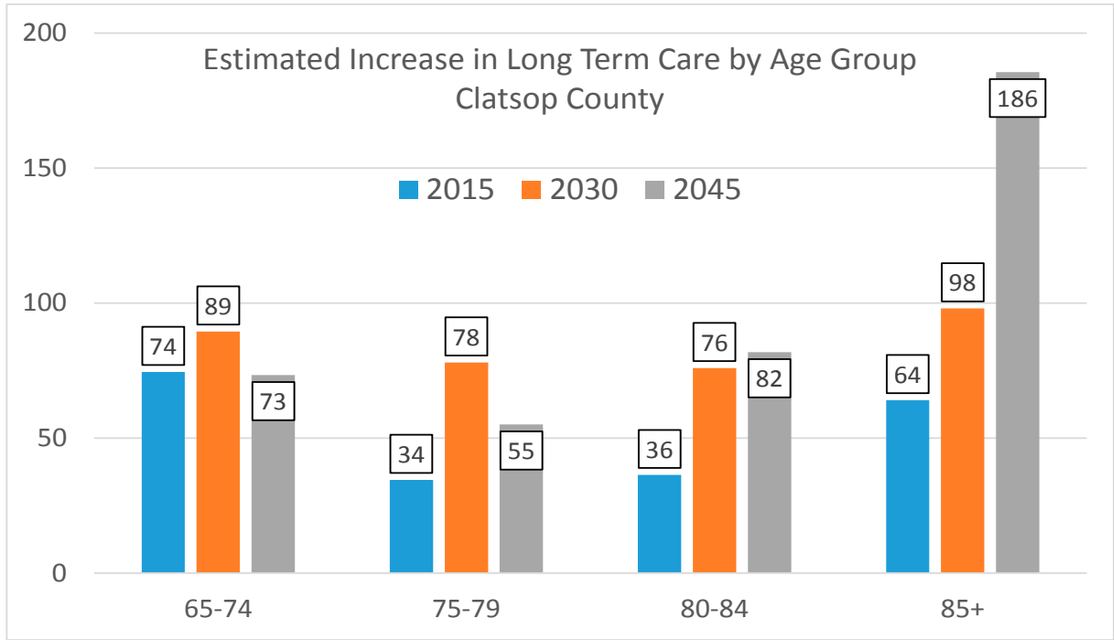
gregory.tooman@state.or.us

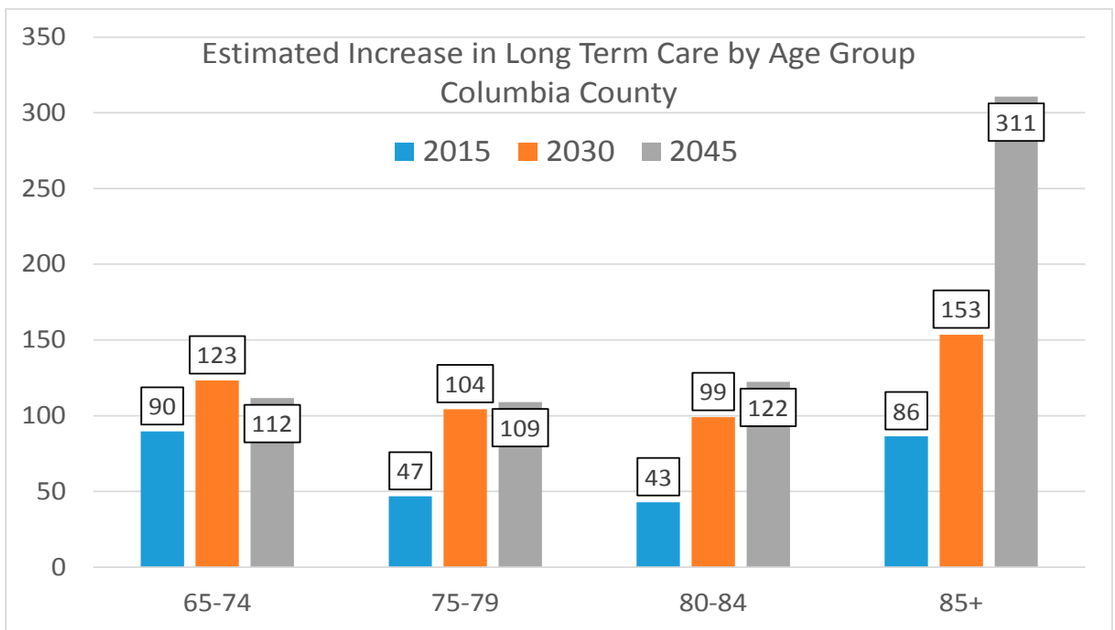
503-945-6239

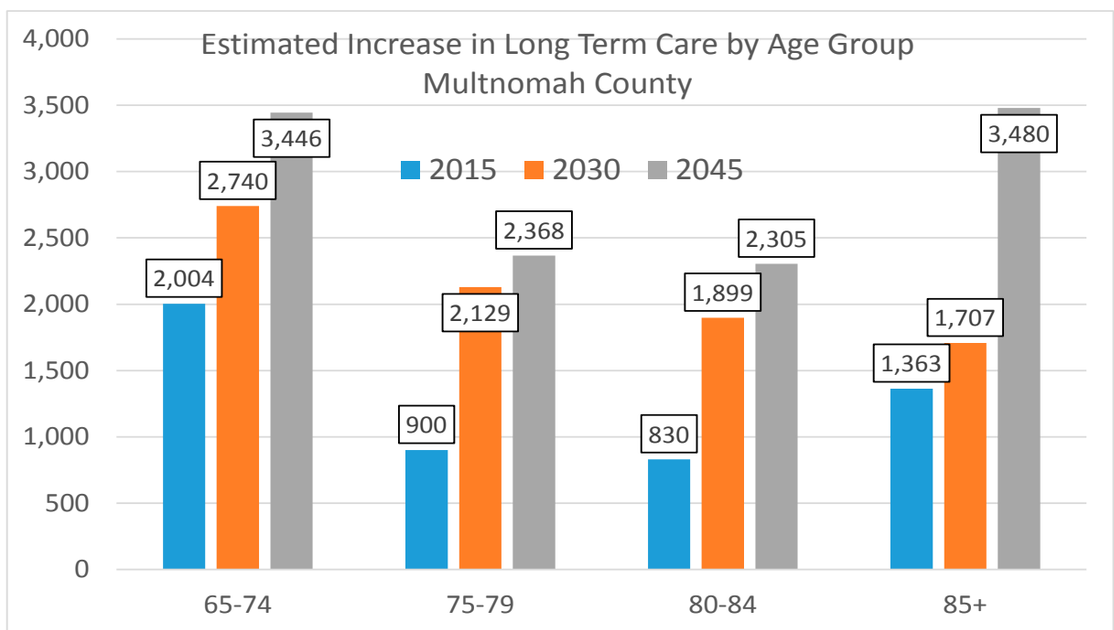
Estimated Increase in Long Term Care by County, Northwestern Oregon

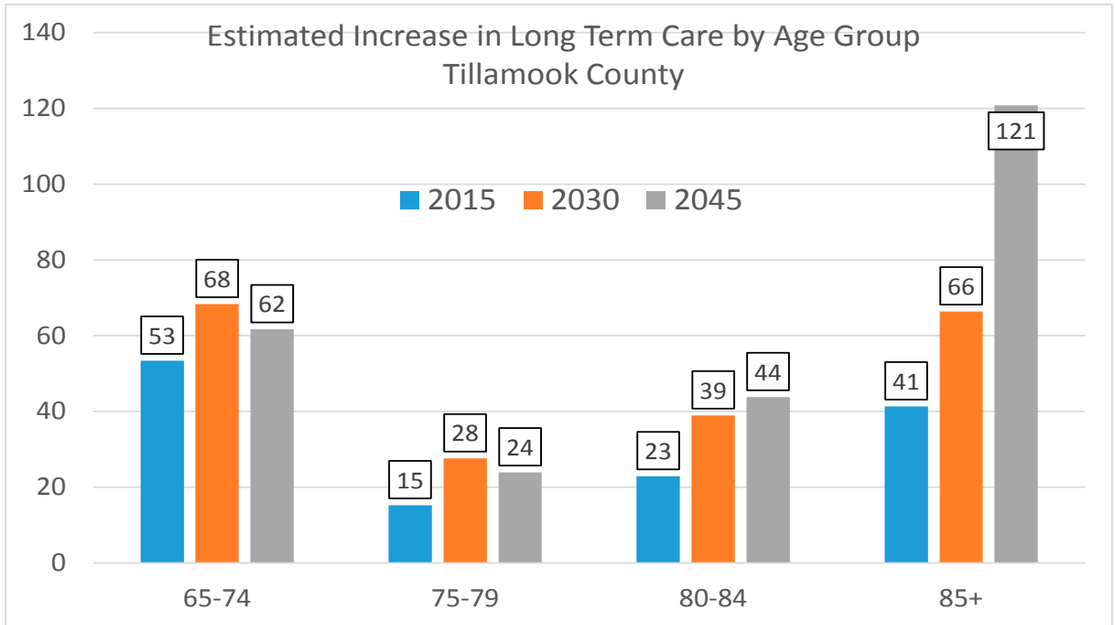


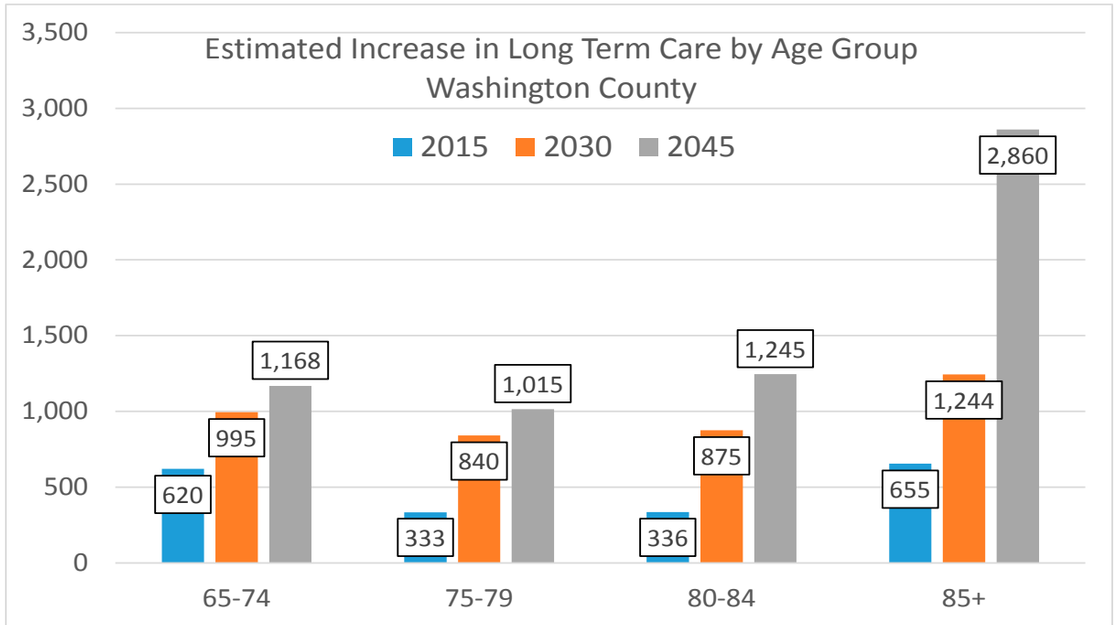

Estimated Increase in Long Term Care by Age Group
Clackamas County
2015
2030
2045
2,500
2,000
1,500
1,000
500
0
590
777
737
332
744
699
295
731
853
678
1,118
2,241
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Clatsop County
2015
2030
2045
200
150
100
50
0
74
89
73
34
78
55
36
76
82
64
98
186
65-74
75-79
80-84
85+

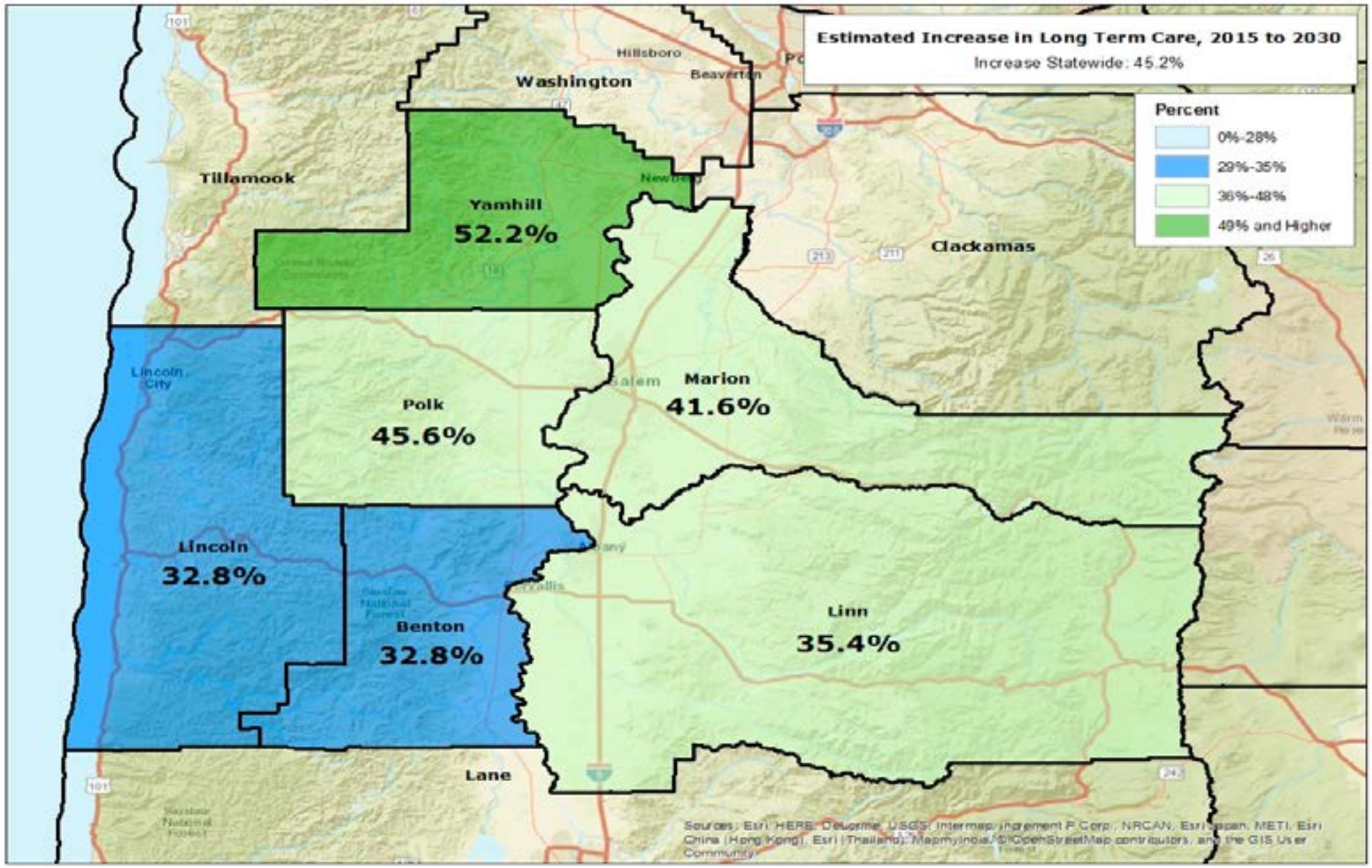

Estimated Increase in Long Term Care by Age Group
Columbia County
2015
2030
2045
350
300
250
200
150
100
50
0
90
123
112
47
104
109
43
99
122
86
153
311
65-74
75-79
80-84
85+

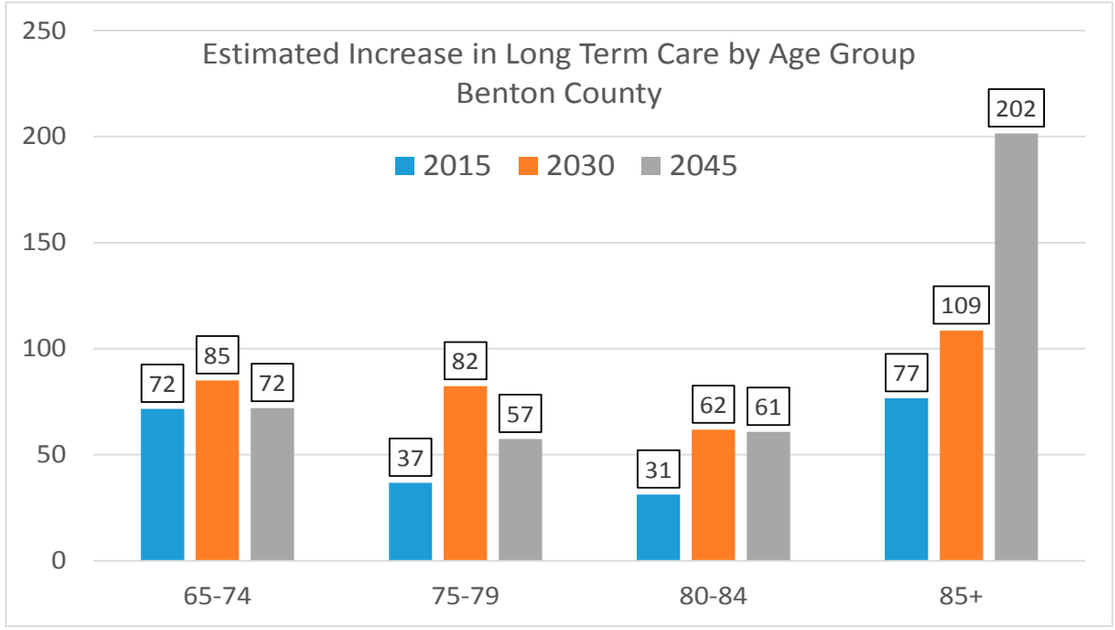

Estimated Increase in Long Term Care by Age Group
Multnomah County
2015
2030
2045
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2,004
2,740
3,446
900
2,129
2,368
830
1,899
2,305
1,363
1,707
3,480
65-74
75-79
80-84
85+

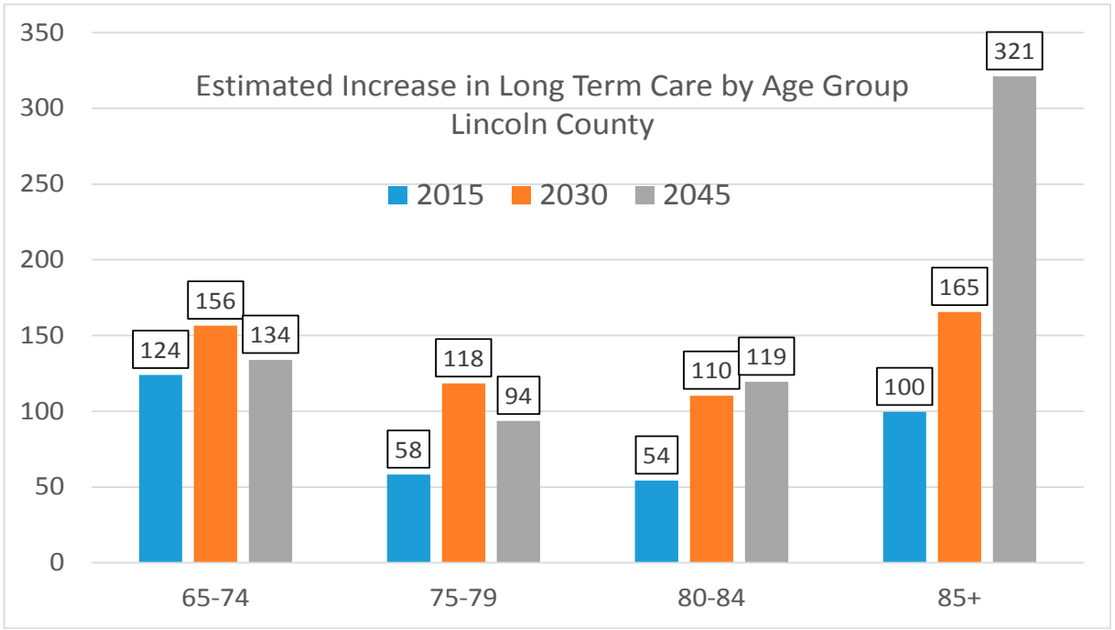

Estimated Increase in Long Term Care by Age Group
Tillamook County
2015
2030
2045
140
120
100
80
60
40
20
0
53
68
62
15
28
24
23
39
44
41
66
121
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Washington County
2015
2030
2045
3,500
3,000
2,500
2,000
1,500
1,000
500
0
620
995
1,168
333
840
1,015
336
875
1,245
655
1,244
2,860
65-74
75-79
80-84
85+

Estimated Increase in Long Term Care by County, Mid-Valley Region




Estimated Increase in Long Term Care by Age Group
Benton County
2015
2030
2045
250
200
150
100
50
0
72
85
72
37
82
57
31
62
61
77
109
202
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Lincoln County
2015
2030
2045
350
300
250
200
150
100
50
0
124
156
134
58
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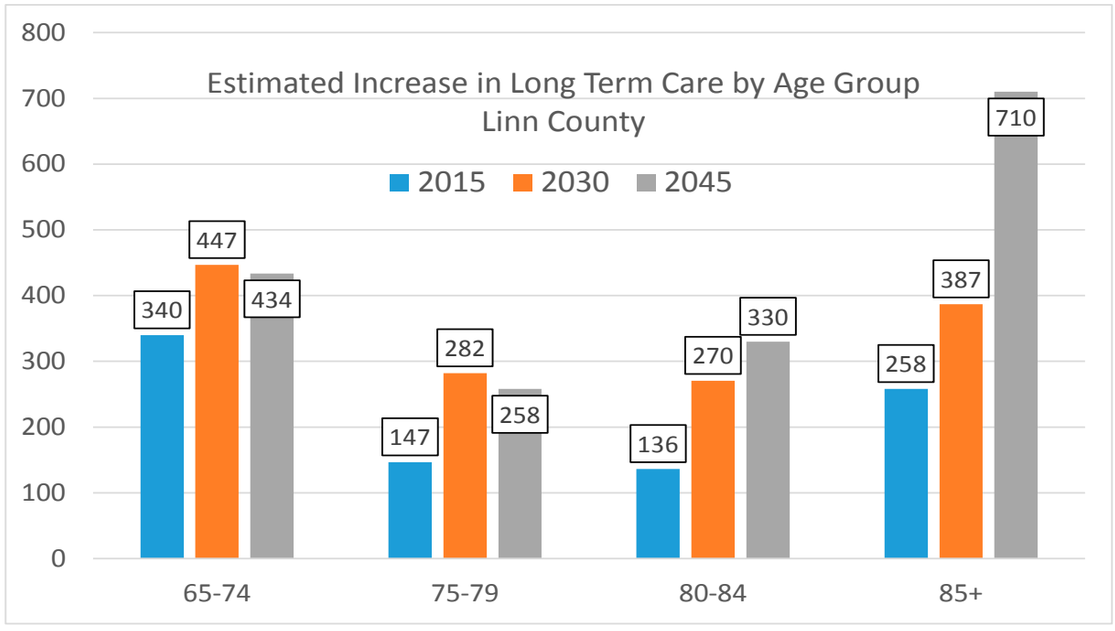
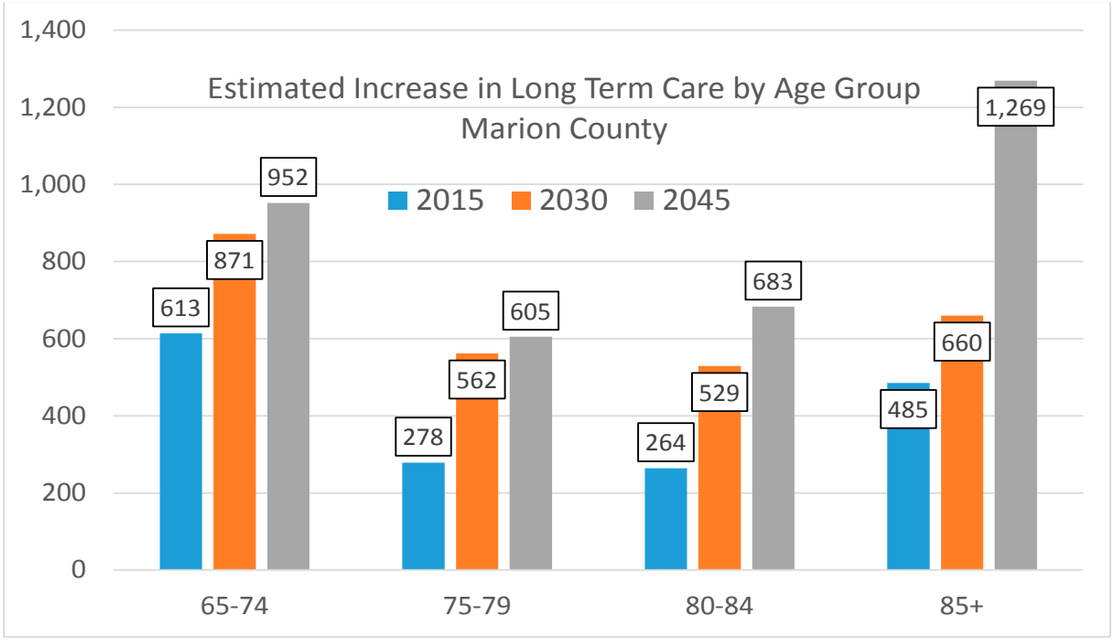
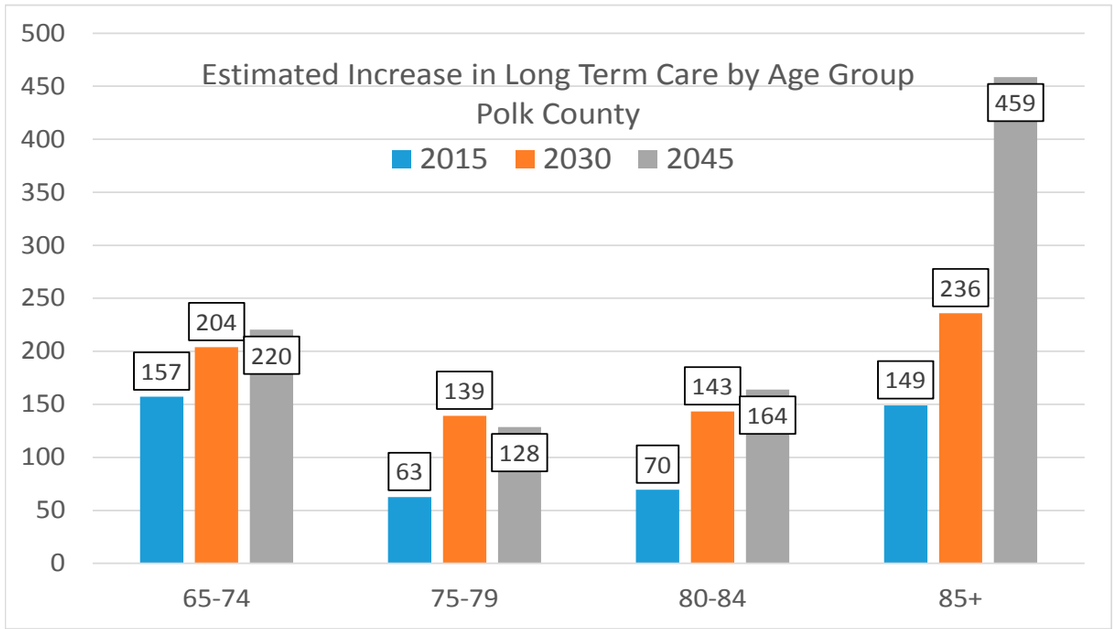
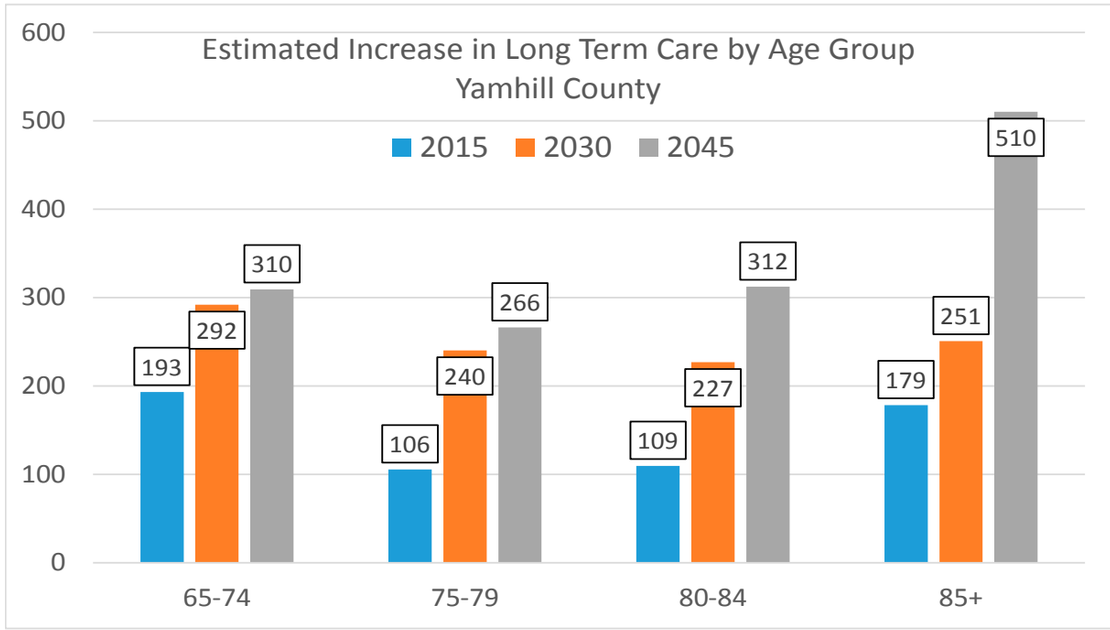
94
54
110
119
100
165
321
65-74
75-79
80-84
85+

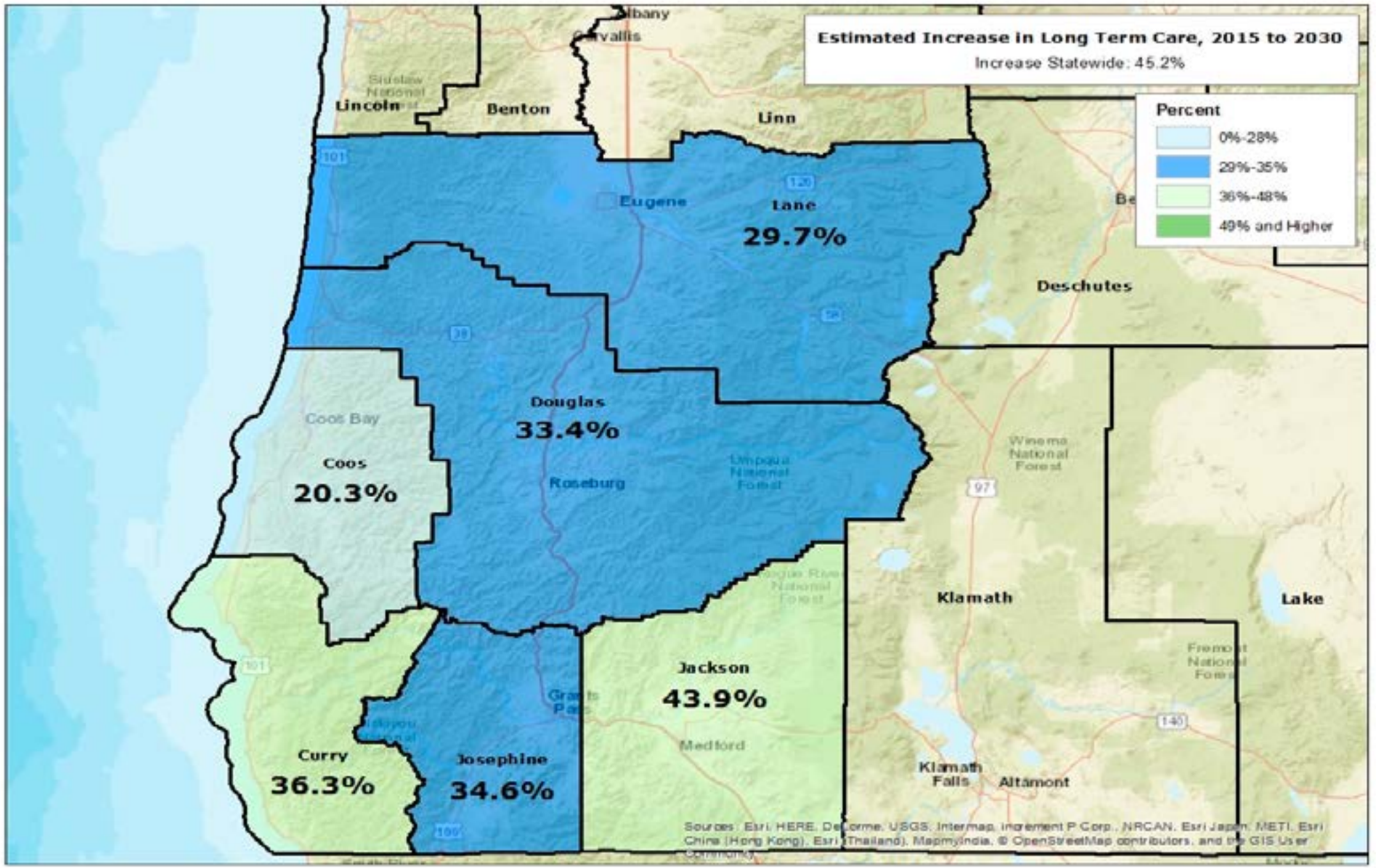

Estimated Increase in Long Term Care by Age Group
Linn County
2015
2030
2045
800
700
600
500
400
300
200
100
0
340
447
434
147
282
258
136
270
330
258
387
710
65-74
75-79
80-84
85+

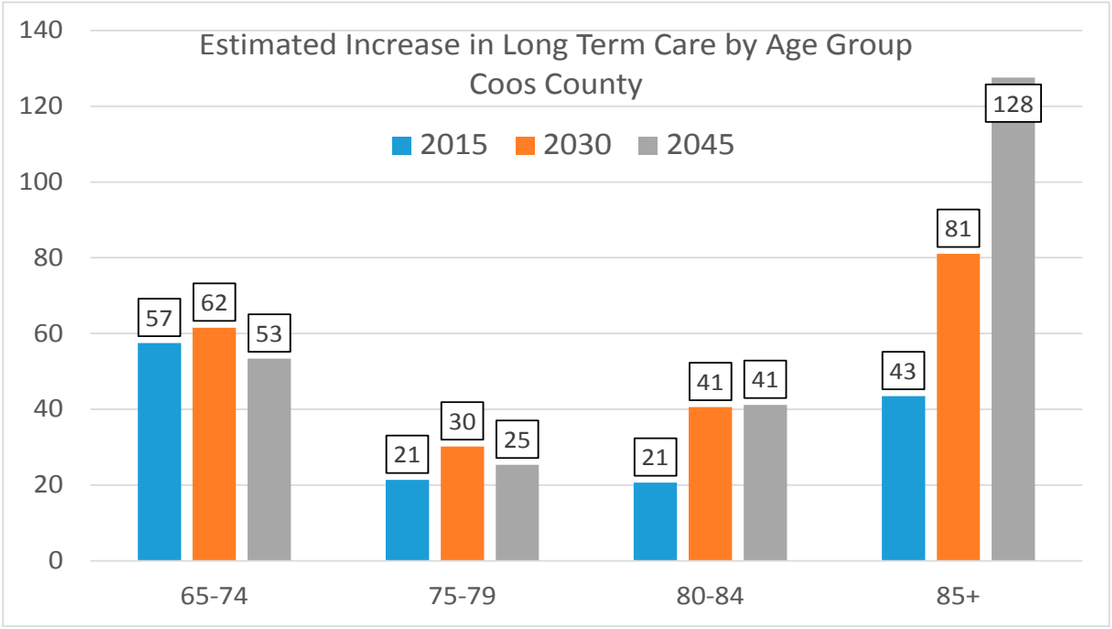

Estimated Increase in Long Term Care by Age Group
Marion County
2015
2030
2045
1,400
1,200
1,000
800
600
400
200
0
613
871
952
278
562
605
264
529
683
485
660
1,269
65-74
75-79
80-84
85+

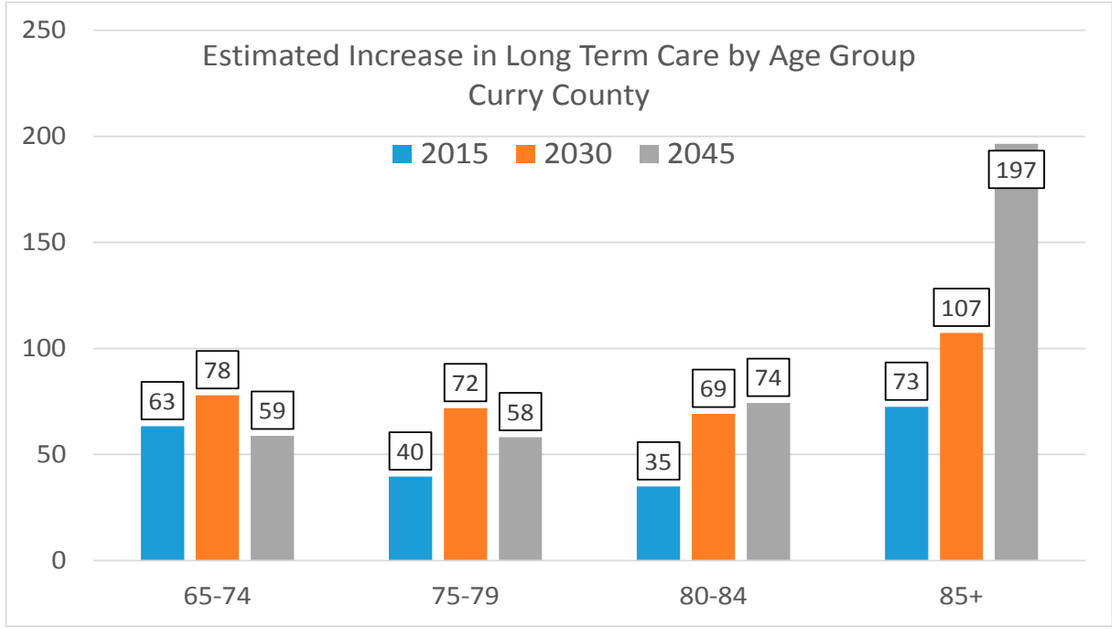

Estimated Increase in Long Term Care by Age Group
Polk County
2015
2030
2045
500
450
400
350
300
250
200
150
100
50
0
157
204
220
63
139
128
70
143
164
149
236
459
65-74
75-79
80-84
85+

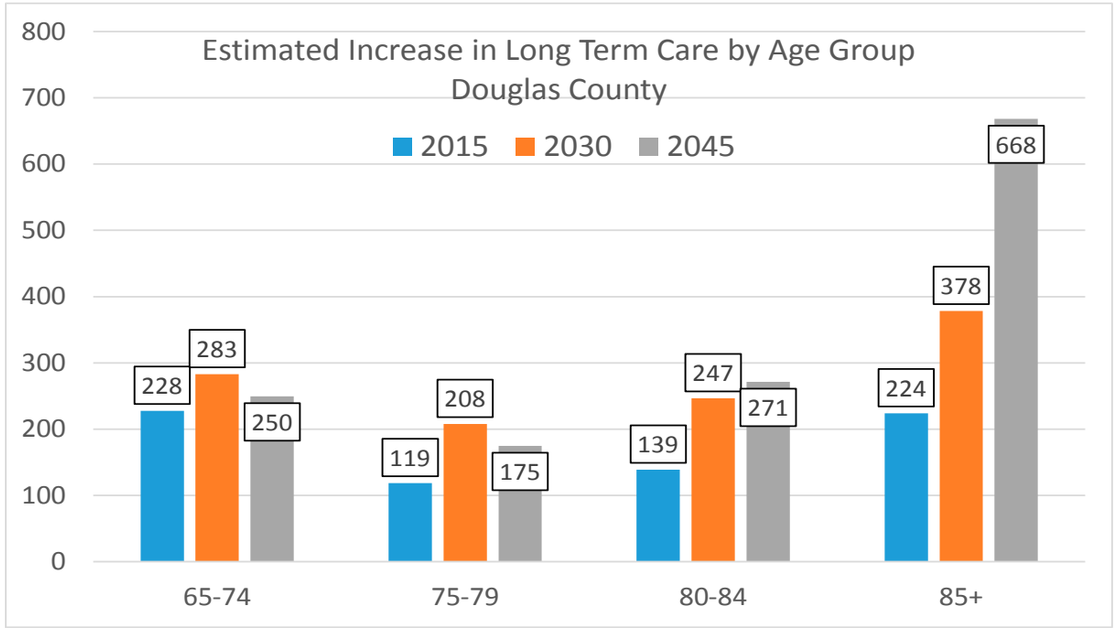

Estimated Increase in Long Term Care by Age Group
Yamhill County
2015
2030
2045
600
500
400
300
200
100
0
193
292
310
106
240
266
109
227
312
179
251
510
65-74
75-79
80-84
85+

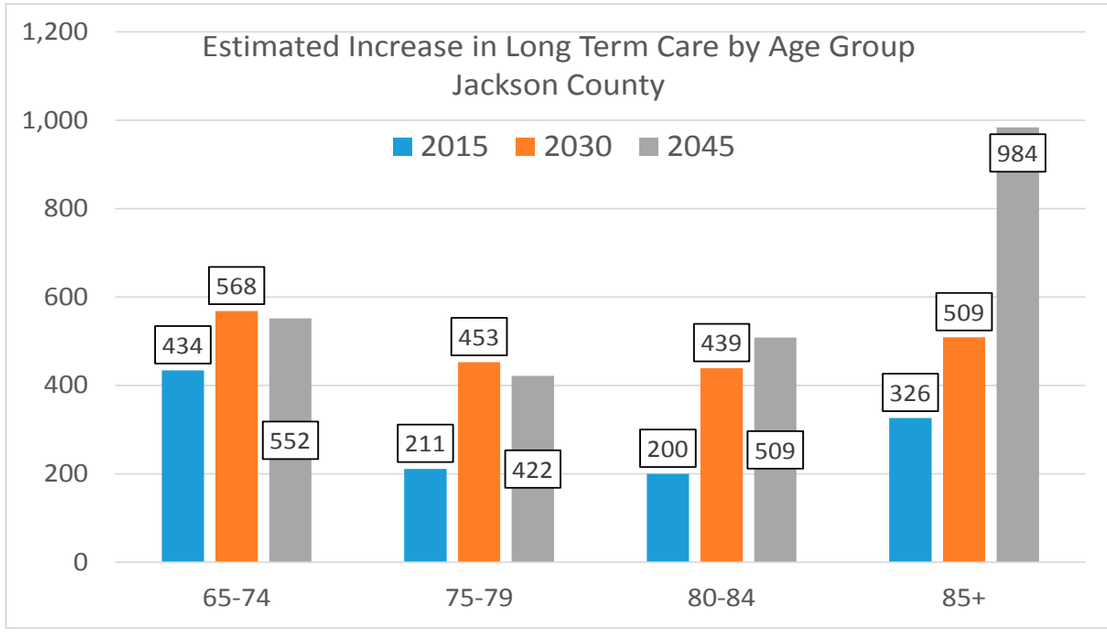
Estimated Increase in Long Term Care by County, Southwest Region

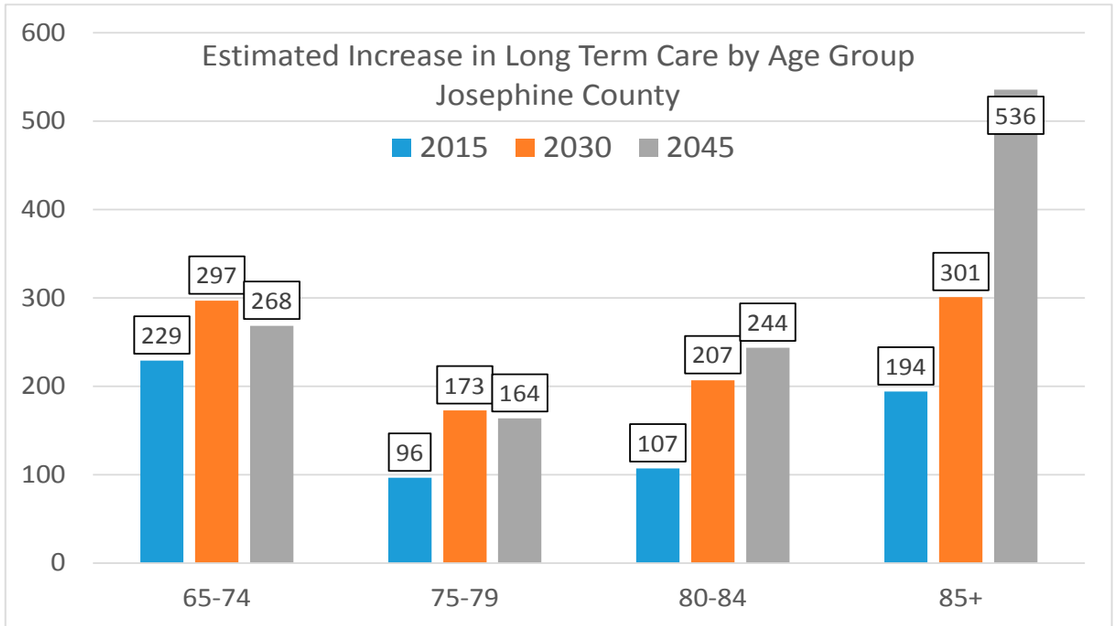


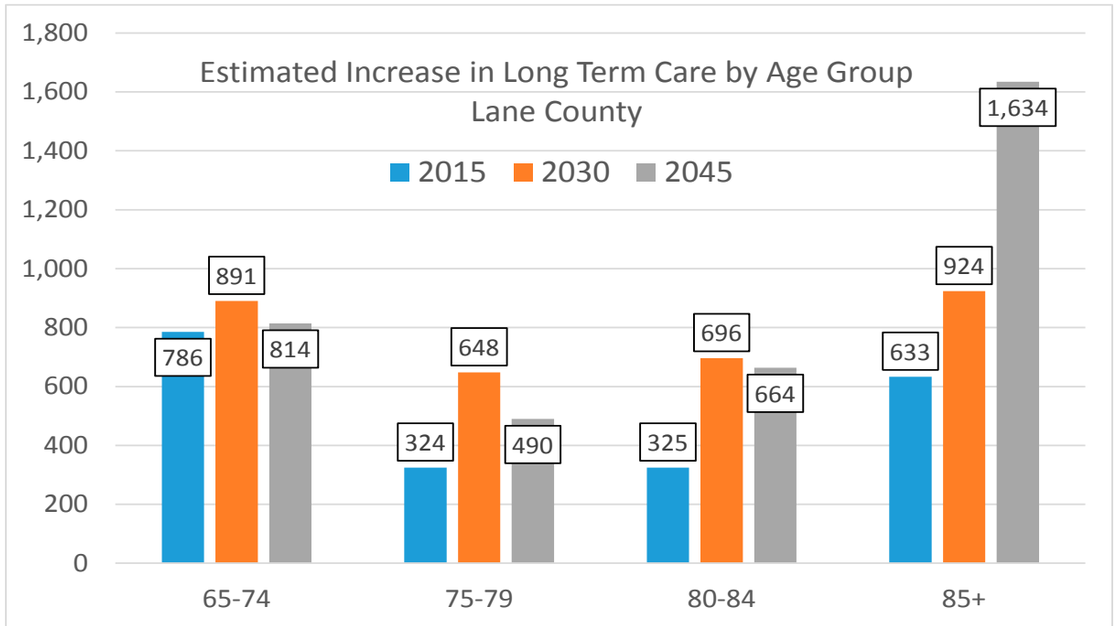

Estimated Increase in Long Term Care by Age Group
Coos County
2015
2030
2045
140
120
100
80
60
40
20
0
57
62
53
21
30
25
21
41
41
43
81
128
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Curry County
2015
2030
2045
250
200
150
100
50
0
63
78
59
40
72
58
35
69
74
73
107
197
65-74
75-79
80-84
85+

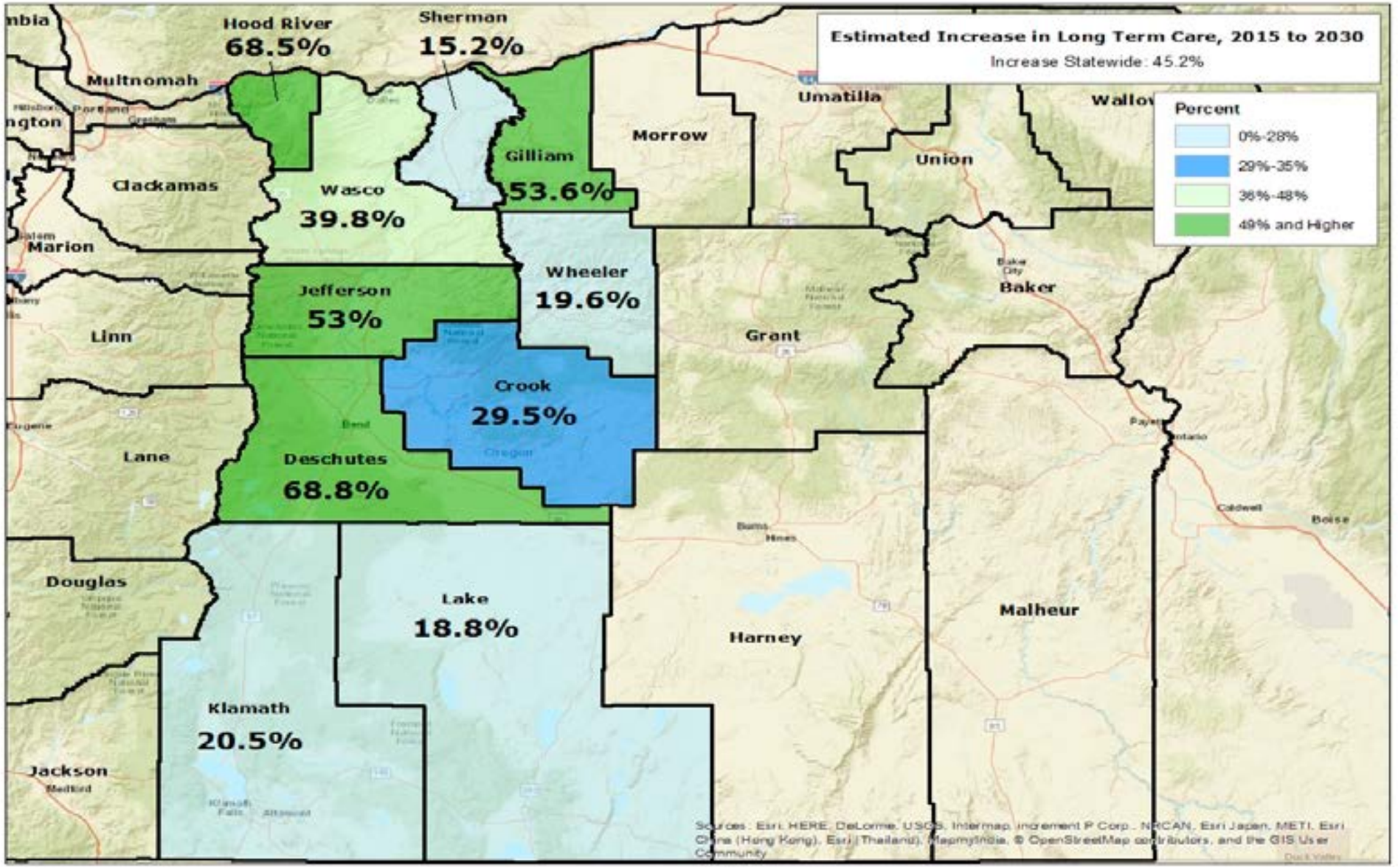

Estimated Increase in Long Term Care by Age Group
Douglas County
2015
2030
2045
800
700
600
500
400
300
200
100
0
228
283
250
119
208
175
139
247
271
224
378
668
65-74
75-79
80-84
85+

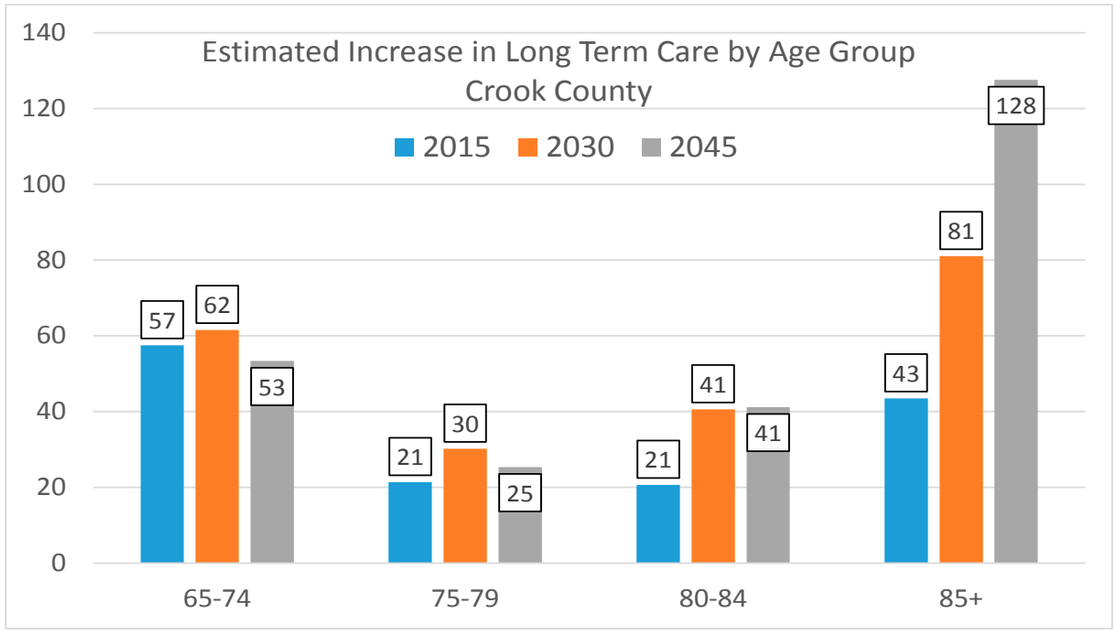

Estimated Increase in Long Term Care by Age Group
Jackson County
2015
2030
2045
1,200
1,000
800
600
400
200
0
434
568
552
211
453
422
200
439
509
326
509
984
65-74
75-79
80-84
85+

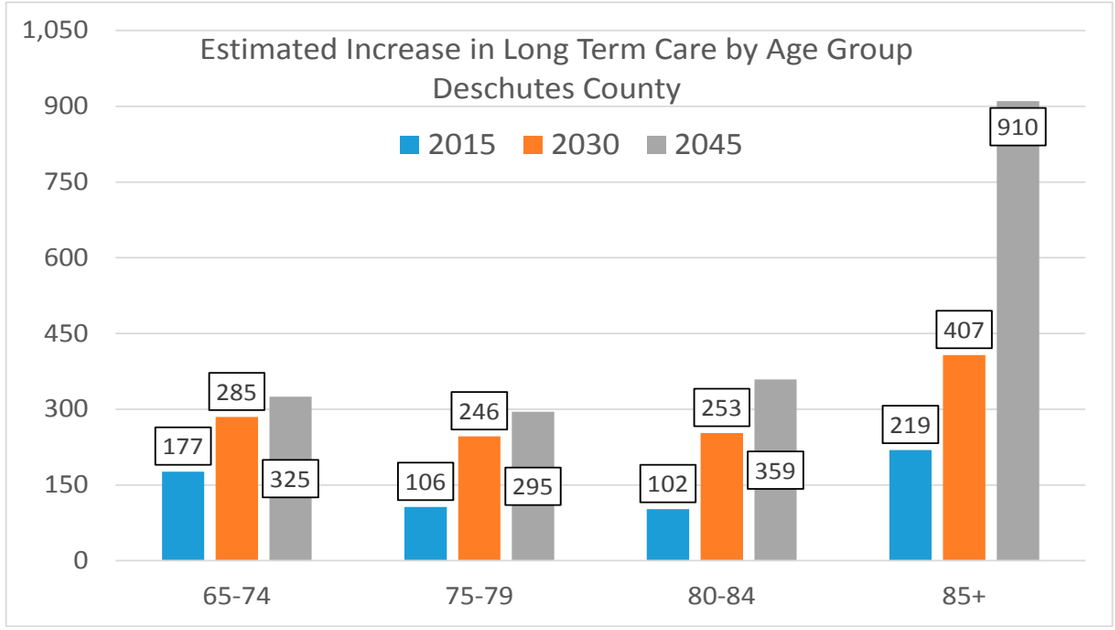

Estimated Increase in Long Term Care by Age Group
Josephine County
2015
2030
2045
600
500
400
300
200
100
0
229
297
268
96
173
164
107
207
244
194
301
536
65-74
75-79
80-84
85+

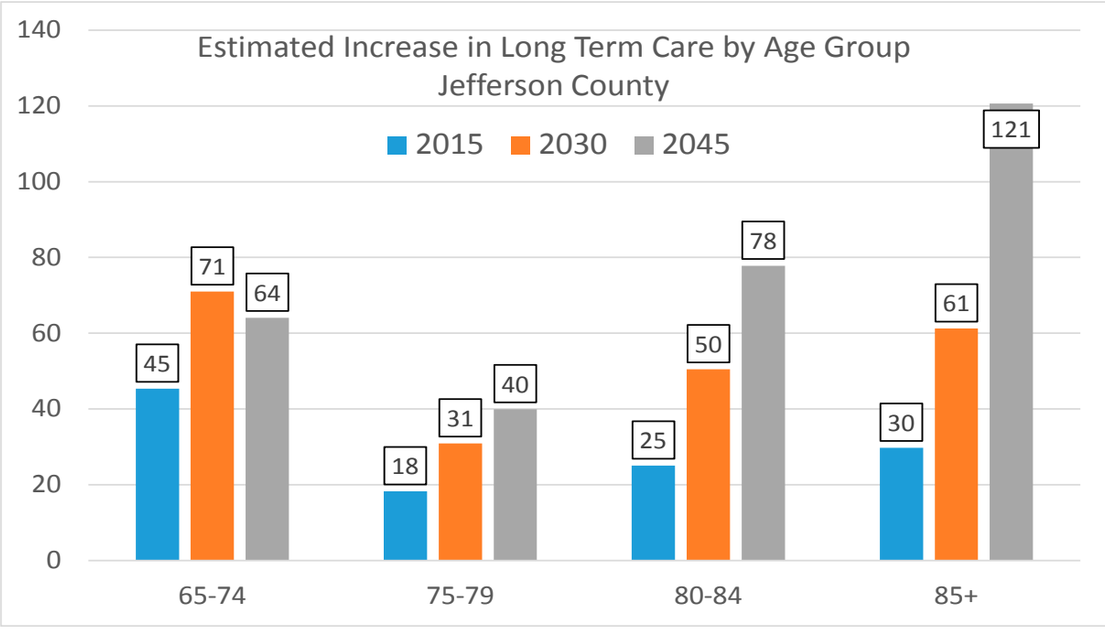

Estimated Increase in Long Term Care by Age Group
Lane County
2015
2030
2045
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
786
891
814
324
648
490
325
696
664
633
924
1,634
65-74
75-79
80-84
85+

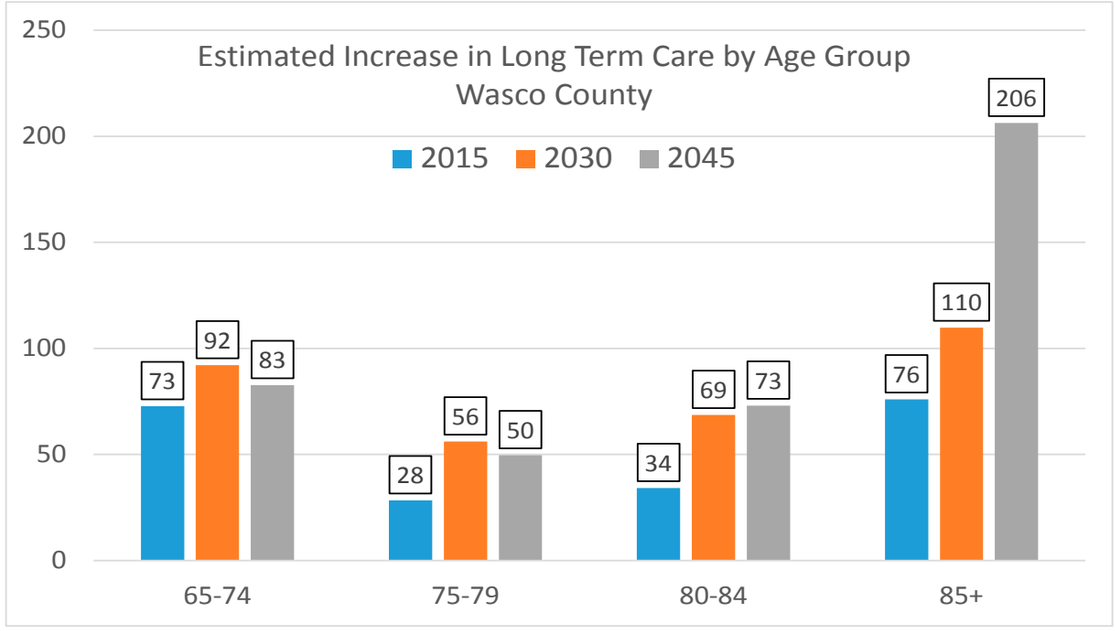
Estimated Increase in Long Term Care by County, Central Oregon



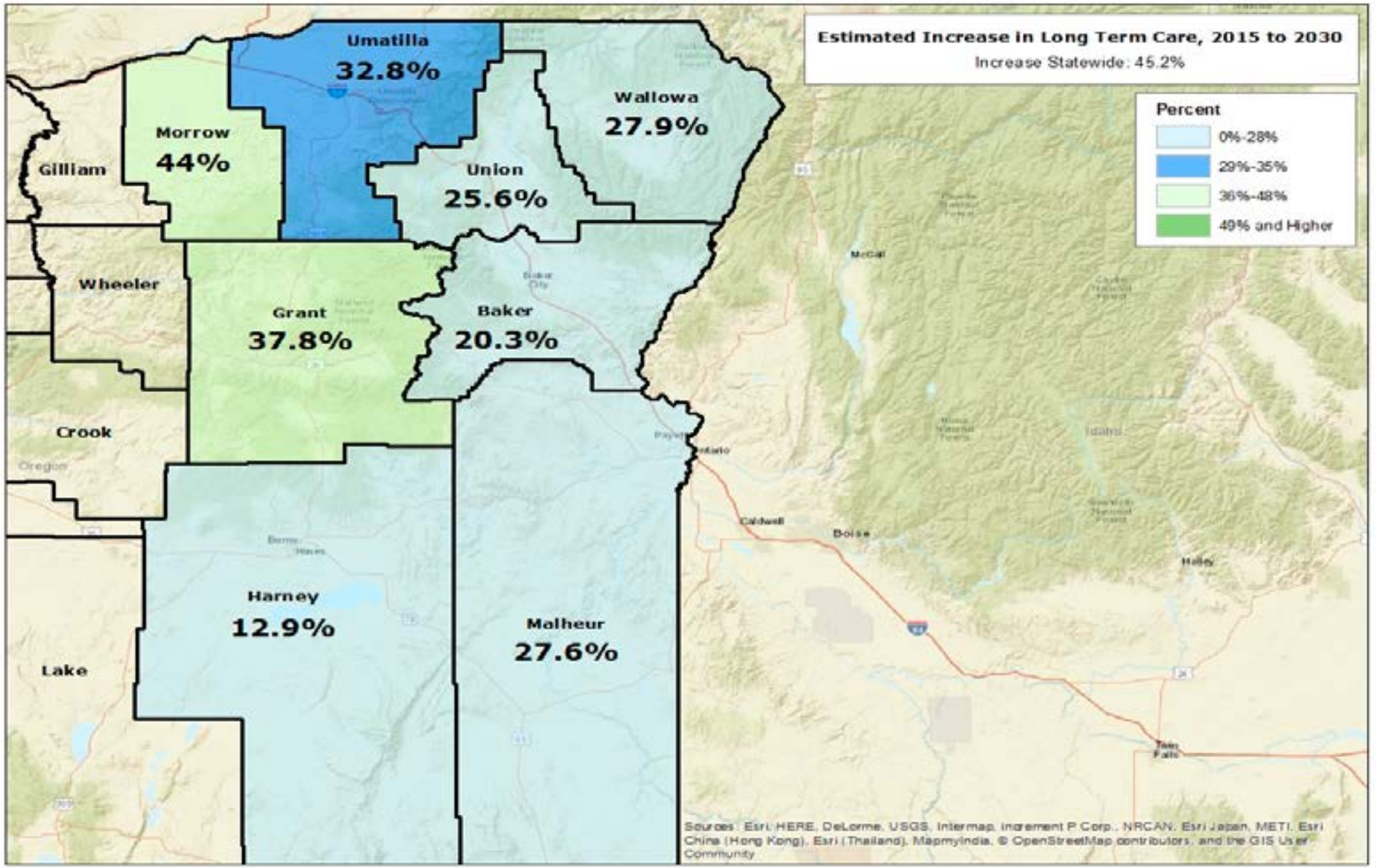

Estimated Increase in Long Term Care by Age Group
Crook County
2015
2030
2045
140
120
100
80
60
40
20
0
57
62
53
21
30
25
21
41
41
43
81
128
65-74
75-79
80-84
85+

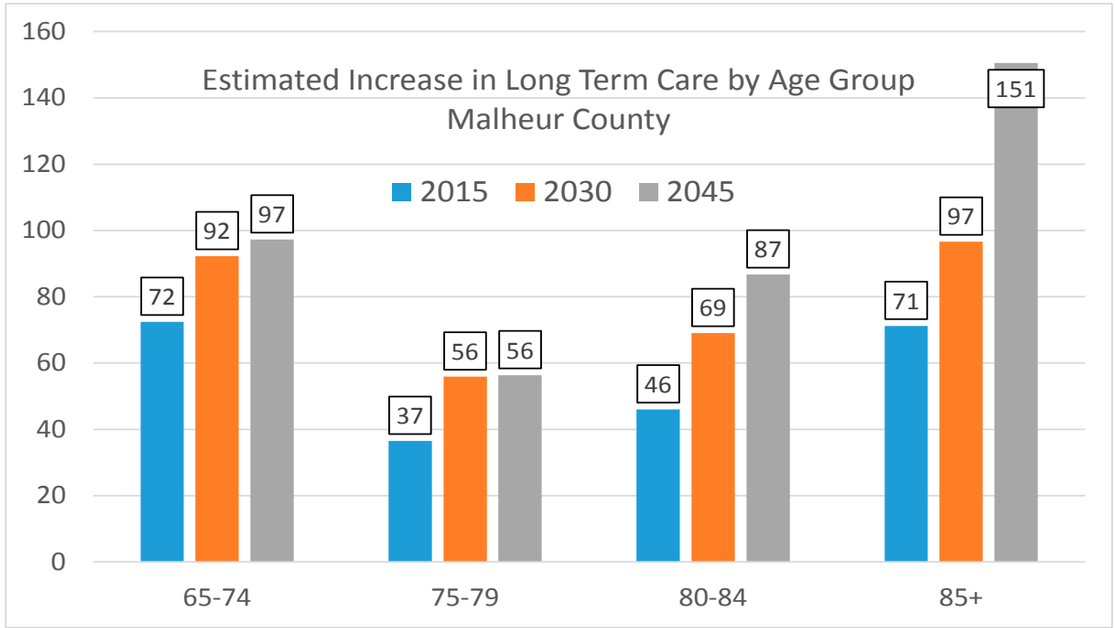

Estimated Increase in Long Term Care by Age Group
Deschutes County
2015
2030
2045
1,050
900
750
600
450
300
150
0
177
285
325
106
246
295
102
253
359
219
407
910
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Jefferson County
2015
2030
2045
140
120
100
80
60
40
20
0
45
71
64
18
31
40
25
50
78
30
61
121
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Wasco County
2015
2030
2045
250
200
150
100
50
0
73
92
83
28
56
50
34
69
73
76
110
206
65-74
75-79
80-84
85+

Estimated Increase in Long Term Care by County, Eastern Oregon




Estimated Increase in Long Term Care by Age Group
Malheur County
2015
2030
2045
160
140
120
100
80
60
40
20
0
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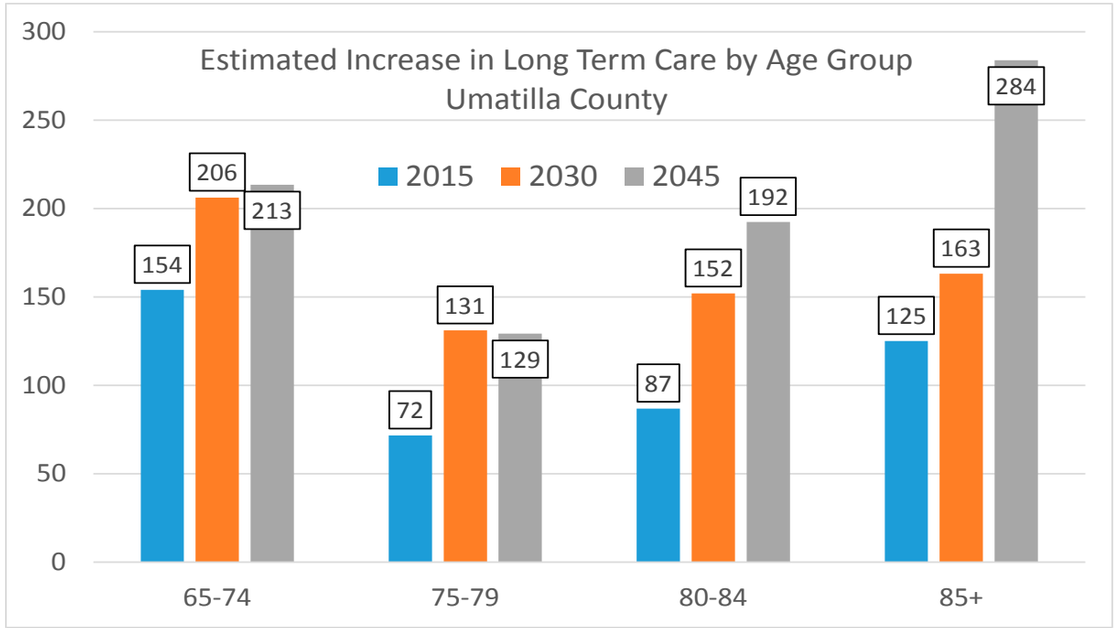
92
97
37
56
56
46
69
87
71
97
151
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Umatilla County
2015
2030
2045
300
250
200
150
100
50
0
154
206
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72
131
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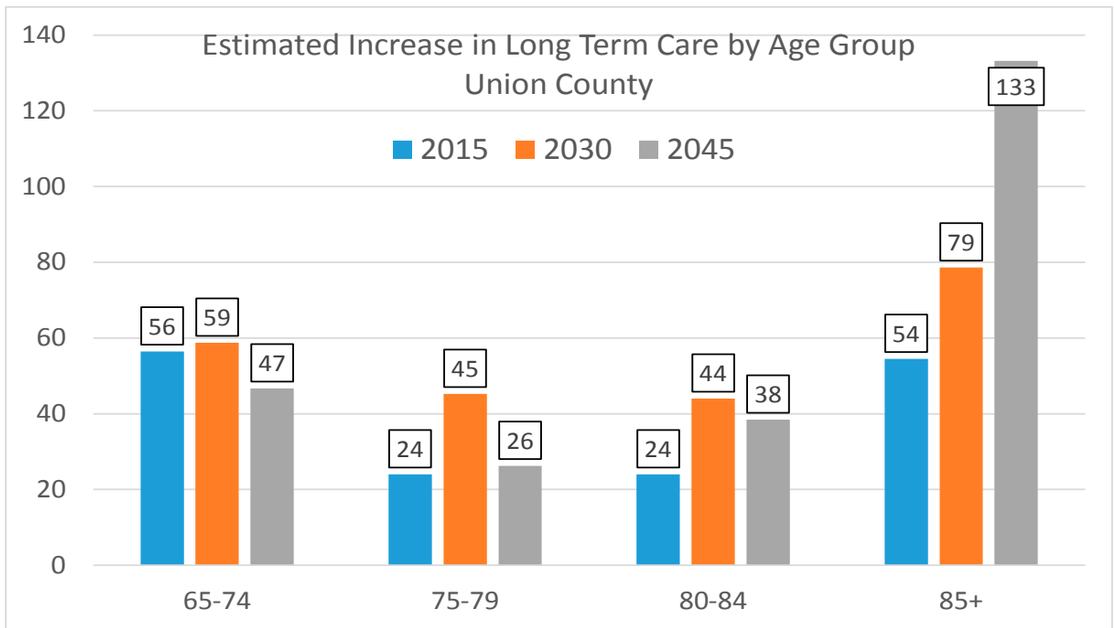
87
152
192
125
163
284
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Union County
2015
2030
2045
140
120
100
80
60
40
20
0
56
59
47
24
45
26
24
44
38
54
79
133
65-74
75-79
80-84
85+

The Future of Long Term Care - Part 2

In order to know the future, you need to appreciate the past and the present. In forecasting, we do that first by looking at the history of a caseload – the near future is almost always related to the recent past. Sometimes, we must look at other variables that we can use to help us understand the future. For example, variables like overall employment rate and how it relates to self-sufficiency. If more people are going to be employed, the need for SNAP will probably go down. Economists often do that with the overall economy using what they call "leading indicators." An example of a leading indicator would be industrial output, which is related to the future of our Gross Domestic Product, and can be given a number. Collect a handful of these indicators, sum them (or something more complicated, because economists like math) and you have a single index score that is an indication of how things are going to go.

I've created an index score for the future of Long Term Care. This isn't a forecast or even an "estimation," like in Part 1 of this section. Instead, it's a way of looking at variables other than demographics that can show how ready a county is for the increase in LTC that is inevitably coming. The index contains four variables – three from the Census Bureau's American Community Survey 5-year estimate (2011-2015), and the fourth from our own data here at DHS. The variables are:

1. **Self-Reported "Independent Living Difficulty" for people age 35 and older.** Those who report difficulties with living independently yield a wider measure than people needing Long Term Care. It can include people who are currently getting by with family help and other supports, but who will perhaps need Long Term Care in the future. By looking at people age 35 and older, I hope to show the volume of people who may be in the caseload in the next 15 to 20 years, rather than people who are already in the caseload.

2. **Labor Force Participation.** Labor force participation has been in the news a bit over the last year or so. Usually, the number of persons age 16-65 in the workforce is about 65 percent. That number has been lower than is typical ever since the "Great Recession." This is an issue at the national level because the ratio of people working to number of people receiving taxpayer-financed services (like Social Security and Medicare) should be at about 7-to-1 in order to pay for all the entitlements seniors have come to count on. Demographics suggests that this ratio will go down, and if current labor force participation is suppressed, it could be worse. At the county level, labor force participation is important because working-age people need to be available to provide aid to those with disabilities that make up the Long Term Care population. Without a good ratio of people in the workforce to people who need LTC aid, needs in the community may not be met.

3. **Mean Retirement Income.** The number of people retiring with a good income is related to the number of people who need Long Term Care from us in an obvious way – the higher the income, the more likely people are to be able to afford their own care without turning to the state for assistance. Indirectly, it can be an indicator of home ownership and other signs of economic well-being that can spare people from needing our services.

4. **SNAP Usage.** Because Oregon has such good outreach to getting people the food aid they need, use of SNAP is a good indicator of general economic health in a community. For this variable, I isolated those people age 50 and older on SNAP. These are people who, in the next 15 to 20 years may need Long Term Care, and may not be in a good position to finance it, given their economic condition now.

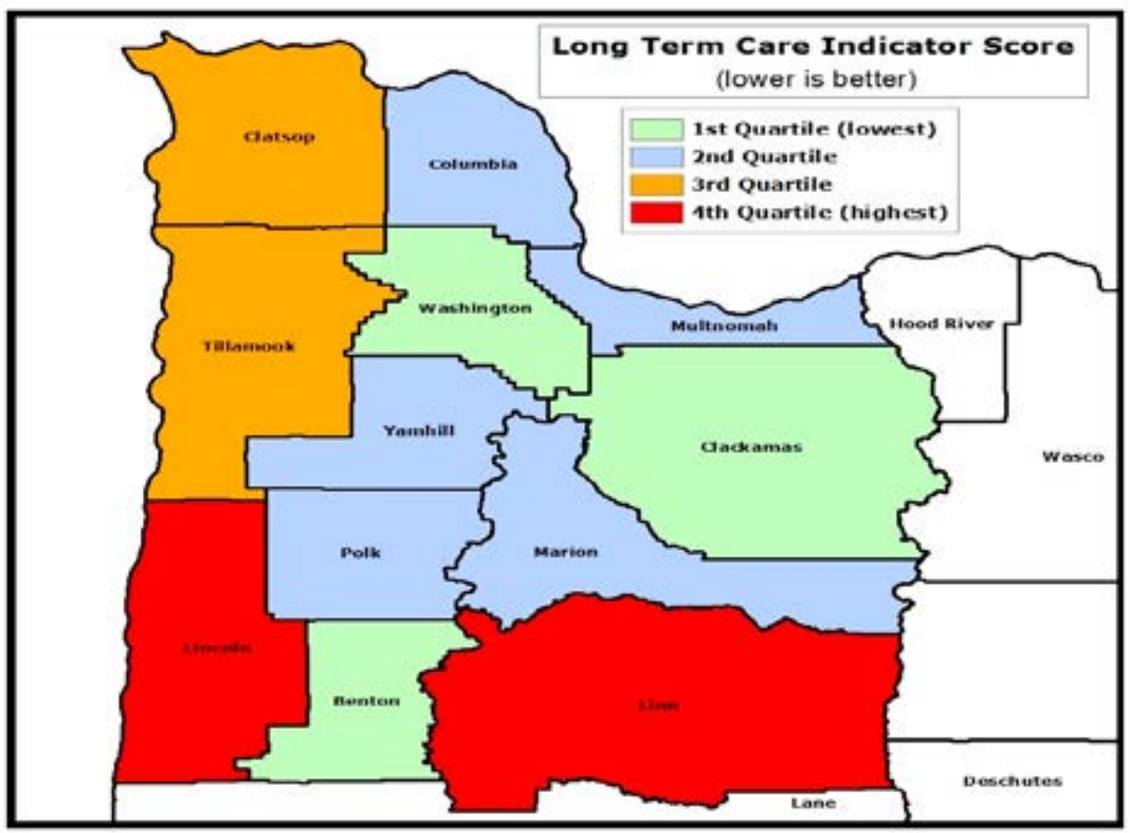
On the next few pages you'll see a table with the four indicator variables, and the "LTC Indicator" Sscore. The scores (and accompanying map) are color-coded – green for counties in the lowest quartile (lower is better on this scale), blue for counties in the second-lowest quartile, yellow for counties in the third lowest quartile, and red for counties in the highest (worst) quartile. Of course, Oregon is a dynamic state experiencing a good deal of economic growth and population increase over the past few years. Things could change between now and 2030, when the number of seniors in Oregon will double. But this is at least a good snapshot of where we are now, as we prepare for a future of greater need for our seniors.

Northwest Oregon

(Columbia, Clatsop, Tillamook, Multnomah, Clackamas, Washington, Polk, Yamhill, Marion, Benton, Lincoln, Linn)

No map on these pages shows the value of urban areas better than this one. Benton County (also known as the "Corvallis metro area" has the best score in the state (that is, lowest). It has achieved this with the lowest percentage of people not in the labor force and lowest percentage of people over 50 on SNAP. Other urban areas like Washington County (Hillsborough/Beaverton) and Clackamas also scored in the top five on the indicator. These counties have a large population, lots of resources, and high income jobs.

This is contrasted with Lincoln and Linn counties, which are among the lowest scoring counties in the state. Both of these counties have relatively high scores on all the measures that go into the indicator. As usual with looking at demographics in Multnomah County, it is about in the middle on the indicator. Multnomah County (e.g. Portland) is the most densely populated county in the state, with a highly diverse population. It ranks among the lowest counties in percent of people not in the workforce, but among the highest in people over 50 on SNAP.

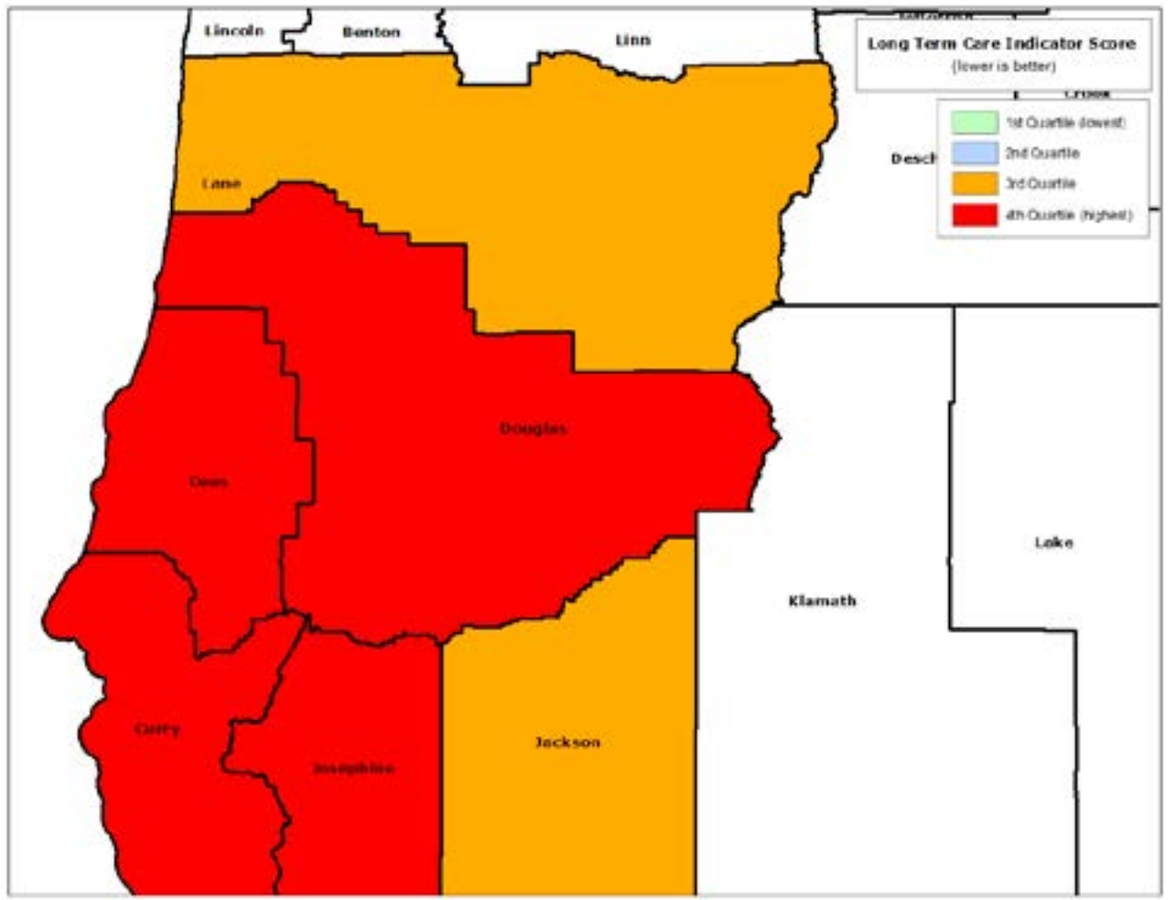


DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Mean Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
1	Columbia	8.2%	41.6%	$21,783	5.5%	156	15
1	Clatsop	9.2%	38.0%	$29,149	6.8%	168	21
1	Tillamook	9.2%	48.1%	$23,538	5.4%	171	26
2	Multnomah	7.7%	31.4%	$24,438	7.5%	159	16
15	Clackamas	6.3%	35.1%	$26,730	3.7%	108	4
16	Washington	5.6%	30.6%	$24,182	3.9%	101	3
3	Polk	8.0%	40.0%	$26,252	5.2%	146	10
3	Yamhill	8.5%	38.7%	$24,290	5.4%	154	12
3	Marion	7.9%	38.0%	$25,568	6.4%	155	14
4	Benton	5.3%	40.6%	$33,467	3.2%	93	1
4	Lincoln	8.8%	44.3%	$23,304	7.0%	179	30
4	Linn	8.7%	41.9%	$19,455	7.0%	179	31
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Southwest Oregon

(Lane, Douglas, Curry, Coos, Jackson, Josephine)

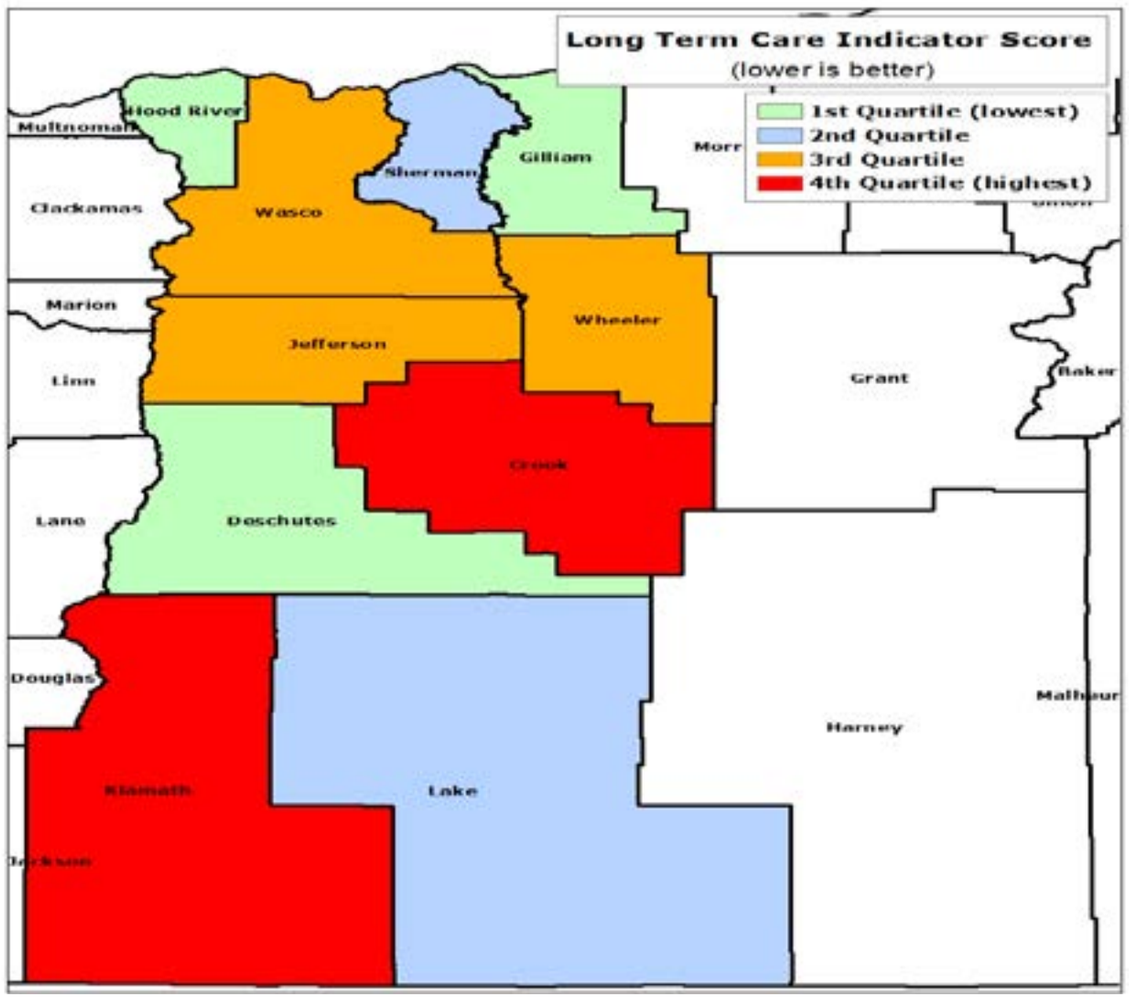
One of the more persistent themes in regional analysis has been the economic and demographic troubles of Southwest Oregon. Although Medford (Jackson County) and Eugene (Lane County) have improving economies, other parts of the area continue to lag. Beyond the economics, the area has the demographic problem of an aging population and a falling number of replacement workers. Less than half the adults are in the labor force in Curry and Josephine counties. Coos County has the highest indicator score in the state, driven by a very high number of people with independent living problems and a very low average retirement income.



DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Mean Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
5	Lane	8.8%	40.3%	$23,731	6.2%	167	20
6	Douglas	8.4%	48.7%	$21,386	6.7%	179	29
7	Curry	9.2%	52.3%	$25,932	6.0%	178	28
7	Coos	12.0%	48.7%	$19,986	8.3%	231	36
8	Jackson	8.4%	41.3%	$23,876	6.7%	169	25
8	Josephine	10.1%	52.3%	$23,455	7.3%	202	34
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Central Oregon

Central Oregon has the most rural counties in the state, which usually means fewer resources for disabled seniors and more poverty. But central Oregon also has some of the best places to grow old in, based on the Long Term Care Indicator Scores. Crook and Klamath have some of the highest scores in the state, influenced by a high percentage of people over age 50 receiving SNAP and a relatively high number of people over 35 experiencing difficulty living independently. Hood River and Deschutes County (the Bend metro area) have among the best scores, with high percentages of adults in the workforce.

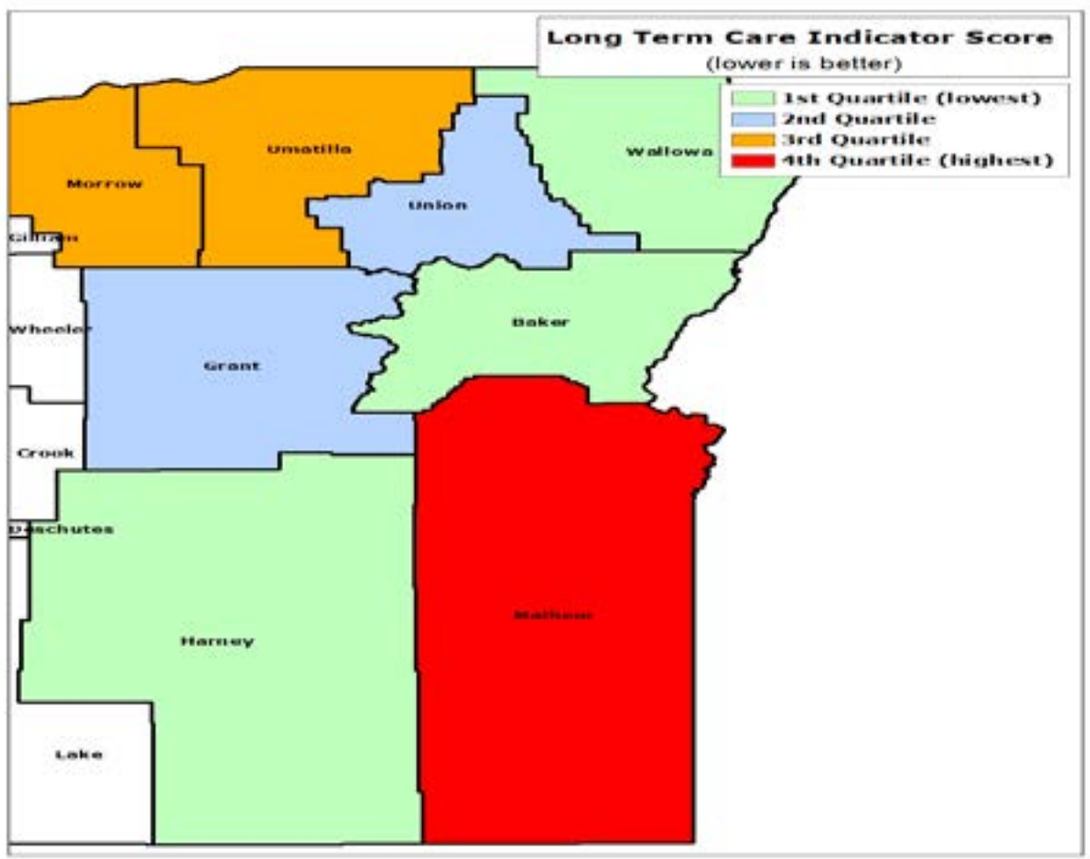


DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Average Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
9	Hood River	5.1%	32.1%	$25,242	3.9%	97	2
9	Gilliam	4.9%	38.3%	$18,770	4.0%	108	5
9	Sherman	8.0%	43.0%	$16,622	4.8%	154	11
9	Wheeler	10.1%	45.3%	$20,854	3.9%	165	19
9	Wasco	8.4%	42.1%	$21,112	6.4%	169	23
10	Deschutes	6.0%	38.5%	$32,799	5.1%	116	6
10	Jefferson	6.7%	44.3%	$24,767	8.7%	173	27
10	Crook	9.0%	46.2%	$18,903	7.0%	188	32
11	Lake	7.3%	44.1%	$17,432	6.3%	162	17
11	Klamath	11.0%	43.1%	$20,282	7.4%	207	35
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Eastern Oregon

Rural counties in eastern Oregon often fare poorly when creating index scores based on demographics and economics, but not this time. Baker, Wallowa, and Harney counties have among the best scores in the state on measures contained in the Long Term Care Indicator. Union and Grant have fairly good scores as well. Malheur County does not fare so well, however, with a high percentage of people with difficulty living independently and a high SNAP participation among people aged 50 and over.

Some individual scores are troublesome in the east – Grand County has a large percentage of people with difficulty living independently, while Harney has a very low average retirement income. But strong scores on other measures make up for that. Malheur doesn't have that feature – all the more worrisome in that Malheur has the second highest population (after Union) in the area.



DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Average Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
12	Morrow	8.2%	37.5%	$18,990	6.8%	169	22
12	Umatilla	7.6%	39.6%	$19,876	7.3%	169	24
13	Baker	7.1%	46.9%	$28,233	5.5%	145	8
13	Wallowa	7.9%	43.1%	$20,046	4.4%	146	9
13	Union	8.5%	43.2%	$22,042	4.9%	155	13
14	Harney	7.1%	43.3%	$19,460	4.8%	143	7
14	Grant	9.6%	47.7%	$23,834	4.3%	163	18
14	Malheur	9.2%	48.9%	$22,133	8.2%	201	33
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Total Department of Human Services Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Self-Sufficiency								
Supplemental Nutrition Assistance Program (Households)	405,818	405,142	-676	-0.2%	405,142	371,503	-33,640	-8.3%
Temporary Assistance for Needy Families - Basic & UN (Families: Cash Assistance)	23,508	23,299	-209	-0.9%	23,299	21,241	-2,057	-8.8%
Child Welfare (children served)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care[1]	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Vocational Rehabilitation	9,310	9,570	260	2.8%	9,570	10,275	705	7.4%
Aging & Physical Disabilities								
Long-Term Care: In Home	18,155	17,959	-196	-1.1%	17,959	19,982	2,023	11.3%
Long-Term Care: Community Based	11,834	11,886	52	0.4%	11,886	12,456	570	4.8%
Long-Term Care: Nursing Facilities	4,184	4,241	57	1.4%	4,241	4,123	-118	-2.8%
Intellectual and Developmental Disabilities								
Total Case Management Enrollment[2]	25,281	25,309	28	0.1%	25,309	28,218	2,909	11.5%
Total I/DD Services	19,141	19,254	113	0.6%	19,254	21,009	1,755	9.1%

1. Includes residential and foster care.

2. Some clients enrolled in Case Management do not receive any additional I/DD services.

Total Oregon Health Authority Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 2016 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Medical Assistance								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	4.2%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	0.6%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	1.1%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	6.5%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	**1,048,498**	**1,043,045**	**-5,453**	**-0.5%**	**1,043,045**	**982,661**	**-60,384**	**-5.8%**
Other Medical Assistance Total	73,016	73,765	749	1.0%	73,765	74,384	619	0.8%
Total Medical Assistance	**1,121,514**	**1,116,810**	**-4,704**	**-0.4%**	**1,116,810**	**1,057,045**	**-59,765**	**-5.4%**
Mental Health [1]								
Under Commitment								
Total Forensic Care	828	859	31	3.7%	859	861	2	0.2%
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	45,425	45,645	220	0.5%	45,645	47,523	1,878	4.1%

1. Numbers reported represent adults only.

Forecasted Biennial Average Totals by County

	SNAP Total			TANF			Long Term Care Total			Oregon Health Plan Total		
Counties	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia
Baker	1,965	1,843	-6.2%	121	113	-6.6%	127	131	3.1%	4,719	4,548	-3.6%
Benton	5,693	5,149	-9.6%	263	260	-1.1%	336	347	3.3%	14,915	14,225	-4.6%
Clackamas	25,397	22,170	-12.7%	1,160	1,071	-7.7%	2,761	2,952	6.9%	74,679	71,372	-4.4%
Clatsop	4,351	4,061	-6.7%	100	83	-17.0%	330	354	7.3%	10,745	10,291	-4.2%
Columbia	5,243	4,977	-5.1%	238	206	-13.4%	390	419	7.4%	12,017	11,490	-4.4%
Coos	10,150	9,545	-6.0%	464	459	-1.1%	1,071	1,187	10.8%	20,650	19,344	-6.3%
Crook	2,537	2,222	-12.4%	117	103	-12.0%	220	237	7.7%	6,699	6,444	-3.8%
Curry	2,883	2,740	-5.0%	71	71	0.0%	283	303	7.1%	6,475	6,233	-3.7%
Deschutes	14,734	12,480	-15.3%	452	272	-39.8%	927	990	6.8%	44,552	42,484	-4.6%
Douglas	15,106	14,633	-3.1%	867	752	-13.3%	1,101	1,119	1.6%	33,996	32,123	-5.5%
Gilliam	148	145	-2.0%	7	7	0.0%	14	15	7.1%	434	438	0.9%
Grant	642	595	-7.3%	17	16	-5.9%	64	67	4.7%	1,640	1,577	-3.8%
Harney	818	803	-1.8%	29	23	-20.7%	60	60	0.0%	2,049	1,966	-4.1%
Hood River	1,528	1,374	-10.1%	51	47	-7.8%	97	97	0.0%	6,621	6,341	-4.2%
Jackson	26,833	25,147	-6.3%	1,669	1,576	-5.6%	1,846	1,964	6.4%	66,838	63,716	-4.7%
Jefferson	3,705	3,670	-0.9%	313	266	-15.0%	185	190	2.7%	9,479	9,503	0.3%
Josephine	13,796	13,290	-3.7%	965	919	-4.8%	953	960	0.7%	30,534	28,787	-5.7%
Klamath	9,867	9,522	-3.5%	473	448	-5.3%	582	626	7.6%	22,352	21,170	-5.3%
Lake	841	782	-7.0%	18	19	5.6%	52	57	9.6%	2,045	1,978	-3.3%
Lane	45,895	44,206	-3.7%	2,083	2,025	-2.8%	3,559	3,968	11.5%	101,207	96,036	-5.1%
Lincoln	6,666	6,433	-3.5%	294	273	-7.1%	580	601	3.6%	14,970	14,196	-5.2%

Forecasted Biennial Average Totals by County (Cont'd)

	SNAP Total			TANF			Long Term Care Total			Oregon Health Plan Total		
Counties	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia
Linn	15,594	15,041	-3.5%	817	709	-13.2%	1,458	1,611	10.5%	36,044	33,029	-8.4%
Malheur	4,201	3,840	-8.6%	315	295	-6.3%	327	344	5.2%	11,032	10,603	-3.9%
Marion	36,595	34,587	-5.5%	2,508	2,272	-9.4%	2,788	3,103	11.3%	98,203	88,837	-9.5%
Morrow	1,081	997	-7.8%	85	80	-5.9%	68	78	14.7%	3,404	3,270	-3.9%
Multnomah	82,803	72,853	-12.0%	5,784	5,197	-10.1%	7,933	8,471	6.8%	207,862	193,255	-7.0%
Polk	7,732	7,349	-5.0%	590	556	-5.8%	718	782	8.9%	20,140	18,968	-5.8%
Sherman	150	154	2.7%	4	4	0.0%	9	9	0.0%	371	381	2.7%
Tillamook	2,620	2,423	-7.5%	67	52	-22.4%	208	225	8.2%	6,897	6,606	-4.2%
Umatilla	7,950	7,264	-8.6%	568	551	-3.0%	688	705	2.5%	22,222	20,826	-6.3%
Union	2,681	2,654	-1.0%	226	217	-4.0%	231	242	4.8%	7,122	6,595	-7.4%
Wallowa	596	589	-1.2%	39	40	2.6%	87	99	13.8%	1,940	1,914	-1.3%
Wasco	2,999	2,727	-9.1%	99	99	0.0%	284	292	2.8%	8,195	7,859	-4.1%
Washington	31,386	26,375	-16.0%	1,774	1,636	-7.8%	2,850	3,020	6.0%	105,674	100,830	-4.6%
Wheeler	153	150	-2.0%	2	2	0.0%	12	16	33.3%	360	362	0.6%
Yamhill	9,522	8,713	-8.5%	548	523	-4.6%	887	913	2.9%	25,960	25,066	-3.4%

Regional Forecasts by District

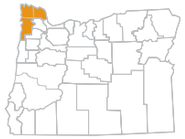
District 1 Regional Forecast

Employment in District 1 has essentially returned to pre-recession levels. As with many parts of the state, however, employment is somewhat restructured. For example, logging and other natural resource-related jobs have not returned, nor have manufacturing jobs related to wood and paper products. In their place are jobs in healthcare, leisure, hospitality, and food service. These tend to be lower-paying jobs than the ones lost during the Great Recession.

Unemployment in Oregon was at 5.4 percent as of August 2016, which is higher than the nation. Oregon unemployment has gone up a bit since the low values seen in the spring, but that is not due to an economic downturn. Instead, the increase is due to more people looking for work – a sign of a healthy economy. The current rate is still in the ballpark of what economists refer to as "full employment." Tillamook and Clatsop counties are employing more people than before the Great Recession. Columbia County is close to that milestone, but is behind its neighbors due to the dramatic loss of logging, construction, and manufacturing jobs after 2007.

Due to the higher unemployment rate in Columbia County, the number of families receiving SNAP benefits is expected to fall slower than statewide. The TANF caseload is expected to fall more quickly in District 1 than the state overall.

DISTRICT 1	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Clatsop	37,652	19.9%	18.1%	$47,337	15.8%	5.9%	5.4%
Columbia	50,882	23.0%	15.5%	$54,605	13.1%	7.5%	6.7%
Tillamook	27,897	19.1%	21.9%	$43,037	17.6%	6.1%	5.6%



District 1 Regional Forecast, Oregon Department of Human Services

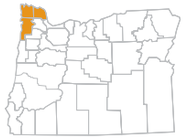
Counties served: Clatsop, Columbia and Tillamook

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Clatsop	2,754	2,662	-3.3%	2,662	2,226	-16.4%
Columbia	3,460	3,422	-1.1%	3,422	3,067	-10.4%
Tillamook	1,715	1,674	-2.4%	1,674	1,428	-14.7%
District 1 Total	**7,929**	**7,758**	**-2.2%**	**7,758**	**6,721**	**-13.4%**
SNAP - Aid to People with Disabilities						
Clatsop	1,683	1,689	0.4%	1,689	1,835	8.6%
Columbia	1,846	1,821	-1.4%	1,821	1,910	4.9%
Tillamook	934	946	1.3%	946	995	5.2%
District 1 Total	**4,463**	**4,456**	**-0.2%**	**4,456**	**4,740**	**6.4%**
TANF						
Clatsop	114	100	-12.3%	100	83	-17.00%
Columbia	254	238	-6.3%	238	206	-13.45%
Tillamook	79	67	-15.2%	67	52	-22.39%
District 1 Total	**447**	**405**	**-9.4%**	**405**	**341**	**-15.8%**

District 1 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Clatsop, Coulumbia and Tillamook

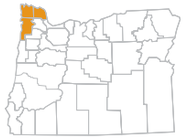
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Clatsop	145	147	1.4%	147	162	10.2%
Columbia	206	194	-5.8%	194	210	8.2%
Tillamook	100	96	-4.0%	96	101	5.2%
District 1 Total	**451**	**437**	**-3.1%**	**437**	**473**	**8.2%**
Community-Based Care						
Clatsop	154	153	-0.6%	153	165	7.8%
Columbia	134	134	0.0%	134	149	11.2%
Tillamook	85	96	12.9%	96	110	14.6%
District 1 Total	**373**	**383**	**2.7%**	**383**	**424**	**10.7%**
Nursing Care						
Clatsop	34	30	-11.8%	30	27	-10.0%
Columbia	60	62	3.3%	62	60	-3.2%
Tillamook	18	16	-11.1%	16	14	-12.5%
District 1 Total	**112**	**108**	**-3.6%**	108	101	**-6.5%**



District 1 Regional Forecast, Oregon Health Authority (clients)

Counties served: Clatsop, Coulumbia and Tillamook

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Clatsop	606	634	4.6%	634	643	1.4%
Columbia	887	977	10.1%	977	987	1.0%
Tillamook	408	440	7.8%	440	440	0.0%
District 1 Total	**1,901**	**2,051**	**7.9%**	**2,051**	**2,070**	**0.9%**
Children's Medicaid Program						
Clatsop	3,441	3,318	-3.6%	3,318	3,385	2.0%
Columbia	3,737	3,710	-0.7%	3,710	3,845	3.6%
Tillamook	2,392	2,292	-4.2%	2,292	2,331	1.7%
District 1 Total	**9,570**	**9,320**	**-2.6%**	**9,320**	**9,561**	**2.6%**
Children's Health Insurance Program (CHIP)						
Clatsop	569	596	4.7%	596	555	-6.9%
Columbia	617	617	0.0%	617	510	-17.3%
Tillamook	365	373	2.2%	373	353	-5.4%
District 1 Total	**1,551**	**1,586**	**2.3%**	**1,586**	**1,418**	**-10.6%**
Pregnant Women Program						
Clatsop	173	183	5.8%	183	158	-13.7%
Columbia	174	182	4.6%	182	151	-17.0%
Tillamook	87	100	14.9%	100	88	-12.0%
District 1 Total	**434**	**465**	**7.1%**	**465**	**397**	**-14.6%**



District 1 Regional Forecast, Oregon Health Authority (continued)

Counties served: Clatsop, Coulumbia and Tillamook

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Clatsop	229	212	-7.4%	212	206	-2.8%
Columbia	350	353	0.9%	353	368	4.2%
Tillamook	111	107	-3.6%	107	109	1.9%
District 1 Total	**690**	**672**	**-2.6%**	**672**	**683**	**1.6%**
Aid to the Blind/Disabled						
Clatsop	859	853	-0.7%	853	860	0.8%
Columbia	1,083	1,082	-0.1%	1,082	1,119	3.4%
Tillamook	598	592	-1.0%	592	621	4.9%
District 1 Total	**2,540**	**2,527**	**-0.5%**	**2,527**	**2,600**	**2.9%**
Old Age Assistance						
Clatsop	371	377	1.6%	377	401	6.4%
Columbia	453	446	-1.5%	446	489	9.6%
Tillamook	236	242	2.5%	242	256	5.8%
District 1 Total	**1,060**	**1,065**	**0.5%**	**1,065**	**1,146**	**7.6%**
ACA Adults						
Clatsop	4,679	4,572	-2.3%	4,572	4,083	-10.7%
Columbia	4,765	4,650	-2.4%	4,650	4,021	-13.5%
Tillamook	2,804	2,751	-1.9%	2,751	2,408	-12.5%
District 1 Total	**12,248**	**11,973**	**-2.2%**	**11,973**	**10,512**	**-12.2%**

Portland Area - Dritricts 2, 15 and 16 Regional Forecast

Previously, we have presented Multnomah County (District 2), Clackamas County (District 15), and Washington County (District 16) in three separate sections. Starting in the spring of 2016 these three districts were presented together as the "Portland Area." The primary reason for the change is to simplify the report, and remove one-county districts. Furthermore, since these counties are linked economically, presenting them together makes sense for readers wanting to understand the Portland Area.

Unemployment is five percent or less for each of the three counties that make up the Portland area. That rate is considered by economists to be essentially "full employment." Over 78,000 more people are employed in the Portland area than were employed before the Great Recession; an increase of 9.2 percent. The economy is not only providing jobs for locals newly entering the workforce, but it is also creating jobs for migrants moving to Portland. Migration to the Portland area has been increasing steadily, and is now at levels not seen since the 1990s. A downside to Portland's population increase is a housing shortage – especially affordable housing.

Despite the good news concerning job growth in the Portland area, there are still soft spots in construction, some types of manufacturing employment, and transportation. Retail sales, leisure, and other service-sector jobs have surged. High-paying professional services and management jobs are also on the rise.

The federal government has reinstated the "Able Bodied Adults without Dependents" or ABAWD rule for SNAP clients in Clackamas County starting in October 2016. The ABAWD rule cuts off SNAP for non-disabled adults without children after three months of assistance (see the special section on ABAWD in the Spring 2016 Regional Forecast for more information). This is the third Oregon county to have the rule reinstated – it was applied to Multnomah and Washington counties in early 2016. It is estimated that as a result of this exclusion, 4.7% of the cases in Clackamas County will close in January 2017 after the three month period ends. This calculation is based on the percentage of single-person cases in Clackamas County (which are the most likely type of case to close as a result of application of ABAWD) and an analysis of the volume of case closures in Multnomah and Washington counties when ABAWD was re-applied there.

TANF and SNAP Self-Sufficiency are likely to fall faster in the Portland Metro Area than the state overall through mid-2019, while Long Term Care is expected to grow more slowly, given that the area has a population skewed toward younger adults.

Portland Area	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Clackamas (District 15)	424,648	22.9%	14.9%	$64,700	9.7%	5.5%	5.0%
Multnomah (District 2)	735,445	20.1%	11.2%	$52,845	18.5%	5.3%	4.8%
Washington (District 16)	599,377	24.9%	11.0%	$65,272	11.8%	5.0%	4.6%

Portland Area Regional Forecast, Oregon Department of Human Services

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Multnomah (District 2)	56,006	54,769	-2.2%	54,769	44,231	-19.2%
Clackamas (District 15)	17,344	17,288	-0.3%	17,288	13,742	-20.5%
Washington (District 16)	23,053	22,795	-1.1%	22,795	17,630	-22.7%
SNAP - Aid to People with Disabilities						
Multnomah (District 2)	28,100	28,034	-0.2%	28,034	28,622	2.1%
Clackamas (District 15)	8,116	8,109	-0.1%	8,109	8,428	3.9%
Washington (District 16)	8,665	8,591	-0.9%	8,591	8,745	1.8%
TANF						
Multnomah (District 2)	5,876	5,784	-1.6%	5,784	5,197	-10.1%
Clackamas (District 15)	1,175	1,160	-1.3%	1,160	1,071	-7.7%
Washington (District 16)	1,773	1,774	0.1%	1,774	1,636	-7.8%

Portland Area Regional Forecast, Oregon Department of Human Services

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Multnomah (District 2)	4,173	4,147	-0.6%	4,147	4,581	10.5%
Clackamas (District 15)	1,361	1,376	1.1%	1,376	1,515	10.1%
Washington (District 16)	1,373	1,310	-4.6%	1,310	1,434	9.5%
Community-Based Care						
Multnomah (District 2)	2,536	2,574	1.5%	2,574	2,699	4.9%
Clackamas (District 15)	1,046	1,024	-2.1%	1,024	1,085	6.0%
Washington (District 16)	1,177	1,166	-0.9%	1,166	1,230	5.5%
Nursing Care						
Multnomah (District 2)	1,211	1,212	0.1%	1,212	1,191	-1.7%
Clackamas (District 15)	355	361	1.7%	361	352	-2.5%
Washington (District 16)	379	374	-1.3%	374	356	-4.8%

Portland Area Regional Forecast, Oregon Health Authority

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Multnomah (District 2)	10,996	12,119	10.2%	12,119	11,498	-5.1%
Clackamas (District 15)	5,010	5,092	1.6%	5,092	5,320	4.5%
Washington (District 16)	6,563	6,658	1.4%	6,658	6,590	-1.0%
Children's Medicaid Program						
Multnomah (District 2)	59,362	60,578	2.0%	60,578	58,800	-2.9%
Clackamas (District 15)	24,429	23,881	-2.2%	23,881	24,347	2.0%
Washington (District 16)	38,496	38,913	1.1%	38,913	39,403	1.3%
Children's Health Insurance Program (CHIP)						
Multnomah (District 2)	9,714	9,896	1.9%	9,896	9,237	-6.7%
Clackamas (District 15)	5,315	5,429	2.1%	5,429	5,099	-6.1%
Washington (District 16)	8,180	8,285	1.3%	8,285	7,750	-6.5%
Pregnant Women Program						
Multnomah (District 2)	3,011	3,064	1.8%	3,064	2,396	-21.8%
Clackamas (District 15)	1,201	1,216	1.2%	1,216	960	-21.1%
Washington (District 16)	1,578	1,643	4.1%	1,643	1,322	-19.5%
Foster Care & Adoption Services						
Multnomah (District 2)	3,322	3,270	-1.6%	3,270	3,271	0.0%
Clackamas (District 15)	1,403	1,469	4.7%	1,469	1,520	3.5%
Washington (District 16)	1,562	1,589	1.7%	1,589	1,633	2.8%

Portland Area Regional Forecast, Oregon Health Authority (continued)

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Multnomah (District 2)	17,675	17,695	0.1%	17,695	18,083	2.2%
Clackamas (District 15)	5,555	5,600	0.8%	5,600	5,807	3.7%
Washington (District 16)	6,198	6,217	0.3%	6,217	6,501	4.6%
Old Age Assistance						
Multnomah (District 2)	10,648	10,754	1.0%	10,754	11,843	10.1%
Clackamas (District 15)	3,185	3,165	-0.6%	3,165	3,441	8.7%
Washington (District 16)	4,605	4,661	1.2%	4,661	5,273	13.1%
ACA Adults						
Multnomah (District 2)	93,039	90,486	-2.7%	90,486	78,127	-13.7%
Clackamas (District 15)	29,573	28,827	-2.5%	28,827	24,878	-13.7%
Washington (District 16)	38,785	37,708	-2.8%	37,708	32,358	-14.2%

District 3 Regional Forecast

Employment conditions have improved in Marion and Polk counties, where unemployment rates are now comparable to statewide numbers. Yamhill County has historically enjoyed unemployment lower than the state overall. Employment is well above pre-recession levels with over 9,200 new jobs created in District 3 between August 2015 and 2016. This represents a growth in employment of almost five percent, second highest in the state.

Manufacturing and construction employment are still below pre-recession levels in Yamhill County, while service-sector jobs in health care and leisure are surging. Marion and Polk counties have seen an increase in construction employment of over 12 percent in one year, an increase that moves construction back to pre-recession levels.

The improved economy is expected to move families off the SNAP and TANF rolls faster in Marion County than in the other District 3 counties, and faster than the state overall. Polk and Yamhill counties will also experience reductions, but at a slower pace.

DISTRICT 3	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Marion	344,443	25.9%	13.6%	$47,360	19.1%	6.6%	5.6%
Polk	83,338	23.8%	15.9%	$51,880	17.0%	6.1%	5.8%
Yamhill	108,812	24.1%	14.5%	$53,864	16.7%	5.6%	5.2%

District 3 Regional Forecast, Oregon Department of Human Services

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Marion	27,101	27,178	0.3%	27,178	24,601	-9.5%
Polk	5,650	5,585	-1.2%	5,585	5,092	-8.8%
Yamhill	6,847	6,885	0.6%	6,885	5,947	-13.6%
District 3 Total	**39,598**	**39,648**	**0.1%**	**39,648**	**35,640**	**-10.1%**
SNAP - Aid to People with Disabilities						
Marion	9,350	9,417	0.7%	9,417	9,986	6.0%
Polk	2,103	2,147	2.1%	2,147	2,257	5.1%
Yamhill	2,646	2,637	-0.3%	2,637	2,766	4.9%
District 3 Total	**14,099**	**14,201**	**0.7%**	**14,201**	**15,009**	**5.7%**
TANF						
Marion	2,593	2,508	-3.3%	2,508	2,272	-9.4%
Polk	615	590	-4.1%	590	556	-5.8%
Yamhill	570	548	-3.9%	548	523	-4.6%
District 3 Total	**3,778**	**3,646**	**-3.5%**	**3,646**	**3,351**	**-8.1%**

District 3 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Marion	1,450	1,519	4.8%	1,519	1,803	18.7%
Polk	365	368	0.8%	368	419	13.9%
Yamhill	339	357	5.3%	357	376	5.3%
District 3 Total	**2,154**	**2,244**	**4.2%**	**2,244**	**2,598**	**15.8%**
Community-Based Care						
Marion	937	973	3.8%	973	1,033	6.2%
Polk	250	272	8.8%	272	297	9.2%
Yamhill	415	409	-1.4%	409	416	1.7%
District 3 Total	**1,602**	**1,654**	**3.2%**	**1,654**	**1,746**	**5.6%**
Nursing Care						
Marion	260	296	13.8%	296	267	-9.8%
Polk	81	78	-3.7%	78	66	-15.4%
Yamhill	120	121	0.8%	121	121	0.0%
District 3 Total	**461**	**495**	**7.4%**	**495**	**454**	**-8.3%**

District 3 Regional Forecast, Oregon Health Authority (clients)

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Marion	5,721	6,143	7.4%	6,143	5,984	-2.6%
Polk	1,520	1,545	1.6%	1,545	1,545	0.0%
Yamhill	1,660	1,812	9.2%	1,812	2,027	11.9%
District 3 Total	**8,901**	**9,500**	**6.7%**	**9,500**	**9,556**	**0.6%**
Children's Medicaid Program						
Marion	40,033	39,362	-1.7%	39,362	34,526	-12.3%
Polk	7,533	7,374	-2.1%	7,374	7,232	-1.9%
Yamhill	9,694	9,407	-3.0%	9,407	9,374	-0.4%
District 3 Total	**57,260**	**56,143**	**-2.0%**	**56,143**	**51,132**	**-8.9%**
Children's Health Insurance Program (CHIP)						
Marion	6,076	6,169	1.5%	6,169	5,640	-8.6%
Polk	1,177	1,227	4.2%	1,227	1,133	-7.7%
Yamhill	1,812	1,858	2.5%	1,858	1,731	-6.8%
District 3 Total	**9,065**	**9,254**	**2.1%**	**9,254**	**8,504**	**-8.1%**
Pregnant Women Program						
Marion	1,579	1,574	-0.3%	1,574	1,290	-18.0%
Polk	268	297	10.8%	297	244	-17.8%
Yamhill	441	453	2.7%	453	351	-22.5%
District 3 Total	**2,288**	**2,324**	**1.6%**	**2,324**	**1,885**	**-18.9%**

District 3 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Marion	1,751	1,747	-0.2%	1,747	1,786	2.2%
Polk	382	392	2.6%	392	402	2.6%
Yamhill	423	411	-2.8%	411	417	1.5%
District 3 Total	**2,556**	**2,550**	**-0.2%**	**2,550**	**2,605**	**2.2%**
Aid to the Blind/Disabled						
Marion	7,024	7,065	0.6%	7,065	7,312	3.5%
Polk	1,570	1,574	0.3%	1,574	1,618	2.8%
Yamhill	1,732	1,751	1.1%	1,751	1,864	6.5%
District 3 Total	**10,326**	**10,390**	**0.6%**	**10,390**	**10,794**	**3.9%**
Old Age Assistance						
Marion	3,500	3,579	2.3%	3,579	4,112	14.9%
Polk	671	689	2.7%	689	721	4.6%
Yamhill	983	1,005	2.2%	1,005	1,131	12.5%
District 3 Total	**5,154**	**5,273**	**2.3%**	**5,273**	**5,964**	**13.1%**
ACA Adults						
Marion	33,381	32,564	-2.4%	32,564	28,187	-13.4%
Polk	7,191	7,042	-2.1%	7,042	6,073	-13.8%
Yamhill	9,438	9,263	-1.9%	9,263	8,171	-11.8%
District 3 Total	**50,010**	**48,869**	**-2.3%**	**48,869**	**42,431**	**-13.2%**

District 4 Regional Forecast

District 4 is the most economically diverse region in this report, with coastal tourism dominating Lincoln County, agriculture and manufacturing dominating Linn County, and university employment dominating Benton County.

Employment in District 4 has finally returned to pre-recession levels, due mostly to the strength of Benton and Linn Counties – Lincoln County still has a way to go. Lincoln experienced a sharp drop in construction and leisure/hospitality jobs, and has yet to fully recover.

Manufacturing is improving in Linn County, which created over 400 new jobs in August 2016 compared to the previous year.

Unemployment in Benton County continues to be among the lowest in the state, while Linn and Lincoln counties have unemployment over six percent – a great improvement over recession-era numbers, but still higher than the state overall.

The caseload for SNAP Self-Sufficiency is expected to decline through the forecast horizon in District 4, but more slowly than statewide. The TANF caseload in Benton County is expected to remain relatively flat, given that it has fallen to a relatively low "floor," and isn't likely to fall further. Linn County is expected to reduce TANF cases at a faster rate than the state overall.

Long Term Care caseloads in Benton and Lincoln Counties are likely to increase slowly through the forecast horizon, with Linn County expected to increase faster.

DISTRICT 4	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Benton	88,995	17.2%	13.2%	$49,338	22.7%	4.6%	4.6%
Lincoln	48,776	17.3%	23.2%	$42,429	17.1%	7.0%	6.1%
Linn	115,156	23.7%	16.2%	$44,965	19.5%	7.3%	6.5%

District 4 Regional Forecast, Oregon Department of Human Services

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Benton	4,344	4,295	-1.1%	4,295	3,623	-15.6%
Lincoln	4,135	4,213	1.9%	4,213	3,912	-7.1%
Linn	10,955	10,865	-0.8%	10,865	10,127	-6.8%
District 4 Total	**19,434**	**19,373**	**-0.3%**	**19,373**	**17,662**	**-8.8%**
SNAP - Aid to People with Disabilities						
Benton	1,398	1,398	0.0%	1,398	1,526	9.2%
Lincoln	2,498	2,453	-1.8%	2,453	2,521	2.8%
Linn	4,745	4,729	-0.3%	4,729	4,914	3.9%
District 4 Total	**8,641**	**8,580**	**-0.7%**	**8,580**	**8,961**	**4.4%**
TANF						
Benton	260	263	1.2%	263	260	-1.1%
Lincoln	291	294	1.0%	294	273	-7.1%
Linn	856	817	-4.6%	817	709	-13.2%
District 4 Total	**1,407**	**1,374**	**-2.3%**	**1,374**	**1,242**	**-9.6%**

District 4 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Benton	173	176	1.7%	176	181	2.8%
Lincoln	430	396	-7.9%	396	412	4.0%
Linn	900	866	-3.8%	866	984	13.6%
District 4 Total	**1,503**	**1,438**	**-4.3%**	**1,438**	**1,577**	**9.7%**
Community-Based Care						
Benton	115	120	4.3%	120	128	6.7%
Lincoln	123	135	9.8%	135	141	4.4%
Linn	415	408	-1.7%	408	444	8.8%
District 4 Total	**653**	**663**	**1.5%**	**663**	**713**	**7.5%**
Nursing Care						
Benton	39	40	2.6%	40	38	-5.0%
Lincoln	42	49	16.7%	49	48	-2.0%
Linn	185	184	-0.5%	184	183	-0.5%
District 4 Total	**266**	**273**	**2.6%**	**273**	**269**	**-1.5%**

District 4 Regional Forecast, Oregon Health Authority (clients)

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Benton	869	929	6.9%	929	925	-0.4%
Lincoln	906	947	4.5%	947	920	-2.9%
Linn	2,385	2,595	8.8%	2,595	2,596	0.0%
District 4 Total	**4,160**	**4,471**	**7.5%**	**4,471**	**4,441**	**-0.7%**
Children's Medicaid Program						
Benton	4,490	4,398	-2.0%	4,398	4,513	2.6%
Lincoln	4,568	4,477	-2.0%	4,477	4,414	-1.4%
Linn	12,690	12,113	-4.5%	12,113	11,074	-8.6%
District 4 Total	**21,748**	**20,988**	**-3.5%**	**20,988**	**20,001**	**-4.7%**
Children's Health Insurance Program (CHIP)						
Benton	1,000	1,059	5.9%	1,059	1,137	7.4%
Lincoln	732	767	4.8%	767	711	-7.3%
Linn	2,006	2,121	5.7%	2,121	1,995	-5.9%
District 4 Total	**3,738**	**3,947**	**5.6%**	**3,947**	**3,843**	**-2.6%**
Pregnant Women Program						
Benton	203	202	-0.5%	202	173	-14.4%
Lincoln	208	219	5.3%	219	177	-19.2%
Linn	598	648	8.4%	648	540	-16.7%
District 4 Total	**1,009**	**1,069**	**5.9%**	**1,069**	**890**	**-16.7%**

District 4 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Benton	214	204	-4.7%	204	203	-0.5%
Lincoln	288	292	1.4%	292	300	2.7%
Linn	721	692	-4.0%	692	706	2.0%
District 4 Total	**1,223**	**1,188**	**-2.9%**	**1,188**	**1,209**	**1.8%**
Aid to the Blind/Disabled						
Benton	1,126	1,148	2.0%	1,148	1,183	3.0%
Lincoln	1,309	1,316	0.5%	1,316	1,345	2.2%
Linn	3,350	3,271	-2.4%	3,271	3,198	-2.2%
District 4 Total	**5,785**	**5,735**	**-0.9%**	**5,735**	**5,726**	**-0.2%**
Old Age Assistance						
Benton	407	407	0.0%	407	425	4.4%
Lincoln	634	655	3.3%	655	778	18.8%
Linn	1,377	1,365	-0.9%	1,365	1,468	7.5%
District 4 Total	**2,418**	**2,427**	**0.4%**	**2,427**	**2,671**	**10.1%**
ACA Adults						
Benton	6,666	6,568	-1.5%	6,568	5,666	-13.7%
Lincoln	6,421	6,297	-1.9%	6,297	5,551	-11.8%
Linn	13,579	13,239	-2.5%	13,239	11,452	-13.5%
District 4 Total	**26,666**	**26,104**	**-2.1%**	**26,104**	**22,669**	**-13.2%**

South-Central Oregon - Districts 5 and 6 Regional Forecast

Lane County (District 5) and Douglas County (District 6) are being presented together as "South-Central Oregon." Although these two counties share the same region, they are somewhat different in terms of economy and demographics.

Lane County is something of a microcosm of the state as a whole: some costal/tourism employment, some agriculture, some manufacturing, and a large white-collar workforce in Eugene. Historically, unemployment has been about the same in Lane County as the state overall, although recently that is not the case. Unemployment is a bit higher in Lane County, and employment levels have yet to return to pre-recession levels. There has been broad-based improvement in most employment sectors, but construction and manufacturing jobs are still well below pre-recession levels, lowering the total employment level. Manufacturing remains 32 percent below pre-recession levels, and construction is 23 percent below 2007 levels. These two sectors alone represent a drop of 8,200 jobs comparing August 2016 to 2007.

Unemployment in Douglas County is among the highest in the state. Still, things are improving from the six years when Douglas County unemployment was in double-digits, which started in 2008. Historically, Douglas County has had higher unemployment than the state overall.

Employment opportunities are improving in Douglas County with over 1,200 more jobs in August 2016 than the year before, but the county still has a ways to go to reach pre-recession levels. Manufacturing and construction jobs remain low, as they are in many parts of the state. Unfortunately, many employment sectors that have bounced back in other parts of Oregon – like hospitality, retail sales, and government – still remain well below pre-recession levels.

Due to the continuing lag in recovery from the Great Recession, SNAP caseloads are forecast to drop more slowly in these counties than statewide. Long Term Care is expected to rise more quickly in Lane County than the state overall due to the increases in In-Home Care. TANF in Douglas County is expected to fall at the same pace as the state overall as employment picks up.

Southwestern Oregon	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Lane (District 5)	365,639	19.4%	16.2%	$43,685	20.4%	6.4%	5.9%
Douglas (District 6)	112,043	19.8%	22.3%	$40,820	19.7%	8.2%	7.0%

South-Central Oregon Regional Forecast, Oregon Department of Human Services

Counties served: Southwestern Oregon: Lane (District 5); Douglas (District 6)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Lane (District 5)	31,515	31,278	-0.8%	31,278	28,643	-8.4%
Douglas (District 6)	9,369	9,523	1.6%	9,523	8,636	-9.3%
SNAP - Aid to People with Disabilities						
Lane (District 5)	14,657	14,617	-0.3%	14,617	15,563	6.5%
Douglas (District 6)	5,625	5,583	-0.7%	5,583	5,997	7.4%
TANF						
Lane (District 5)	2,057	2,083	1.3%	2,083	2,025	-2.8%
Douglas (District 6)	918	867	-5.6%	867	752	-13.3%
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Lane (District 5)	2,092	2,061	-1.5%	2,061	2,446	18.7%
Douglas (District 6)	636	624	-1.9%	624	648	3.8%
Community-Based Care						
Lane (District 5)	1,049	1,042	-0.7%	1,042	1,060	1.7%
Douglas (District 6)	369	361	-2.2%	361	359	-0.6%
Nursing Care						
Lane (District 5)	457	456	-0.2%	456	462	1.3%
Douglas (District 6)	116	116	0.0%	116	112	-3.4%

South-Central Oregon Regional Forecast, Oregon Health Authority (clients)

Counties served: Southwestern Oregon: Lane (District 5); Douglas (District 6)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Lane (District 5)	6,334	6,638	4.8%	6,638	6,684	0.7%
Douglas (District 6)	2,284	2,588	13.3%	2,588	2,505	-3.2%
Children's Medicaid Program						
Lane (District 5)	28,353	28,614	0.9%	28,614	28,214	-1.4%
Douglas (District 6)	10,826	10,564	-2.4%	10,564	10,495	-0.7%
Children's Health Insurance Program (CHIP)						
Lane (District 5)	5,312	5,531	4.1%	5,531	5,347	-3.3%
Douglas (District 6)	1,394	1,402	0.6%	1,402	1,302	-7.1%
Pregnant Women Program						
Lane (District 5)	1,622	1,699	4.7%	1,699	1,410	-17.0%
Douglas (District 6)	461	505	9.5%	505	394	-22.0%
Foster Care & Adoption Services						
Lane (District 5)	2,572	2,602	1.2%	2,602	2,733	5.0%
Douglas (District 6)	833	855	2.6%	855	898	5.0%

South-Central Oregon Regional Forecast, Oregon Health Authority (continued)

Counties served: Southwestern Oregon: Lane (District 5); Douglas (District 6)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Lane (District 5)	9,795	9,719	-0.8%	9,719	10,008	3.0%
Douglas (District 6)	3,121	3,104	-0.5%	3,104	3,193	2.9%
Old Age Assistance						
Lane (District 5)	3,934	4,000	1.7%	4,000	4,632	15.8%
Douglas (District 6)	1,210	1,201	-0.7%	1,201	1,251	4.2%
ACA Adults						
Lane (District 5)	43,142	42,404	-1.7%	42,404	37,008	-12.7%
Douglas (District 6)	14,060	13,777	-2.0%	13,777	12,085	-12.3%

District 7 Regional Forecast

Coos and Curry counties have still not recovered from employment losses incurred during the Great Recession. However, both counties are adding jobs – Curry County added 360 jobs and Coos County added 120 comparing August 2016 to the August 2015. Unemployment in both counties is higher than statewide, but is improving.

Both counties had an extreme draw-down in construction employment, logging, and wood products manufacturing during the Great Recession. Local government in Coos County employs significantly fewer people than before the recession; a result of a lower tax base and insecurity about continued funding from federal timber payments.

The economies of Coos and Curry counties are also fighting uphill against a demographic tide. The region is losing its population of young working-age adults. This hampers the region's ability 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, while at the same time the district has a smaller base of employment-age adults to provide those services.

SNAP caseloads are expected to fall in Coos and Curry counties in line with statewide expectations. TANF caseloads have reached pre-recession levels in both counties, and are therefore expected to remain flat at this caseload "floor." Coos County is expected to increase Long Term Care faster than the state overall, due to increases in In-Home Care.

DISTRICT 7	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Coos	63,897	18.7%	22.7%	$39,193	18.0%	7.9%	7.0%
Curry	22,112	15.7%	29.5%	$41,939	15.4%	8.9%	7.5%

District 7 Regional Forecast, Oregon Department of Human Services (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Coos	5,979	6,237	4.3%	6,237	5,477	-12.2%
Curry	1,481	1,534	3.6%	1,534	1,343	-12.5%
District 7 Total	**7,460**	**7,771**	**4.2%**	**7,771**	**6,820**	**-12.2%**
SNAP - Aid to People with Disabilities						
Coos	3,901	3,913	0.3%	3,913	4,068	4.0%
Curry	1,351	1,349	-0.1%	1,349	1,397	3.6%
District 7 Total	**5,252**	**5,262**	**0.2%**	**5,262**	**5,465**	**3.9%**
TANF						
Coos	470	464	-1.3%	464	459	-1.1%
Curry	71	71	0.0%	71	71	0.0%
District 7 Total	**541**	**535**	**-1.1%**	**535**	**530**	**-0.9%**

District 7 Regional Forecast, Oregon Department of Human Services (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Coos	684	689	0.7%	689	795	15.4%
Curry	118	131	11.0%	131	148	13.0%
District 7 Total	**802**	**820**	**2.2%**	**820**	**943**	**15.0%**
Community-Based Care						
Coos	284	283	-0.4%	283	290	2.5%
Curry	133	126	-5.3%	126	129	2.4%
District 7 Total	**417**	**409**	**-1.9%**	**409**	**419**	**2.4%**
Nursing Care						
Coos	93	99	6.5%	99	102	3.0%
Curry	24	26	8.3%	26	26	0.0%
District 7 Total	**117**	**125**	**6.8%**	**125**	**128**	**2.4%**

District 7 Regional Forecast, Oregon Health Authority (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Coos	1,323	1,390	5.1%	1,390	1,347	-3.1%
Curry	387	425	9.8%	425	427	0.5%
District 7 Total	**1,710**	**1,815**	**6.1%**	**1,815**	**1,774**	**-2.3%**
Children's Medicaid Program						
Coos	6,058	5,805	-4.2%	5,805	5,561	-4.2%
Curry	1,850	1,815	-1.9%	1,815	1,865	2.8%
District 7 Total	**7,908**	**7,620**	**-3.6%**	**7,620**	**7,426**	**-2.5%**
Children's Health Insurance Program (CHIP)						
Coos	905	907	0.2%	907	836	-7.8%
Curry	280	288	2.9%	288	272	-5.6%
District 7 Total	**1,185**	**1,195**	**0.8%**	**1,195**	**1,108**	**-7.3%**
Pregnant Women Program						
Coos	272	279	2.6%	279	230	-17.6%
Curry	84	87	3.6%	87	75	-13.8%
District 7 Total	**356**	**366**	**2.8%**	**366**	**305**	**-16.7%**
Foster Care & Adoption Services						
Coos	588	578	-1.7%	578	589	1.9%
Curry	75	81	8.0%	81	81	0.0%
District 7 Total	**663**	**659**	**-0.6%**	**659**	**670**	**1.7%**

District 7 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Coos	2,322	2,316	-0.3%	2,316	2,387	3.1%
Curry	610	607	-0.5%	607	632	4.1%
District 7 Total	**2,932**	**2,923**	**-0.3%**	**2,923**	**3,019**	**3.3%**
Old Age Assistance						
Coos	1,057	1,060	0.3%	1,060	1,091	2.9%
Curry	365	379	3.8%	379	435	14.8%
District 7 Total	**1,422**	**1,439**	**1.2%**	**1,439**	**1,526**	**6.0%**
ACA Adults						
Coos	8,454	8,315	-1.6%	8,315	7,303	-12.2%
Curry	2,854	2,793	-2.1%	2,793	2,446	-12.4%
District 7 Total	**11,308**	**11,108**	**-1.8%**	**11,108**	**9,749**	**-12.2%**

District 8 Regional Forecast

Recovery from the Great Recession has been slow, but has finally paid off in the Rogue Valley. Employment contraction in the Medford area began in 2006, a year before the recession started for the rest of the state. But things have been improving steadily for the past few years, and the region has finally recovered all the jobs lost since the Great Recession. However, the employment base is restructuring. For example, construction and natural resource jobs (mining and logging) are still lagging, while new growth is coming from the lower-paying health and social assistance sector. Although Medford has recovered manufacturing and transportation jobs, which is a good sign; Grants Pass has not.

The region is expected to see a boost from households moving to the Rogue Valley from other states – especially California – at levels similar to what was seen in the 1990s.

TANF caseloads are expected to drop very slowly across the forecast horizon for both counties. Josephine County is also expected to see SNAP caseloads fall more slowly than the state overall. Long Term Care in Josephine County is expected to remain rather flat, as Nursing Facility Care continues to fall.

DISTRICT 8	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Jackson	223,464	21.4%	18.8%	$44,086	17.8%	7.3%	6.7%
Josephine	89,211	19.9%	23.4%	$37,447	19.7%	8.5%	7.5%

District 8 Regional Forecast, Oregon Department of Human Services

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Jackson	18,524	18,695	0.9%	18,695	16,753	-10.4%
Josephine	9,299	9,426	1.4%	9,426	8,804	-6.6%
District 8 Total	**27,823**	**28,121**	**1.1%**	**28,121**	**25,557**	**-9.1%**
SNAP - Aid to People with Disabilities						
Jackson	8,102	8,138	0.4%	8,138	8,394	3.1%
Josephine	4,402	4,370	-0.7%	4,370	4,486	2.7%
District 8 Total	**12,504**	**12,508**	**0.0%**	**12,508**	**12,880**	**3.0%**
TANF						
Jackson	1,511	1,669	10.5%	1,669	1,576	-5.6%
Josephine	984	965	-1.9%	965	919	-4.8%
District 8 Total	**2,495**	**2,634**	**5.6%**	**2,634**	**2,495**	**-5.3%**
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Jackson	961	962	0.1%	962	1,052	9.4%
Josephine	500	474	-5.2%	474	483	1.9%
District 8 Total	**1,461**	**1,436**	**-1.7%**	**1,436**	**1,535**	**6.9%**
Community-Based Care						
Jackson	742	728	-1.9%	728	751	3.2%
Josephine	361	351	-2.8%	351	372	6.0%
District 8 Total	**1,103**	**1,079**	**-2.2%**	**1,079**	**1,123**	**4.1%**
Nursing Care						
Jackson	159	156	-1.9%	156	161	3.2%
Josephine	122	128	4.9%	128	105	-18.0%
District 8 Total	**281**	**284**	**1.1%**	**284**	**266**	**-6.3%**

District 8 Regional Forecast, Oregon Health Authority (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Jackson	4,487	4,855	8.2%	4,855	4,968	2.3%
Josephine	2,106	2,239	6.3%	2,239	2,206	-1.5%
District 8 Total	**6,593**	**7,094**	**7.6%**	**7,094**	**7,174**	**1.1%**
Children's Medicaid Program						
Jackson	22,046	21,608	-2.0%	21,608	22,077	2.2%
Josephine	9,383	9,241	-1.5%	9,241	9,161	-0.9%
District 8 Total	**31,429**	**30,849**	**-1.8%**	**30,849**	**31,238**	**1.3%**
Children's Health Insurance Program (CHIP)						
Jackson	3,878	3,968	2.3%	3,968	3,677	-7.3%
Josephine	1,337	1,374	2.8%	1,374	1,302	-5.2%
District 8 Total	**5,215**	**5,342**	**2.4%**	**5,342**	**4,979**	**-6.8%**
Pregnant Women Program						
Jackson	1,076	1,187	10.3%	1,187	978	-17.6%
Josephine	495	539	8.9%	539	444	-17.6%
District 8 Total	**1,571**	**1,726**	**9.9%**	**1,726**	**1,422**	**-17.6%**
Foster Care & Adoption Services						
Jackson	1,280	1,313	2.6%	1,313	1,354	3.1%
Josephine	562	571	1.6%	571	580	1.6%
District 8 Total	**1,842**	**1,884**	**2.3%**	**1,884**	**1,934**	**2.7%**

District 8 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Jackson	4,485	4,524	0.9%	4,524	4,573	1.1%
Josephine	2,552	2,542	-0.4%	2,542	2,530	-0.5%
District 8 Total	**7,037**	**7,066**	**0.4%**	**7,066**	**7,103**	**0.5%**
Old Age Assistance						
Jackson	2,225	2,233	0.4%	2,233	2,452	9.8%
Josephine	1,168	1,173	0.4%	1,173	1,229	4.8%
District 8 Total	**3,393**	**3,406**	**0.4%**	**3,406**	**3,681**	**8.1%**
ACA Adults						
Jackson	27,768	27,150	-2.2%	27,150	23,637	-12.9%
Josephine	13,053	12,855	-1.5%	12,855	11,335	-11.8%
District 8 Total	**40,821**	**40,005**	**-2.0%**	**40,005**	**34,972**	**-12.6%**

District 9 Regional Forecast

District 9 is the largest service district in the state in terms of number of counties, but is the least populated. It contains three counties (Gilliam, Sherman, and Wheeler) that have a very limited, farm-based economy and two (Hood River and Wasco) that are relatively more populated and serve as the economic drivers for the region.

Unemployment in the region is a mixed bag: Gilliam County's unemployment, at 7.3 percent, is among the highest in the state, while Hood River (at 4.4 percent) has the lowest. Most counties in the district have lower unemployment than the state overall and have recovered the jobs lost due to the Great Recession, but Gilliam County employs almost 17 percent fewer people now than in 2007.

Hood River County has been one of the fastest growing counties in the state, and the state demographer expects that growth to continue, bringing with it economic stimulus and a chance to further diversify the county's economy.

DISTRICT 9	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Gilliam	2,016	20.4%	23.3%	$46,490	7.8%	7.4%	7.3%
Hood River	23,485	25.4%	13.7%	$56,417	15.7%	4.7%	4.4%
Sherman	1,986	19.2%	23.7%	$39,960	19.4%	6.8%	4.7%
Wasco	24,297	22.5%	18.7%	$43,226	16.9%	5.6%	5.2%
Wheeler	1,591	15.3%	30.7%	$34,808	18.3%	5.7%	4.9%

District 9 Regional Forecast, Oregon Department of Human Services

Counties served: Gilliam, Hood River, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Gilliam	92	90	-2.2%	90	80	-11.1%
Hood River	1,154	1,109	-3.9%	1,109	897	-19.1%
Sherman	83	91	9.6%	91	95	4.4%
Wasco	1,876	1,939	3.4%	1,939	1,622	-16.3%
Wheeler	81	86	6.2%	86	77	-10.5%
District 9 Total	**3,286**	**3,315**	**0.9%**	**3,315**	**2,771**	**-16.4%**
SNAP - Aid to People with Disabilities						
Gilliam	52	58	11.5%	58	65	12.1%
Hood River	421	419	-0.5%	419	477	13.8%
Sherman	57	59	3.5%	59	59	0.0%
Wasco	1,051	1,060	0.9%	1,060	1,105	4.2%
Wheeler	62	67	8.1%	67	73	9.0%
District 9 Total	**1,643**	**1,663**	**1.2%**	**1,663**	**1,779**	**7.0%**
TANF						
Gilliam	7	7	0.0%	7	7	0.0%
Hood River	51	51	0.0%	51	47	-7.8%
Sherman	3	4	33.3%	4	4	0.0%
Wasco	102	99	-2.9%	99	99	0.0%
Wheeler	1	2	100.0%	2	2	0.0%
District 9 Total	**164**	**163**	**-0.6%**	**163**	**159**	**-2.5%**

District 9 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Gilliam, Hood River, Sherman, Wasco, and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Gilliam	5	6	20.0%	6	7	16.7%
Hood River	30	32	6.7%	32	30	-6.3%
Sherman	4	5	25.0%	5	5	0.0%
Wasco	96	101	5.2%	101	107	5.9%
Wheeler	2	4	100.0%	4	7	75.0%
District 9 Total	**137**	**148**	**8.0%**	**148**	**156**	**5.4%**
Community-Based Care						
Gilliam	8	8	0.0%	8	8	0.0%
Hood River	30	31	3.3%	31	32	3.2%
Sherman	3	3	0.0%	3	3	0.0%
Wasco	76	79	3.9%	79	79	0.0%
Wheeler	9	8	-11.1%	8	9	12.5%
District 9 Total	**126**	**129**	**2.4%**	**129**	**131**	**1.6%**
Nursing Care						
Gilliam	0	0	0.0%	0	0	0.0%
Hood River	32	34	6.3%	34	35	2.9%
Sherman	1	1	0.0%	1	1	0.0%
Wasco	97	104	7.2%	104	106	1.9%
Wheeler	1	0	-100.0%	0	0	0.0%
District 9 Total	**131**	**139**	**6.1%**	**139**	**142**	**2.2%**

District 9 Regional Forecast, Oregon Health Authority (clients)

Counties served: Gilliam, Hood River, Sherman, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Gilliam	24	29	20.8%	29	31	6.9%
Hood River	316	307	-2.8%	307	308	0.3%
Sherman	31	28	-9.7%	28	27	-3.6%
Wasco	465	493	6.0%	493	492	-0.2%
Wheeler	33	29	-12.1%	29	30	3.4%
District 9 Total	**869**	**886**	**2.0%**	**886**	**888**	**0.2%**
Children's Medicaid Program						
Gilliam	166	157	-5.4%	157	170	8.3%
Hood River	2,757	2,594	-5.9%	2,594	2,624	1.2%
Sherman	119	113	-5.0%	113	119	5.3%
Wasco	2,950	2,855	-3.2%	2,855	2,913	2.0%
Wheeler	107	99	-7.5%	99	113	14.1%
District 9 Total	**6,099**	**5,818**	**-4.6%**	**5,818**	**5,939**	**2.1%**
Children's Health Insurance Program (CHIP)						
Gilliam	25	31	24.0%	31	35	12.9%
Hood River	631	646	2.4%	646	597	-7.6%
Sherman	11	16	45.5%	16	18	12.5%
Wasco	540	551	2.0%	551	516	-6.4%
Wheeler	10	12	20.0%	12	17	41.7%
District 9 Total	**1,217**	**1,256**	**3.2%**	**1,256**	**1,183**	**-5.8%**

District 9 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Gilliam, Hood River, Sherman, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Pregnant Women Program						
Gilliam	4	3	-25.0%	3	3	0.0%
Hood River	111	116	4.5%	116	98	-15.5%
Sherman	6	7	16.7%	7	8	14.3%
Wasco	150	158	5.3%	158	139	-12.0%
Wheeler	5	5	0.0%	5	5	0.0%
District 9 Total	**276**	**289**	**4.7%**	**289**	**253**	**-12.5%**
Foster Care & Adoption Services						
Gilliam	13	10	-23.1%	10	9	-10.0%
Hood River	73	89	21.9%	89	100	12.4%
Sherman	14	14	0.0%	14	14	0.0%
Wasco	184	175	-4.9%	175	175	0.0%
Wheeler	8	11	37.5%	11	10	-9.1%
District 9 Total	**292**	**299**	**2.4%**	**299**	**308**	**3.0%**
Aid to the Blind/Disabled						
Gilliam	30	30	0.0%	30	30	0.0%
Hood River	238	236	-0.8%	236	241	2.1%
Sherman	28	27	-3.6%	27	27	0.0%
Wasco	640	628	-1.9%	628	629	0.2%
Wheeler	18	20	11.1%	20	21	5.0%
District 9 Total	**954**	**941**	**-1.4%**	**941**	**948**	**0.7%**

District 9 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Gilliam, Hood River, Sherman, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Old Age Assistance						
Gilliam	18	18	0.0%	18	18	0.0%
Hood River	161	160	-0.6%	160	170	6.3%
Sherman	7	9	28.6%	9	9	0.0%
Wasco	324	340	4.9%	340	349	2.6%
Wheeler	18	20	11.1%	20	22	10.0%
District 9 Total	**528**	**547**	**3.6%**	**547**	**568**	**3.8%**
ACA Adults						
Gilliam	151	156	3.3%	156	142	-9.0%
Hood River	2,519	2,473	-1.8%	2,473	2,203	-10.9%
Sherman	150	157	4.7%	157	159	1.3%
Wasco	3,043	2,995	-1.6%	2,995	2,646	-11.7%
Wheeler	175	164	-6.3%	164	144	-12.2%
District 9 Total	**6,038**	**5,945**	**-1.5%**	**5,945**	**5,294**	**-11.0%**

District 10 Regional Forecast

The Central Oregon economy has been growing fast – there has been a 5.7 percent increase in employment comparing August 2016 to the previous year. That's the biggest increase in the state. In Deschutes County, the total number of persons working exceeds pre-recession levels. The economy has been re-structured in Bend, though, with more jobs in lower-paying health-services and food services, and fewer in manufacturing and construction.

Crook County was among the worst hit during the Great Recession, receiving the one-two punch of losing both construction and wood-products jobs when the housing boom went bust. Unemployment remains higher than most counties in the state, but is still an improvement from the double-digit rates experienced for six years prior to 2014. Total non-farm employment is still almost 17 percent below pre-recession levels. Wood products manufacturing has not yet recovered, nor has manufacturing-dependent transportation jobs.

Jefferson is one of the least populated counties in the state, but unlike many other sparsely populated areas, it has mostly recovered from the Great Recession. However, unemployment is relatively high. Jobs in wood products manufacturing and wholesale trade are still below pre-recession levels, but jobs in health services are on the rise.

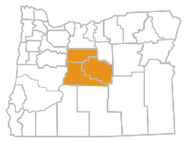
The TANF caseload are expected to continue to fall at a fast pace in Deschutes County, fueled by an excellent jobs market. SNAP is expected to fall in Deschutes and Crook counties faster than the rest of the state, while Jefferson County caseloads are expected to drop much more slowly.

DISTRICT 10	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Crook	25,249	20.3%	22.7%	$36,158	20.8%	8.8%	7.5%
Deschutes	178,418	22.2%	16.6%	$49,584	15.0%	6.5%	5.4%
Jefferson	24,079	24.7%	16.5%	$46,588	20.9%	7.5%	7.1%

District 10 Regional Forecast, Oregon Department of Human Services

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Crook	1,538	1,597	3.8%	1,597	1,282	-19.7%
Deschutes	10,298	10,434	1.3%	10,434	8,042	-22.9%
Jefferson	2,714	2,742	1.0%	2,742	2,652	-3.3%
District 10 Total	**14,550**	**14,773**	**1.5%**	**14,773**	**11,976**	**-18.9%**
SNAP - Aid to People with Disabilities						
Crook	954	940	-1.5%	940	940	0.0%
Deschutes	4,277	4,300	0.5%	4,300	4,438	3.2%
Jefferson	973	963	-1.0%	963	1,018	5.7%
District 10 Total	**6,204**	**6,203**	**0.0%**	**6,203**	**6,396**	**3.1%**
TANF						
Crook	117	117	0.0%	117	103	-12.0%
Deschutes	512	452	-11.7%	452	272	-39.8%
Jefferson	346	313	-9.5%	313	266	-15.0%
District 10 Total	**975**	**882**	**-9.5%**	**882**	**641**	**-27.3%**



District 10 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Crook	144	137	-4.9%	137	153	11.7%
Deschutes	483	435	-9.9%	435	471	8.3%
Jefferson	106	102	-3.8%	102	105	2.9%
District 10 Total	**733**	**674**	**-8.0%**	**674**	**729**	**8.2%**
Community-Based Care						
Crook	58	60	3.4%	60	61	1.7%
Deschutes	428	430	0.5%	430	455	5.8%
Jefferson	68	71	4.4%	71	72	1.4%
District 10 Total	**554**	**561**	**1.3%**	**561**	**588**	**4.8%**
Nursing Care						
Crook	23	23	0.0%	23	23	0.0%
Deschutes	57	62	8.8%	62	64	3.2%
Jefferson	11	12	9.1%	12	13	8.3%
District 10 Total	**91**	**97**	**6.6%**	**97**	**100**	**3.1%**

District 10 Regional Forecast, Oregon Health Authority (clients)

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Crook	488	493	1.0%	493	460	-6.7%
Deschutes	2,748	2,925	6.4%	2,925	2,953	1.0%
Jefferson	741	770	3.9%	770	774	0.5%
District 10 Total	**3,977**	**4,188**	**5.3%**	**4,188**	**4,187**	**0.0%**
Children's Medicaid Program						
Crook	2,321	2,263	-2.5%	2,263	2,395	5.8%
Deschutes	14,206	14,151	-0.4%	14,151	14,428	2.0%
Jefferson	3,720	3,729	0.2%	3,729	4,102	10.0%
District 10 Total	**20,247**	**20,143**	**-0.5%**	**20,143**	**20,925**	**3.9%**
Children's Health Insurance Program (CHIP)						
Crook	415	414	-0.2%	414	382	-7.7%
Deschutes	3,910	3,844	-1.7%	3,844	3,627	-5.6%
Jefferson	375	379	1.1%	379	343	-9.5%
District 10 Total	**4,700**	**4,637**	**-1.3%**	**4,637**	**4,352**	**-6.1%**
Pregnant Women Program						
Crook	95	106	11.6%	106	88	-17.0%
Deschutes	660	734	11.2%	734	616	-16.1%
Jefferson	135	144	6.7%	144	118	-18.1%
District 10 Total	**890**	**984**	**10.6%**	**984**	**822**	**-16.5%**

District 10 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Crook	101	109	7.9%	109	119	9.2%
Deschutes	603	611	1.3%	611	637	4.3%
Jefferson	242	257	6.2%	257	268	4.3%
District 10 Total	**946**	**977**	**3.3%**	**977**	**1,024**	**4.8%**
Aid to the Blind/Disabled						
Crook	499	488	-2.2%	488	534	9.4%
Deschutes	2,520	2,547	1.1%	2,547	2,702	6.1%
Jefferson	643	638	-0.8%	638	696	9.1%
District 10 Total	**3,662**	**3,673**	**0.3%**	**3,673**	**3,932**	**7.1%**
Old Age Assistance						
Crook	222	225	1.4%	225	241	7.1%
Deschutes	1,045	1,059	1.3%	1,059	1,195	12.8%
Jefferson	254	261	2.8%	261	287	10.0%
District 10 Total	**1,521**	**1,545**	**1.6%**	**1,545**	**1,723**	**11.5%**
ACA Adults						
Crook	2,659	2,601	-2.2%	2,601	2,225	-14.5%
Deschutes	18,971	18,681	-1.5%	18,681	16,326	-12.6%
Jefferson	3,291	3,301	0.3%	3,301	2,915	-11.7%
District 10 Total	**24,921**	**24,583**	**-1.4%**	**24,583**	**21,466**	**-12.7%**

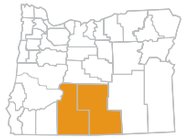
District 11 Regional Forecast

Klamath and Lake counties have higher unemployment than the rest of the state – but that's been historically true since before the Great Recession. Added to the historical weakness in the labor market, the Klamath Basin has suffered an extreme drought. Drought conditions resulted in negative direct effects on farmers and ranchers as well as negative indirect effects to businesses that provide goods and services to those farmers and ranchers. The snowpack in the winter of 2015-16 was 113 percent of average, which is good news for irrigators, but may take multiple years of good precipitation for the land to recover completely.

Employment has been growing in both Klamath and Lake counties, but still remains below pre-recession levels.

SNAP and TANF caseloads are expected to fall at the same rate as the state overall in Klamath County. The TANF counts in Lake County fell sharply starting in 2011, and are now below pre-recession levels. It is expected to remain at this unprecedented "floor" through the forecast horizon.

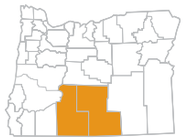
DISTRICT 11	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Klamath	68,851	21.8%	18.2%	$39,534	18.6%	8.3%	7.4%
Lake	7,468	18.4%	21.3%	$34,535	17.8%	7.9%	6.6%



District 11 Regional Forecast, Oregon Department of Human Services

Counties served: Klamath and Lake

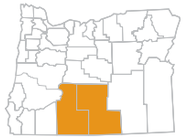
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Klamath	6,871	6,771	-1.5%	6,771	6,249	-7.7%
Lake	465	481	3.4%	481	420	-12.7%
District 11 Total	**7,336**	**7,252**	**-1.1%**	**7,252**	**6,669**	**-8.0%**
SNAP - Aid to People with Disabilities						
Klamath	3,090	3,096	0.2%	3,096	3,273	5.7%
Lake	366	360	-1.6%	360	362	0.6%
District 11 Total	**3,456**	**3,456**	**0.0%**	**3,456**	**3,635**	**5.2%**
TANF						
Klamath	470	473	0.6%	473	448	-5.3%
Lake	19	18	-5.3%	18	19	5.6%
District 11 Total	**489**	**491**	**0.4%**	**491**	**467**	**-4.9%**
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Klamath	388	351	-9.5%	351	391	11.4%
Lake	30	32	6.7%	32	35	9.4%
District 11 Total	**418**	**383**	**-8.4%**	**383**	**426**	**11.2%**
Community-Based Care						
Klamath	186	188	1.1%	188	191	1.6%
Lake	3	4	33.3%	4	5	25.0%
District 11 Total	**189**	**192**	**1.6%**	**192**	**196**	**2.1%**
Nursing Care						
Klamath	38	43	13.2%	43	44	2.3%
Lake	13	16	23.1%	16	17	6.3%
District 11 Total	**51**	**59**	**15.7%**	**59**	**61**	**3.4%**



District 11 Regional Forecast, Oregon Health Authority (clients)

Counties served: Klamath and Lake

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Klamath	1,593	1,679	5.4%	1,679	1,672	-0.4%
Lake	111	138	24.3%	138	141	2.2%
District 11 Total	**1,704**	**1,817**	**6.6%**	**1,817**	**1,813**	**-0.2%**
Children's Medicaid Program						
Klamath	7,471	7,330	-1.9%	7,330	7,195	-1.8%
Lake	697	680	-2.4%	680	701	3.1%
District 11 Total	**8,168**	**8,010**	**-1.9%**	**8,010**	**7,896**	**-1.4%**
Children's Health Insurance Program (CHIP)						
Klamath	861	855	-0.7%	855	765	-10.5%
Lake	78	80	2.6%	80	77	-3.8%
District 11 Total	**939**	**935**	**-0.4%**	**935**	**842**	**-9.9%**
Pregnant Women Program						
Klamath	350	382	9.1%	382	317	-17.0%
Lake	32	33	3.1%	33	35	6.1%
District 11 Total	**382**	**415**	**8.6%**	**415**	**352**	**-15.2%**
Foster Care & Adoption Services						
Klamath	584	588	0.7%	588	603	2.6%
Lake	55	54	-1.8%	54	49	-9.3%
District 11 Total	**639**	**642**	**0.5%**	**642**	**652**	**1.6%**



District 11 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Klamath and Lake

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Klamath	2,013	2,006	-0.3%	2,006	2,066	3.0%
Lake	181	184	1.7%	184	186	1.1%
District 11 Total	**2,194**	**2,190**	**-0.2%**	**2,190**	**2,252**	**2.8%**
Old Age Assistance						
Klamath	726	746	2.8%	746	849	13.8%
Lake	73	77	5.5%	77	82	6.5%
District 11 Total	**799**	**823**	**3.0%**	**823**	**931**	**13.1%**
ACA Adults						
Klamath	8,892	8,766	-1.4%	8,766	7,703	-12.1%
Lake	812	799	-1.6%	799	707	-11.5%
District 11 Total	**9,704**	**9,565**	**-1.4%**	**9,565**	**8,410**	**-12.1%**

District 12 Regional Forecast

Information systems jobs have Morrow County booming, with employment now over 33 percent higher than in 2007. Many of the new jobs have attracted people with specialized skills, growing the population. With booms come busts, however, and the construction boost related to new industries moving into the area has ended. The result is a modest contraction in overall employment, and an unemployment rate higher than the state overall.

Umatilla County has almost recovered all jobs lost during the Great Recession. Manufacturing, transportation, and health services are expanding.

District 12 will likely see a drop in SNAP caseload equivalent to the state overall. Umatilla County experienced a sharp drop in TANF from 2013 to 2015, but the caseload has now flattened out at a rate well above pre-recession levels. TANF is expected to fall very slowly in Umatilla County.

DISTRICT 12	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Morrow	15,011	28.2%	13.2%	$50,443	19.3%	6.2%	5.9%
Umatilla	79,701	26.2%	13.3%	$47,185	17.1%	6.7%	5.9%

District 12 Regional Forecast, Oregon Department of Human Services

Counties served: Morrow and Umatilla

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Morrow	734	770	4.9%	770	665	-13.6%
Umatilla	5,610	5,640	0.5%	5,640	4,886	-13.4%
District 12 Total	**6,344**	**6,410**	**1.0%**	**6,410**	**5,551**	**-13.4%**
SNAP - Aid to People with Disabilities						
Morrow	317	311	-1.9%	311	332	6.8%
Umatilla	2,310	2,310	0.0%	2,310	2,378	2.9%
District 12 Total	**2,627**	**2,621**	**-0.2%**	**2,621**	**2,710**	**3.4%**
TANF						
Morrow	90	85	-5.6%	85	80	-5.9%
Umatilla	565	568	0.5%	568	551	-3.0%
District 12 Total	**655**	**653**	**-0.3%**	**653**	**631**	**-3.4%**
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Morrow	43	46	7.0%	46	54	17.4%
Umatilla	392	381	-2.8%	381	399	4.7%
District 12 Total	**435**	**427**	**-1.8%**	**427**	**453**	**6.1%**
Community-Based Care						
Morrow	12	16	33.3%	16	18	12.5%
Umatilla	226	223	-1.3%	223	222	-0.4%
District 12 Total	**238**	**239**	**0.4%**	**239**	**240**	**0.4%**
Nursing Care						
Morrow	9	6	-33.3%	6	6	0.0%
Umatilla	85	84	-1.2%	84	84	0.0%
District 12 Total	**94**	**90**	**-4.3%**	**90**	**90**	**0.0%**

District 12 Regional Forecast, Oregon Health Authority (clients)

Counties served: Morrow and Umatilla

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Morrow	223	229	2.7%	229	227	-0.9%
Umatilla	1,451	1,532	5.6%	1,532	1,450	-5.4%
District 12 Total	**1,674**	**1,761**	**5.2%**	**1,761**	**1,677**	**-4.8%**
Children's Medicaid Program						
Morrow	1,681	1,610	-4.2%	1,610	1,635	1.6%
Umatilla	9,438	9,221	-2.3%	9,221	9,038	-2.0%
District 12 Total	**11,119**	**10,831**	**-2.6%**	**10,831**	**10,673**	**-1.5%**
Children's Health Insurance Program (CHIP)						
Morrow	200	211	5.5%	211	183	-13.3%
Umatilla	1,344	1,347	0.2%	1,347	1,203	-10.7%
District 12 Total	**1,544**	**1,558**	**0.9%**	**1,558**	**1,386**	**-11.0%**
Pregnant Women Program						
Morrow	43	49	14.0%	49	39	-20.4%
Umatilla	415	367	-11.6%	367	288	-21.5%
District 12 Total	**458**	**416**	**-9.2%**	**416**	**327**	**-21.4%**
Foster Care & Adoption Services						
Morrow	43	49	14.0%	49	54	10.2%
Umatilla	393	390	-0.8%	390	410	5.1%
District 12 Total	**436**	**439**	**0.7%**	**439**	**464**	**5.7%**

District 12 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Klamath and Lake

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Morrow	201	209	4.0%	209	224	7.2%
Umatilla	1,584	1,560	-1.5%	1,560	1,591	2.0%
District 12 Total	**1,785**	**1,769**	**-0.9%**	**1,769**	**1,815**	**2.6%**
Old Age Assistance						
Morrow	89	90	1.1%	90	97	7.8%
Umatilla	814	836	2.7%	836	858	2.6%
District 12 Total	**903**	**926**	**2.5%**	**926**	**955**	**3.1%**
ACA Adults						
Morrow	993	957	-3.6%	957	811	-15.3%
Umatilla	7,123	6,969	-2.2%	6,969	5,988	-14.1%
District 12 Total	**8,116**	**7,926**	**-2.3%**	**7,926**	**6,799**	**-14.2%**

District 13 Regional Forecast

Northeastern Oregon is sparsely populated, and like a lot of rural areas has struggled to climb out of the hole created by the Great Recession. Unemployment remains higher in the area than the state overall, especially in Baker County.

Wallowa and Baker County are adding jobs, while Union is holding steady to recent gains, but all three still have a ways to go to reach pre-recession levels.

Unemployment has been historically higher in Baker County than the state overall, but the county is creating new jobs in most employment sectors. Weakness in the tourism-driven leisure and hospitality sector is cause for some concern.

The employment picture in Northeast Oregon is hampered by demographics. Prime working age is generally defined as ages 25 to 54, and there are fewer workers in Eastern Oregon that fall into that category than anywhere else in the state.

SNAP and TANF caseloads are expected to fall at the same pace as the state overall in Baker County, and slower in the other counties of District 13.

DISTRICT 13	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Baker	16,717	19.8%	23.6%	$40,576	18.3%	7.6%	7.0%
Union	26,545	22.2%	17.6%	$43,265	18.8%	6.6%	6.4%
Wallowa	7,611	18.6%	25.1%	$41,522	13.9%	7.9%	6.8%

District 13 Regional Forecast, Oregon Department of Human Services

Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Baker	1,211	1,249	3.1%	1,249	1,130	-9.5%
Union	1,767	1,811	2.5%	1,811	1,753	-3.2%
Wallowa	327	332	1.5%	332	305	-8.1%
District 13 Total	**3,305**	**3,392**	**2.6%**	**3,392**	**3,188**	**-6.0%**
SNAP - Aid to People with Disabilities						
Baker	736	716	-2.7%	716	713	-0.4%
Union	877	870	-0.8%	870	901	3.6%
Wallowa	268	264	-1.5%	264	284	7.6%
District 13 Total	**1,881**	**1,850**	**-1.6%**	**1,850**	**1,898**	**2.6%**
TANF						
Baker	120	121	0.8%	121	113	-6.6%
Union	217	226	4.1%	226	217	-4.0%
Wallowa	34	39	14.7%	39	40	2.6%
District 13 Total	**371**	**386**	**4.0%**	**386**	**370**	**-4.1%**

District 13 Regional Forecast, Oregon Department of Human Services (continued)

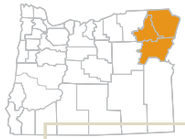
Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Baker	52	51	-1.9%	51	51	0.0%
Union	101	105	4.0%	105	118	12.4%
Wallowa	53	53	0.0%	53	64	20.8%
District 13 Total	**206**	**209**	**1.5%**	**209**	**233**	**11.5%**
Community-Based Care						
Baker	70	73	4.3%	73	80	9.6%
Union	102	107	4.9%	107	113	5.6%
Wallowa	29	31	6.9%	31	32	3.2%
District 13 Total	**201**	**211**	**5.0%**	**211**	**225**	**6.6%**
Nursing Care						
Baker	2	3	50.0%	3	0	-100.0%
Union	26	19	-26.9%	19	11	-42.1%
Wallowa	3	3	0.0%	3	3	0.0%
District 13 Total	**31**	**25**	**-19.4%**	**25**	**14**	**-44.0%**

District 13 Regional Forecast, Oregon Health Authority (clients)

Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Baker	321	349	8.7%	349	351	0.6%
Union	472	515	9.1%	515	495	-3.9%
Wallowa	129	133	3.1%	133	137	3.0%
District 13 Total	**922**	**997**	**8.1%**	**997**	**983**	**-1.4%**
Children's Medicaid Program						
Baker	1,550	1,562	0.8%	1,562	1,645	5.3%
Union	2,427	2,483	2.3%	2,483	2,466	-0.7%
Wallowa	581	563	-3.1%	563	575	2.1%
District 13 Total	**4,558**	**4,608**	**1.1%**	**4,608**	**4,686**	**1.7%**
Children's Health Insurance Program (CHIP)						
Baker	193	198	2.6%	198	177	-10.6%
Union	431	443	2.8%	443	416	-6.1%
Wallowa	200	204	2.0%	204	238	16.7%
District 13 Total	**824**	**845**	**2.5%**	**845**	**831**	**-1.7%**
Pregnant Women Program						
Baker	55	63	14.5%	63	54	-14.3%
Union	128	138	7.8%	138	122	-11.6%
Wallowa	16	18	12.5%	18	16	-11.1%
District 13 Total	**199**	**219**	**10.1%**	**219**	**192**	**-12.3%**



District 13 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Baker	134	130	-3.0%	130	136	4.6%
Union	151	155	2.6%	155	160	3.2%
Wallowa	22	19	-13.6%	19	20	5.3%
District 13 Total	**307**	**304**	**-1.0%**	**304**	**316**	**3.9%**
Aid to the Blind/Disabled						
Baker	423	412	-2.6%	412	420	1.9%
Union	628	613	-2.4%	613	616	0.5%
Wallowa	161	161	0.0%	161	168	4.3%
District 13 Total	**1,212**	**1,186**	**-2.1%**	**1,186**	**1,204**	**1.5%**
Old Age Assistance						
Baker	169	175	3.6%	175	177	1.1%
Union	229	232	1.3%	232	235	1.3%
Wallowa	86	94	9.3%	94	113	20.2%
District 13 Total	**484**	**501**	**3.5%**	**501**	**525**	**4.8%**
ACA Adults						
Baker	1,850	1,830	-1.1%	1,830	1,588	-13.2%
Union	2,638	2,543	-3.6%	2,543	2,085	-18.0%
Wallowa	761	748	-1.7%	748	647	-13.5%
District 13 Total	**5,249**	**5,121**	**-2.4%**	**5,121**	**4,320**	**-15.6%**

District 14 Regional Forecast

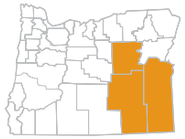
District 14 continues to struggle with high unemployment. Grant County has had the highest unemployment in the state for the past 11 months (October 2015 to August 2016). Although all three counties in the district have been adding jobs over the last 12 months, it has not been fast enough to keep pace with demand.

Employment in Malheur County is approaching pre-recession levels, and is growing in the traditionally higher-paying manufacturing, natural resource extraction, and construction areas. This is good news given that Malheur County has the highest percentage of residents in poverty in the state.

Employment in the area is hampered by demographics. Prime working age is generally defined as ages 25 to 54, and there are fewer workers in Eastern Oregon that fall into that category than elsewhere in the state.

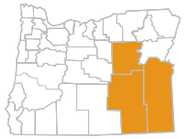
SNAP is projected to remain virtually unchanged in Harney County through the forecast horizon. Malheur County SNAP and TANF caseloads will fall in line with the expected statewide rate of decline. TANF in Grant County has returned to historical levels last seen before the Great Recession and is not expected to fall much lower than its current low level.

DISTRICT 14	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Grant	7,562	18.7%	25.1%	$37,258	15.4%	8.8%	8.0%
Harney	7,779	21.3%	20.4%	$35,828	21.1%	7.4%	6.7%
Malheur	35,552	25.0%	15.4%	$34,380	28.4%	6.9%	6.2%



District 14 Regional Forecast, Oregon Department of Human Services
Counties served: Grant, Harney and Malheur

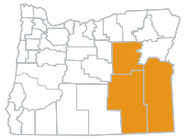
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Grant	347	365	5.2%	365	322	-11.8%
Harney	452	469	3.8%	469	424	-9.6%
Malheur	2,754	2,850	3.5%	2,850	2,410	-15.4%
District 14 Total	**3,553**	**3,684**	**3.7%**	**3,684**	**3,156**	**-14.3%**
SNAP - Aid to People with Disabilities						
Grant	285	277	-2.8%	277	273	-1.4%
Harney	361	349	-3.3%	349	379	8.6%
Malheur	1,335	1,351	1.2%	1,351	1,430	5.8%
District 14 Total	**1,981**	**1,977**	**-0.2%**	**1,977**	**2,082**	**5.3%**
TANF						
Grant	17	17	0.0%	17	16	-5.9%
Harney	32	29	-9.4%	29	23	-20.7%
Malheur	336	315	-6.3%	315	295	-6.3%
District 14 Total	**385**	**361**	**-6.2%**	**361**	**334**	**-7.5%**



District 14 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Grant, Harney and Malheur

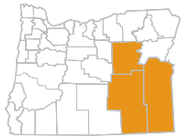
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Grant	28	26	-7.1%	26	27	3.8%
Harney	30	31	3.3%	31	32	3.2%
Malheur	162	167	3.1%	167	174	4.2%
District 14 Total	**220**	**224**	**1.8%**	**224**	**233**	**4.0%**
Community-Based Care						
Grant	25	28	12.0%	28	31	10.7%
Harney	32	28	-12.5%	28	27	-3.6%
Malheur	143	144	0.7%	144	157	9.0%
District 14 Total	**200**	**200**	**0.0%**	**200**	**215**	**7.5%**
Nursing Care						
Grant	10	10	0.0%	10	9	-10.0%
Harney	1	1	0.0%	1	1	0.0%
Malheur	21	16	-23.8%	16	13	-18.8%
District 14 Total	**32**	**27**	**-15.6%**	**27**	**23**	**-14.8%**



District 14 Regional Forecast, Oregon Health Authority (clients)

Counties served: Grant, Harney and Malheur

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Grant	101	111	9.9%	111	113	1.8%
Harney	105	120	14.3%	120	124	3.3%
Malheur	796	866	8.8%	866	877	1.3%
District 14 Total	**1,002**	**1,097**	**9.5%**	**1,097**	**1,114**	**1.5%**
Children's Medicaid Program						
Grant	483	499	3.3%	499	519	4.0%
Harney	668	653	-2.2%	653	671	2.8%
Malheur	4,796	4,765	-0.6%	4,765	4,905	2.9%
District 14 Total	**5,947**	**5,917**	**-0.5%**	**5,917**	**6,095**	**3.0%**
Children's Health Insurance Program (CHIP)						
Grant	98	105	7.1%	105	101	-3.8%
Harney	115	116	0.9%	116	109	-6.0%
Malheur	379	383	1.1%	383	198	-48.3%
District 14 Total	**592**	**604**	**2.0%**	**604**	**408**	**-32.5%**
Pregnant Women Program						
Grant	21	21	0.0%	21	18	-14.3%
Harney	33	36	9.1%	36	27	-25.0%
Malheur	174	182	4.6%	182	157	-13.7%
District 14 Total	**228**	**239**	**4.8%**	**239**	**202**	**-15.5%**



District 14 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Grant, Harney and Malheur

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Grant	39	40	2.6%	40	40	0.0%
Harney	44	44	0.0%	44	43	-2.3%
Malheur	201	206	2.5%	206	213	3.4%
District 14 Total	**284**	**290**	**2.1%**	**290**	**296**	**2.1%**
Aid to the Blind/Disabled						
Grant	138	142	2.9%	142	144	1.4%
Harney	196	197	0.5%	197	209	6.1%
Malheur	940	932	-0.9%	932	973	4.4%
District 14 Total	**1,274**	**1,271**	**-0.2%**	**1,271**	**1,326**	**4.3%**
Old Age Assistance						
Grant	81	80	-1.2%	80	80	0.0%
Harney	79	77	-2.5%	77	78	1.3%
Malheur	447	448	0.2%	448	475	6.0%
District 14 Total	**607**	**605**	**-0.3%**	**605**	**633**	**4.6%**
ACA Adults						
Grant	644	642	-0.3%	642	562	-12.5%
Harney	833	806	-3.2%	806	705	-12.5%
Malheur	3,277	3,250	-0.8%	3,250	2,805	-13.7%
District 14 Total	**4,754**	**4,698**	**-1.2%**	**4,698**	**4,072**	**-13.3%**

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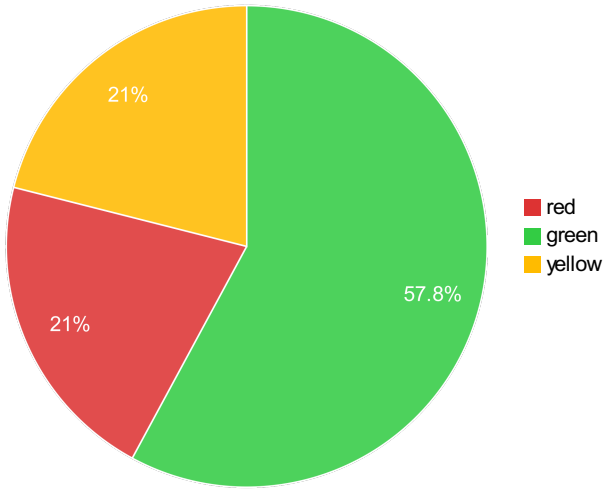
Human Services, Department of

Annual Performance Progress Report

Reporting Year 2016

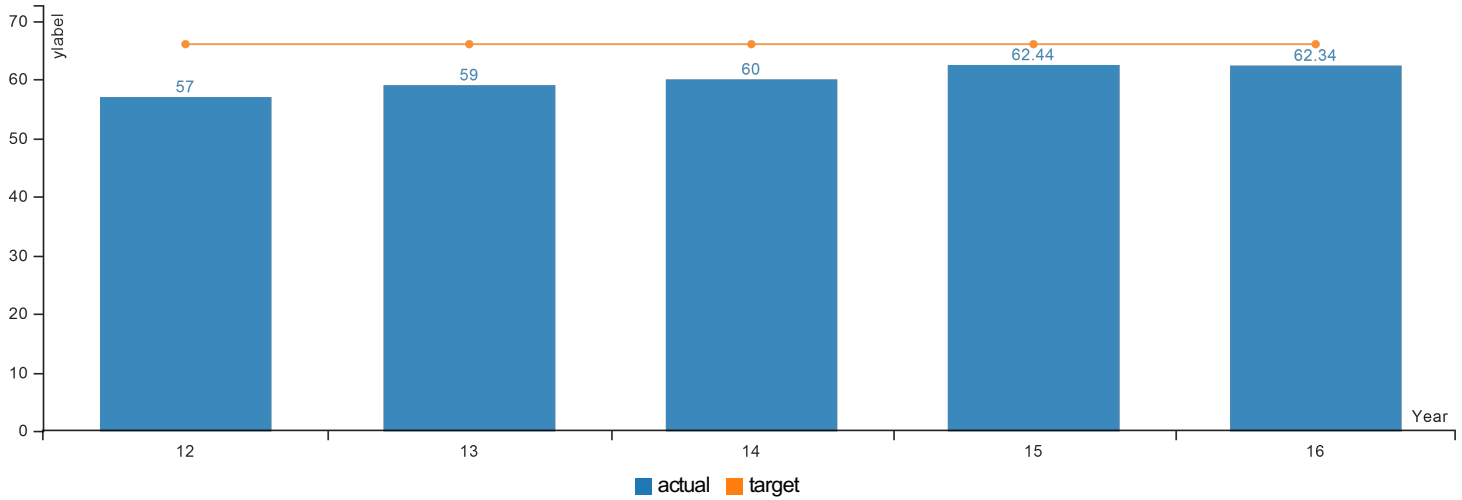
Published: 10/7/2016 9:46:38 AM

KPM #	Approved Key Performance Measures (KPMs)
1	OVRS CLOSED - EMPLOYED – The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.
2	TANF FAMILY STABILITY - The percentage of children receiving TANF who entered foster care.
3	TANF RE-ENTRY - The percentage of Temporary Assistance for Needy Families (TANF) cases who have not returned within 18 months after exit due to employment.
4	SNAP (Supplemental Nutrition Assistance Program) UTILIZATION - The ratio of Oregonians served by SNAP to the number of low-income Oregonians.
5	SNAP (Supplemental Nutrition Assistance Program) ACCURACY - The percentage of accurate SNAP payments
6	ENHANCED CHILD CARE - The percentage of children receiving care from providers who are receiving the enhanced or licensed rate for child care subsidized by DHS
7	ABSENCE OF REPEAT MALTREATMENT - The percentage of abused/neglected children who were not subsequently victimized within 6 months of prior victimization.
8	TIMELY REUNIFICATION - The percentage of foster children exiting to reunification within 12 months of foster care entry.
9	TIMELINESS OF ADOPTION ONCE LEGALLY FREE - Percent of Legally free children adopted in less than 12 months
10	LTC NEED PREVENTION - Percentage of seniors (65+) needing publicly-funded long term care services.
11	LTC RECIPIENTS LIVING OUTSIDE OF NURSING FACILITIES - The percentage of Oregonians accessing publicly-funded long-term care services who are living outside of nursing facilities.
12	DEVELOPMENTAL DISABILITY SUPPORT SERVICES - The percentage of eligible adults who are receiving adult support services within 90 days of request.
13	PEOPLE WITH DISABILITIES LIVING AT HOME - The percentage of individuals enrolled in the Intellectual/Developmental disabilities program who are receiving services in their own home.
14	SUPPORTED EMPLOYMENT - Increase the number of individuals who receive developmental disability services in supported employment.
15	ABUSE OF PEOPLE WITH DEVELOPMENTAL DISABILITIES - The percentage of people with developmental disabilities experiencing abuse.
16	ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES - The percentage of seniors and adults with physical disabilities experiencing abuse.
17	CUSTOMER SERVICE - Percentage of customers rating their satisfaction with DHS above average or excellent: overall, timeliness, accuracy, helpfulness, expertise, availability of information.
18	PLACEHOLDER: SERVICE EQUITY -
19	CHILDREN SERVED BY CHILD WELFARE RESIDING IN PARENTAL HOME - The percent of children served in Child Welfare on an average daily basis (In Home and Foster Care) who were served while residing in their parent's home.
20	TANF JOBS PLACEMENTS - The percentage of clients who achieve job placement each month compared to those anticipated to achieve placement.



	Green	Yellow	Red
	= Target to -5%	= Target -6% to -15%	= Target > -15%
Summary Stats:	57.89%	21.05%	21.05%

KPM #1	OVRS CLOSED - EMPLOYED – The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.
	Data Collection Period: Oct 01 - Sep 30



Report Year	2012	2013	2014	2015	2016
OVRS CLOSED - EMPLOYED					
Actual	57%	59%	60%	62.44%	62.34%
Target	66%	66%	66%	66%	66%

How Are We Doing

We have consistently missed this target since Federal Fiscal Year 2003

Factors Affecting Results

When we conducted a Boosted Logistic Regression on the Factors that impacted a client closing as a rehabilitation, there were eleven primary factors sorted below in order of importance:

- Desired Plan Occupation
- Number of months in plan
- Counselor
- Wages earned during the four quarters prior to application
- Total cost of services purchased for the client
- Unemployment Rate
- Work Status at application
- Primary Source of Income at Application
- Eligibility Priority
- Primary Disability

Generally, the higher the wages earned during the four quarters prior to application, the higher the rehabilitation rate. This generally, though not entirely reflects OVRS providing accommodations

to clients currently employed when they apply to the program. Those clients who had worked for 4 quarters during the year prior to application on the average had $20,873 per year annual earnings (based on Unemployment Insurance Wages reported) had a percent rehabilitated of 77% versus 56% for those clients who did not work during the year prior to application.

Correspondingly, those clients whose work status at application is that they are currently employed, have a higher rehabilitation rate than those who are unemployed. The percent rehabilitated is 57% for those clients who were unemployed at application versus 83% who were employed at application.

Similarly those clients who report at application that their primary source of income at application is personal income have higher rehabilitation rates (67%) than those who report Public Assistance as their primary source of income (55%).

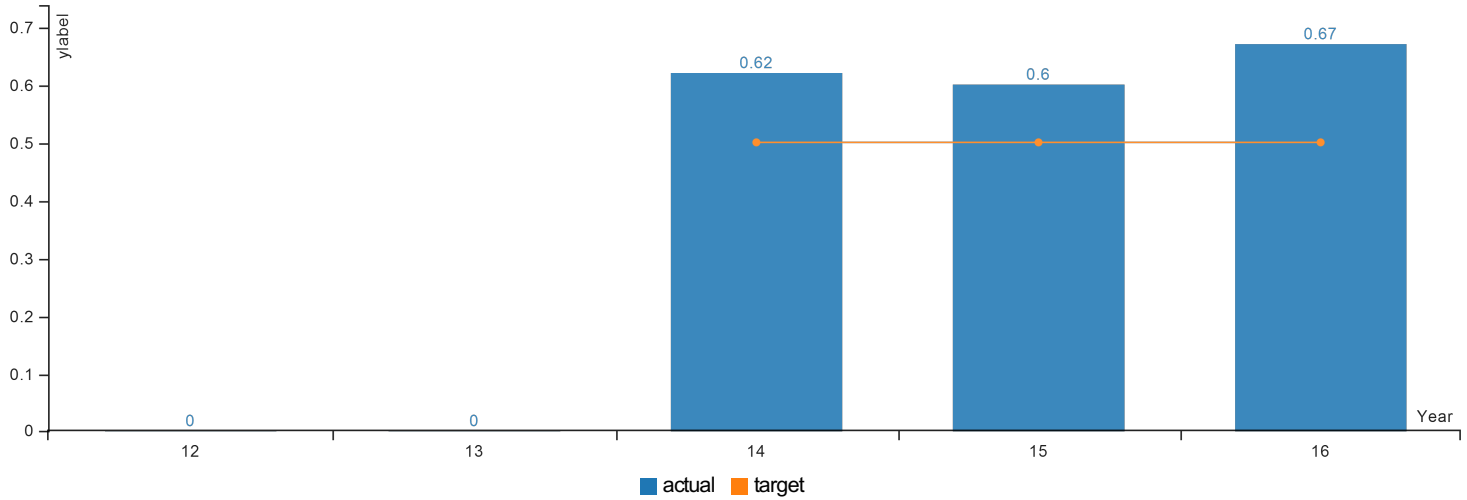
The rehabilitation rates for clients by their primary disability range from a low of 46% for clients with a primary disability of other mental impairments to 93% for clients whose primary disability is hearing loss, communication auditory (primarily providing hearing aids to clients employed at application). The largest percentage of the clients closing from plan (29%) are clients with a cognitive disability (such as intellectual developmentally disability) who have a rehabilitation rate of 65%. The three largest disability groups help lower the rehabilitation rate below the desired target of 66% (Cognitive Disability-65.7%, Psychosocial Impairments-55% and Other Mental Impairments-52%).

The effect of the unemployment rate is a little more ambiguous. Given that one can have a high rehabilitation rate in an area of high unemployment if the number of clients closing from a plan is small, there is not a consistent trend.

When looking at the occupational categories in which we are able to place clients into employment, the Office and administration and the Health Care Practitioners occupations are what lower than the overall rehabilitation rate. Roughly 16% of our clients are closed from a plan with occupational goals in these categories but only 55% are rehabilitated. Unfortunately, our data at this time does not allow us to identify to what degree the lower rehabilitation rate for these occupations is related to the percent not successfully completing occupational skills training in these occupations.

Generally, when the total cost of services purchased for the client increases, the percent rehabilitated increases. At less than $1,034.82, only 42% were rehabilitated versus 73% when $4,864 or greater is spent on the client.

KPM #2	TANF FAMILY STABILITY - The percentage of children receiving TANF who entered foster care.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2012	2013	2014	2015	2016
TANF Family Stability					
Actual	No Data	No Data	0.62%	0.60%	0.67%
Target	TBD	TBD	0.50%	0.50%	0.50%

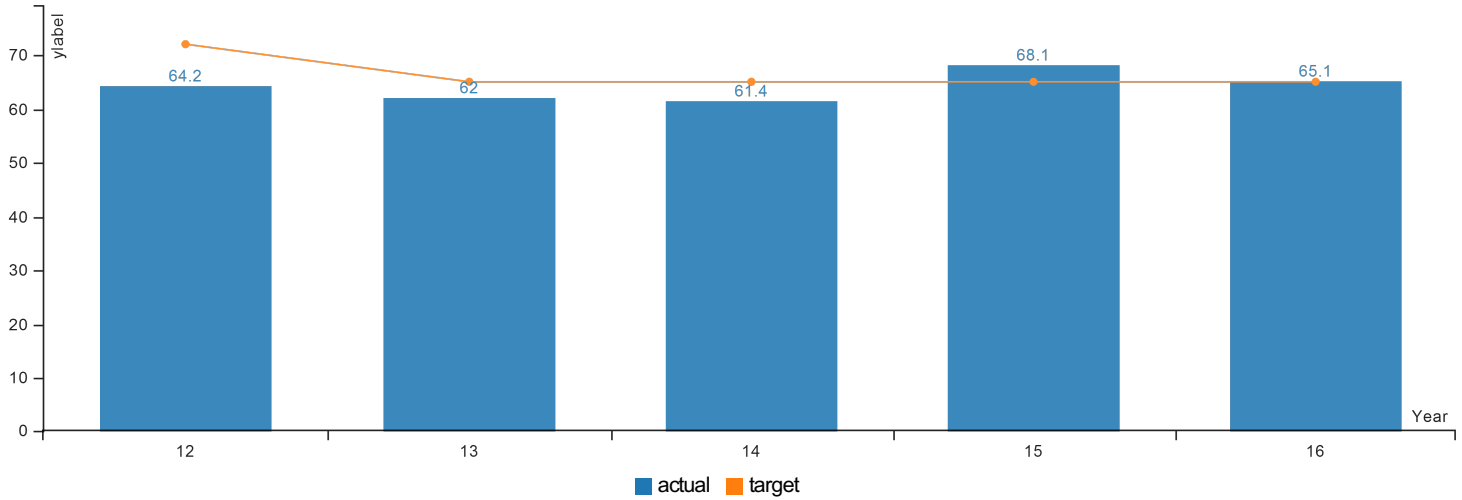
How Are We Doing

This measure tracks children living in extreme poverty who are receiving TANF and have child welfare involvement in the final month of a three-month timeframe. Our objective is to decrease the percentage of child TANF recipients needing to be placed in foster care. In State Fiscal Year (SFY) 2014, .60 percent of child TANF recipients had been receiving TANF cash assistance prior to entering foster care. In SFY 2015 there was an increase to .67 percent.

Factors Affecting Results

The factors affecting results include: multiple child abuse risk factors present in families such as, domestic violence, alcohol or drug abuse, parental involvement with law enforcement, homelessness, previous child welfare involvement and unemployment. Often there are several of these factors in families of child abuse/neglect victims. While Oregon’s overall economy is improving, the economy is recovering inconsistently across the state with certain areas of the state still experiencing high rates of unemployment and poverty.

KPM #3	TANF RE-ENTRY - The percentage of Temporary Assistance for Needy Families (TANF) cases who have not returned within 18 months after exit due to employment.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
TANF RE-ENTRY					
Actual	64.20%	62%	61.40%	68.10%	65.10%
Target	72%	65%	65%	65%	65%

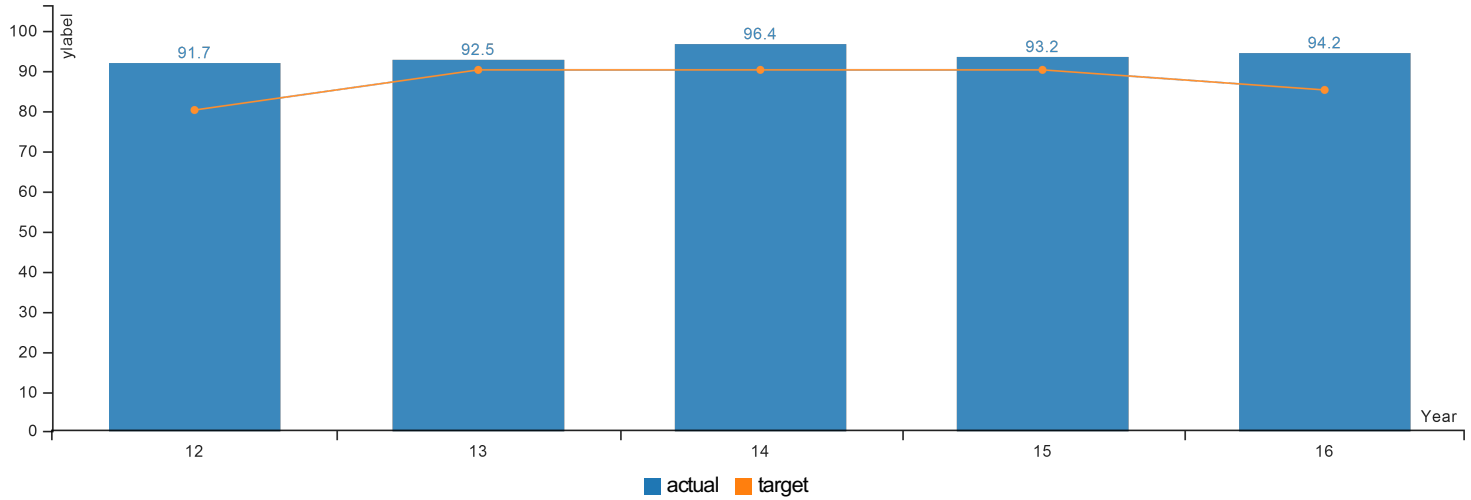
How Are We Doing

Our objective with this KPM measure is to increase the number of former TANF participants who do not require future TANF cash assistance after leaving the program due to employment. In State Fiscal Year (SFY) 2016, 65.1 percent of TANF participants did not return to TANF 18 months after leaving TANF due to employment. This represents a decrease from SFY 2015.

Factors Affecting Results

This measure may be affected by several things, including the status of the economy, the availability of jobs, and industry factors. It can also be affected by the structure of the Job Opportunity and Basic Skills (JOBS) program and the effectiveness of other agency and community partnerships that help connect TANF recipients into jobs. The effects of the TANF program reinvestment in 2015 likely also impact this measure's goals. The recent data show the agency is meeting its target which may be due in part by an improving economy. While Oregon's overall economy is improving, the economy is recovering inconsistently across the state with certain areas of the state still experiencing high rates of unemployment and poverty.

KPM #4	SNAP (Supplemental Nutrition Assistance Program) UTILIZATION - The ratio of Oregonians served by SNAP to the number of low-income Oregonians.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
SNAP UTILIZATION					
Actual	91.70%	92.50%	96.40%	93.20%	94.20%
Target	80%	90%	90%	90%	85%

How Are We Doing

SNAP participation has increased in the past however has remained steady for the past three years. During July 2015, 757,824 people received SNAP benefits in Oregon. During July 2016, 703,552 people received SNAP benefits. The decline is likely due to increased economic recovery in Oregon (1 in 5 state residents are SNAP participants). The DHS SNAP program has received federal participation bonuses for the past ten federal fiscal years for ranking in the top states nation-wide in participation rate.

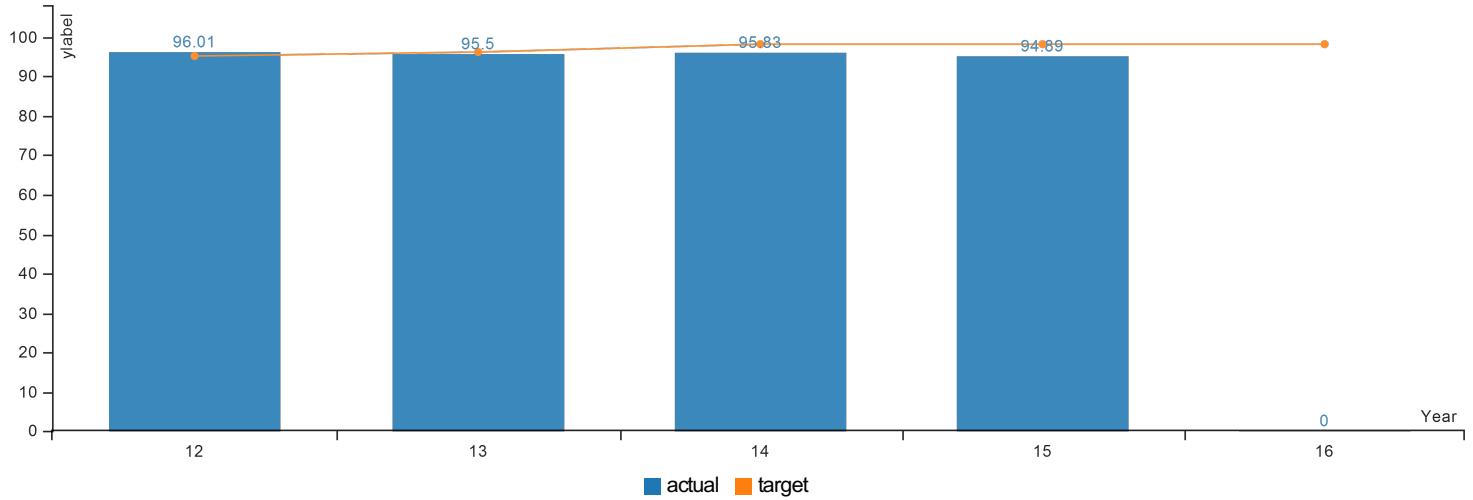
In 2013 (the most recent federal data available), Oregon was ranked number 7 in the nation in participation according to the PAI. In 2008, 2012 and 2009, Oregon was ranked second in the nation in SNAP participation based on the PAI and has remained one of the highest ranked states for participation. FNS ranking is based on the number of potentially eligible people compared to the number receiving benefits. Oregon consistently has a high participation rate and consistently regularly ranks at the top.

Factors Affecting Results

Oregon has had great success in easing access to SNAP benefits. One effort has been encouraging use of the on-line application. Another has been serving clients the same day or the next work day after they apply for benefits. Oregon has also been working to expand outreach efforts to identify and remove barriers to the SNAP program in all populations. Oregon's outreach partners have been educating clients to complete reports timely preventing eligible people from losing benefits.

The recession created critical need for basic necessities such as food in households which never expected to ask for help. During the recession we saw a rise in our caseload. As the economy has been improving the number of people receiving SNAP benefits has decreased to 86% of the highest number in 2012. The number of people receiving SNAP benefits continues to be more than before the recession hit. The number of people receiving benefits during July 2016 is 160% of the number during July 2007.

KPM #5	SNAP (Supplemental Nutrition Assistance Program) ACCURACY - The percentage of accurate SNAP payments
	Data Collection Period: Oct 01 - Sep 30



Report Year	2012	2013	2014	2015	2016
SNAP Accuracy					
Actual	96.01%	95.50%	95.83%	94.89%	0%
Target	95%	96%	98%	98%	98%

How Are We Doing

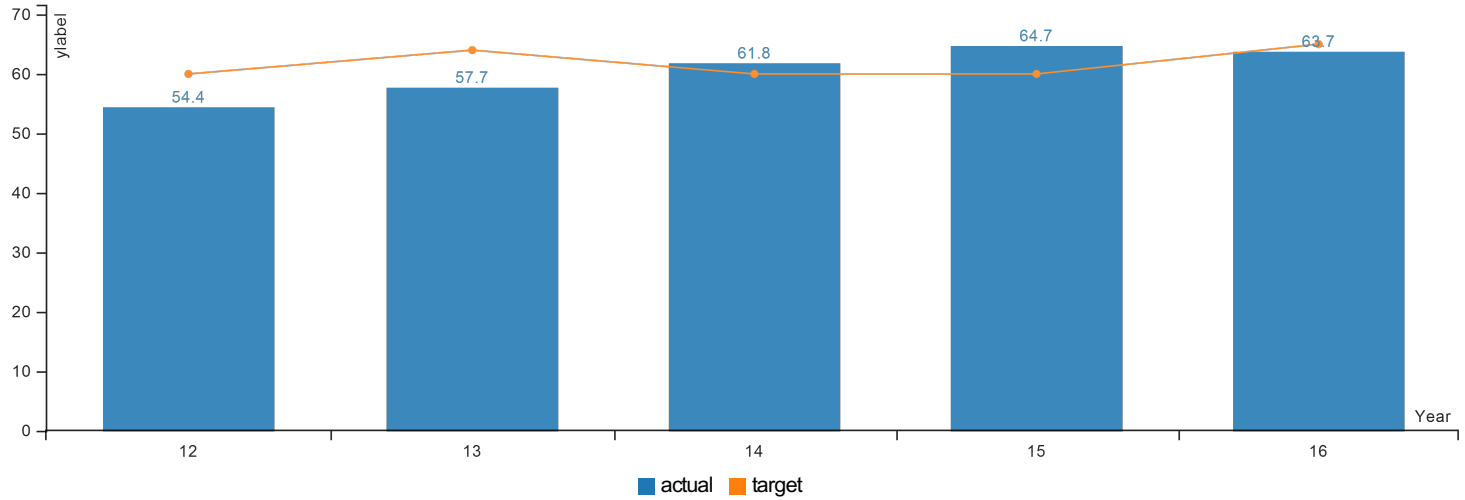
The latest data available is FY 2014, Oregon’s accuracy rate was 95.83% and the national average was 96.34%. State reported data for FY 2015 showed an accuracy rate of 96.56%, but Federal data has been delayed.

Factors Affecting Results

Data for Federal Fiscal Year 2015 is not yet available for KPM #5. Due to ongoing federal integrity reviews of each state's quality control activities the publication of final regressed error rates has been postponed. This information is expected to become available no later than 12/31/2016. Oregon's reported accuracy rate for Federal Fiscal Year 2015 is 96.56%.

The final regressed error rate differs from the state reported error rate based on the number of reviews completed, and the extent to which discrepancies are found in federal subsample of quality control reviews.

KPM #6	ENHANCED CHILD CARE - The percentage of children receiving care from providers who are receiving the enhanced or licensed rate for child care subsidized by DHS
	Data Collection Period: Oct 01 - Oct 31



Report Year	2012	2013	2014	2015	2016
Enhanced Child Care					
Actual	54.40%	57.70%	61.80%	64.70%	63.70%
Target	60%	64%	60%	60%	65%

How Are We Doing

There was a steady increase in the percentage of children receiving care either from a license-exempt provider receiving the enhanced rate or from a licensed provider from 2009 through present. Policy changes have had a direct impact on the percentage of children in licensed care. In April 2013 DHS stopped paying for any child care that was done prior to the provider passing a background check, or back paying, this resulted in two percent more children in licensed care within one month.

Our strategy is to improve the quality of care available to subsidized families, DHS subsidy rates for providers were increased to the 75th percentile of the current Child Care Market Price Study or higher in January 2016. The 2016 Child Care Market Price Study found the percent of slots that could be purchased with the value of DHS payment rates increased from 69% to 76% between 2014 and 2016 giving families access to higher quality care. Beginning April 2016, DHS provided an incentive payment to providers on the Quality Rating Improvement System (QRIS) and in September 2016, a lower copay for families that chose a provider on the QRIS. DHS license exempt providers can complete additional trainings to receive the enhanced rate that is 6 - 17% above the standard rate.

DHS partners with 211Info, Child Care Resource & Referral Agencies (CCR&R), Service Employees International Union Local 503 (SEIU), American Federation of State, County and Municipal Employees Local 132 (AFSCME) and the Oregon Registry. 211Info provides consumer education and helps parents find quality child care. The CCR&R's assist with provider training that is required to qualify for the DHS enhanced rate and to help meet licensing and QRIS standards. The Oregon Registry documents provider training and encourages trained providers to care for families on the DHS subsidy. DHS, 211Info, the CCR&Rs, SEIU, AFSCME and the Oregon Registry team together to publicize training and resources available.

A Child Care Orientation class is required for all new license-exempt providers. The Orientation class includes information on resources available including no-cost training on First Aid/CPR, Recognizing and Reporting Child Abuse and Neglect, and Food Handlers to publicize the enhanced rate as well as the USDA Food Program. Registered and new license-exempt providers are also required to complete a pre-service Health and Safety training.

DHS is working with the Early Learning Division on the Early Head Start Child Care Partnerships to build stronger collaborations with other agencies and partners to integrate our ERDC program with the state's early learning system. Guiding more of our providers through the Oregon's Quality Rating Improvement system (QRIS) is a priority.

DHS will continue to work with the Office of Child Care to promote innovations in subsidy intake and consumer education to increase access to high quality child care.

What needs to be done: Efforts to inform parents and providers of the importance of high quality child care and training continue to be improved. Exempt family providers are represented by SEIU. DHS, 211Info, Child Care Resource and Referral agencies and SEIU will continue to work together to promote provider training and the professional development continuum for exempt providers to access the training required to earn the enhanced rate, qualify for licensing and the QRIS. The Early Learning Division (ELD) has a position dedicated to identifying and implementing supports to improve the quality of exempt family providers caring for subsidy children. DHS is also partnering with the Early Learning Division to promote Vroom. Vroom is a set of tools and messages that empower parents and providers to be brain builders. It elevates what parents and providers are already doing right and enables them to make the most out of their time with their children. Vroom toolkits were dispersed to the DHS field offices in August 2016. The kits included flyers and posters to promote Vroom, tip cards and stickers for parents to utilize each day to promote learning with their children.

Factors Affecting Results
The 2007 Legislature authorized significant rate increases that took effect October 1, 2007. This gave parents increased access to licensed providers. In addition the Legislature authorized significant funding for outreach and training for license-exempt providers. The combination of more parents selecting licensed providers and increased investment in exempt provider training resulted in a steady increase in the percentage of children receiving care from providers earning the enhanced rate or the licensed rate. In July 2010, a Child Care Orientation class became required for all new license-exempt providers.

An analysis of Subsidy Employment by Industry Sector was completed by the DHS Forecasting Unit in April 2010. The majority of ERDC clients work in industries that constrain child care options. Many subsidy parents work evening or night shifts, weekend shift or have a week or less advance notice of work schedule. A recent study confirmed that the majority of subsidy participants have two or more constraints on child care options. Most regulated child care facilities only operate during the day, and many require the parent pay for a part-time or full-time slot, so this limits subsidy parents

A new federal strategic framework from the Administration for Children and Families was made available in June of 2013. The Office of Child Care recognizes the importance of access to high quality child care that supports parental employment in stable jobs that help parents provide for their families. This leads to healthy, happy and competent children who are ready for school with the necessary pre-academic skills; and high functioning CCDF grantees that use program dollars effectively, efficiently and with integrity, to the benefit of eligible children and families. The goal for DHS which aligns with federal ideals is to build a child care subsidy system that is child-focused, family friendly and fair to providers.

The Race to the Top Early Learning Challenge Grant is a four year federal grant recognizing Oregon's early learning work, and strengthening a statewide early care and education system. State recipients were chosen based on their ability to implement coherent, compelling, and comprehensive early learning education reform. This funding is designed to spur broad system improvement over four years to ensure Oregon children enter school ready to learn and succeed. The Early Learning Council prioritized the activities below through determining the greatest impact on young children, and that fit grant scope and requirements:

• Quality Rating Improvement System
Race to the Top resources will engage providers with more training, mentorship, and professional development.
• Early Childhood Workforce
Race to the Top resources will provide professional development to support career pathways for early childhood educators to develop expertise in quality early learning and best practices.
• Family and Community Access
Race to the Top resources will provide dedicated outreach to build an informed, engaged public around quality early learning environments.
• Enhance the QRIS Data System
Race to the Top resources will enhance and connect data systems to capture quality information to deliver service providers, policy makers, and funders information needed to ensure better outcomes for children.
• Kindergarten Assessment
Race to the Top resources will allow Oregon to align statewide early learning with K-12 Common Core standards, launch the statewide rollout of the assessment, and gauge where children are at when they enter school.

Activities connecting early learning programs and the K-12 system are a priority throughout. Grant funding provides Oregon an opportunity to execute the system, making historic progress. There are sustainability concerns as this funding ends December 2016.

HB 2015 and Federal Reauthorization:

HB 2015 and Federal Child Care Development Fund Reauthorization includes several fundamental changes to the DHS Employment Related Day Care (ERDC) program. These substantial program enhancements provide parents access to high quality child care that supports their employment as well as fostering healthy child development and school success including:.

- Twelve month eligibility
- Priority child care processing for homeless families or families applying for child care for a foster
- Working student child care
- Self-Employment coverage reinstated

Higher exit income limit of about 250% of the federal poverty level:

- DHS subsidy rates for all providers increased to the 75th percentile of the current Child Care Market Price Study or higher
- An incentive payment for QRIS Child Care Providers who accept subsidy families.
- Lower copay for families that choose a provider who is part of the Quality Rating and Improvement System (QRIS).

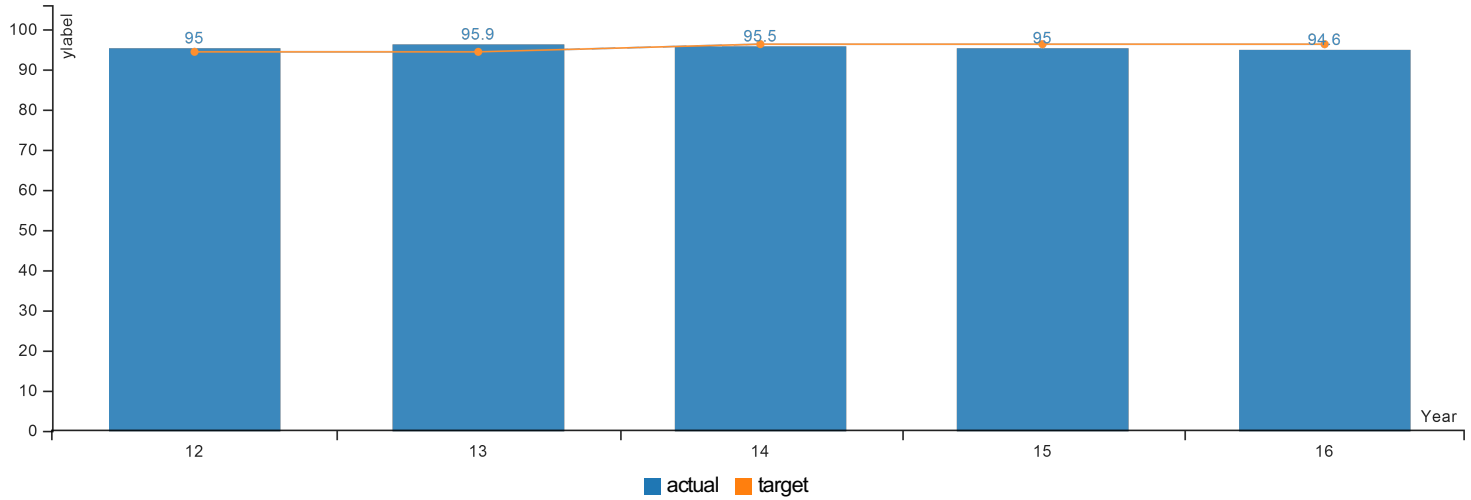
EARLY LEARNING DIVISION/DHS PARTNERSHIP

- Monitoring visits by the Office of Child Care (OCC) for license-exempt child care providers who care for subsidy children. **Compliance by 11/19/2016**.
- Increased Health and Safety Requirements – pre service first aid, CPR, recognizing and reporting child abuse and neglect and emergency preparedness on-line training. **Compliance by 11/19/2016.**
- Fingerprinting requirement for all background checks. **Compliance by 1/1/2017**

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

Reporting cycle - point in time, October of each year. This measure is reported as a percentage. The data are taken from the DHS Provider Pay system and compares the number of children in care with providers earning the enhanced and licensed rate to the total number of active providers in the system. As a result, the number is very reliable. Any variance caused by possible coding errors would be too small to be statistically significant. The data includes all contracted child care.

KPM #7	ABSENCE OF REPEAT MALTREATMENT - The percentage of abused/neglected children who were not subsequently victimized within 6 months of prior victimization.
	Data Collection Period: Oct 01 - Sep 30



Report Year	2012	2013	2014	2015	2016
ABSENCE OF REPEAT CHILD MALTREATMENT					
Actual	95%	95.90%	95.50%	95%	94.60%
Target	94.10%	94.10%	96%	96%	96%

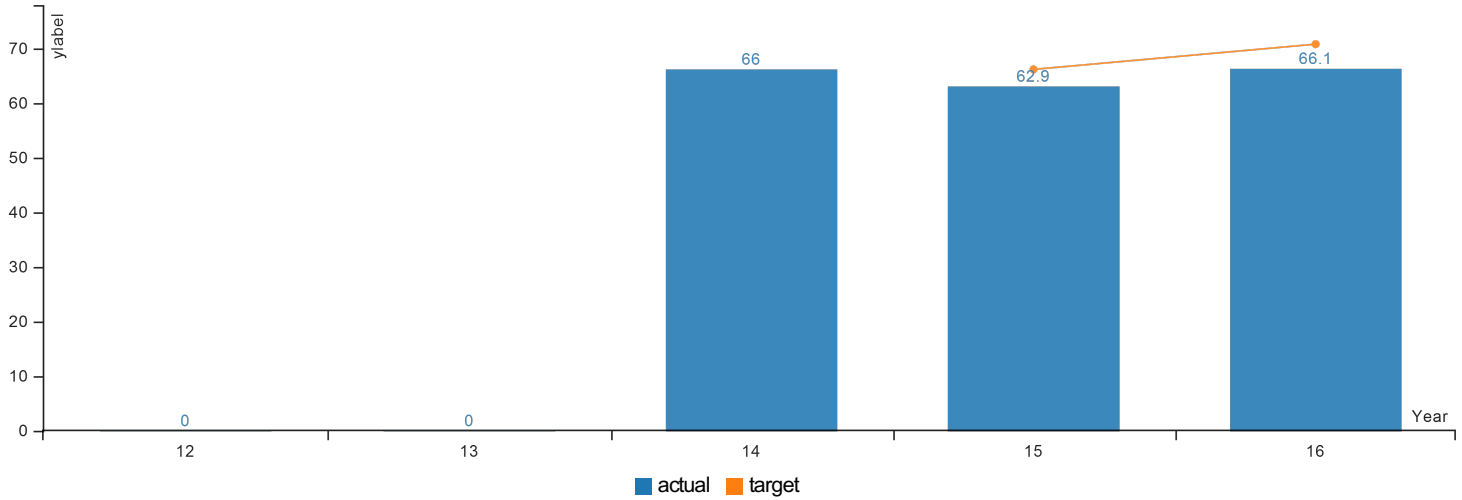
How Are We Doing

From 2014 to 2015 Oregon had a small decrease in this performance measure of .4%. After further analysis the decrease appears to be less than what was originally thought. This was based on the inclusion of pended reports which are not in fact founded dispositions and do support the conclusion that a child suffered a second incident of abuse within a six month period. Removing pended reports from the calculation means the decrease, .2%, is slight better than the original number. Even though Oregon has essentially maintained the numbers from the year before, 94.8% still falls short of the 96% target. Oregon continues its commitment to not only ensure the number remains consistent moving forward, but to make continued efforts to improve.

Factors Affecting Results

The major factors affecting families of abused and neglected children continue to be drug/alcohol abuse, mental illness, parental involvement with law enforcement, domestic violence and poverty. Often times, there are several of these factors co-occurring in families of child abuse/neglect victims and a pattern of generational occurrence. While the comprehensive nature of child protective services assessments is designed to culminate into effective sustainable intervention this takes significant resources and workload demand.

KPM #8	TIMELY REUNIFICATION - The percentage of foster children exiting to reunification within 12 months of foster care entry.
	Data Collection Period: Oct 01 - Sep 30



Report Year	2012	2013	2014	2015	2016
Timely Reunification					
Actual	No Data	No Data	66%	62.90%	66.10%
Target	TBD	TBD	TBD	66%	70.60%

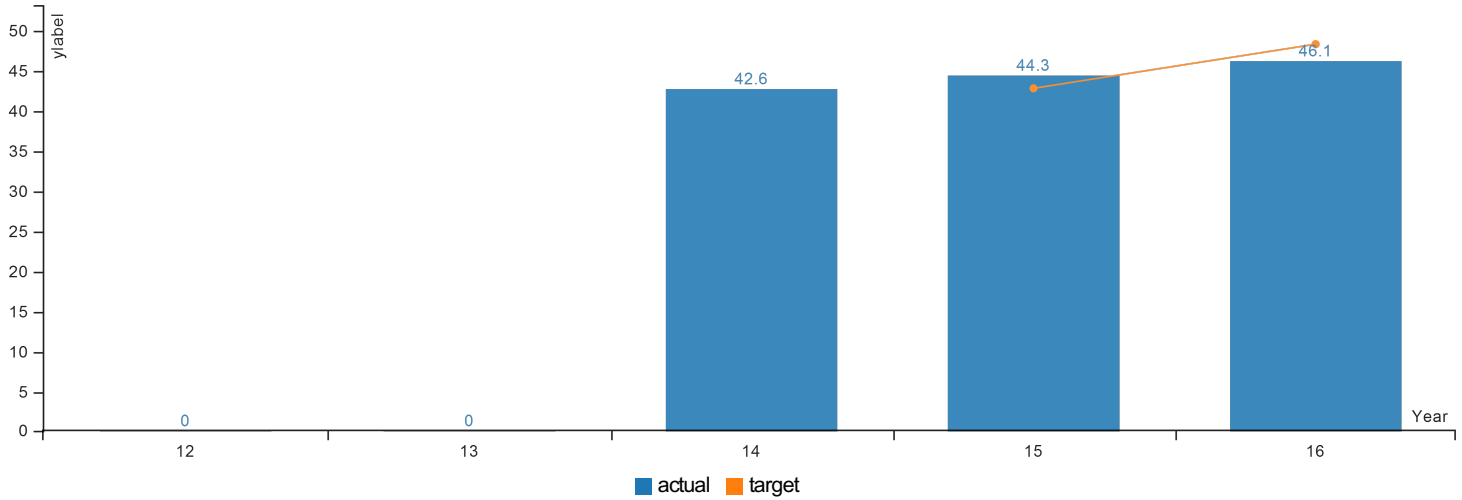
How Are We Doing

Oregon saw a decrease in this performance measure of 3.1 percentage points between federal fiscal years 2013 and 2014, but increased in the measure between FFY 2014 and 2015 by 3.2 percentage points. Oregon beat its stated target for last year, but is 4.5 percentage points short of the increased target goal we set for ourselves for this year. We are 3.8 percentage points below the national goal (which is based on the 75th percentile of all states) so Oregon still has work to do in this area.

Factors Affecting Results

The family dynamics that contribute to child safety issues are long standing and some of the most prevalent continue to be drug and alcohol abuse, domestic violence, parental involvement with law enforcement, mental illness, and unemployment. Availability of prevention strategies, targeted services, and community resources are factors that impact whether children enter foster care or remain in foster care. Differential response which is now implemented in half of Oregon's counties is intended to reduce the number of children entering care and thereby reduce the number of children requiring reunification. However, if differential response has the intended impact, the children who do enter foster care may have experienced more severe abuse or neglect, or have more acute needs. A factor that also affects results of this measurement is the fact that a child is not defined as having reunified until the DHS custody case is dismissed. Children who are returned home but remain under DHS custody and supervision are considered to still be in foster care for the first six months of the return. Some jurisdictions keep the DHS case open longer than others once a child returns in home.

KPM #9	TIMELINESS OF ADOPTION ONCE LEGALLY FREE - Percent of Legally free children adopted in less than 12 months
	Data Collection Period: Oct 01 - Sep 30



Report Year	2012	2013	2014	2015	2016
Timeliness of Adoption Once Legally Free					
Actual	No Data	No Data	42.60%	44.30%	46.10%
Target	TBD	TBD	TBD	42.70%	48.20%

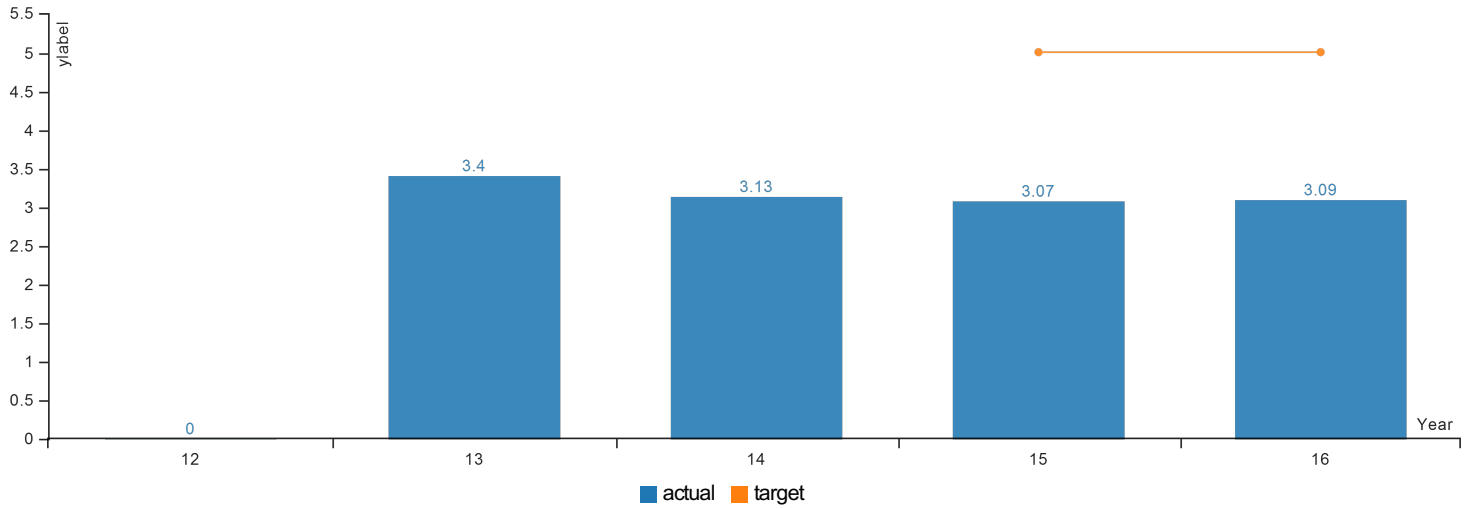
How Are We Doing

Oregon saw an increase in this performance measure of 1.7 percentage points between federal fiscal years 2013 and 2014, then increased in the measure again between FFY 2014 and 2015 by another 1.8 percentage points. While meeting last year's target, Oregon aggressively increased its target and fell short of reaching it by 2.1 percentage points this year. The national target for percent of legally free children adopted in less than 12 months is 45.8%, so Oregon is performing just over the national goal (which is based on the 75th percentile of all states)

Factors Affecting Results

Multiple factors affect the results of this measure, but the primary issue is the sheer volume of paperwork associated with the adoption process, and lack of concurrent work being done in the field while the case is being prepared for termination of parental rights. Ongoing casework is often crisis driven and once a child is legally free and especially if living in their adoptive environment, the paperwork to finalize the adoption can become less of a priority on individual caseloads. There are other factors that impact this measure including the length of recruitment time for high needs children, additional time associated with children placed out of state, the required six month supervision period, mediation between adoptive parents and birth parents, adoptive parent applications for adoption assistance not submitted timely, to name a few. But the primary factor appears to be volume of paperwork that must be prepared and submitted to central office before the consent to finalize an adoption can be prepared.

KPM #10	LTC NEED PREVENTION - Percentage of seniors (65+) needing publicly-funded long term care services.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
LTC NEED PREVENTION					
Actual	No Data	3.40%	3.13%	3.07%	3.09%
Target	TBD	TBD	TBD	5%	5%

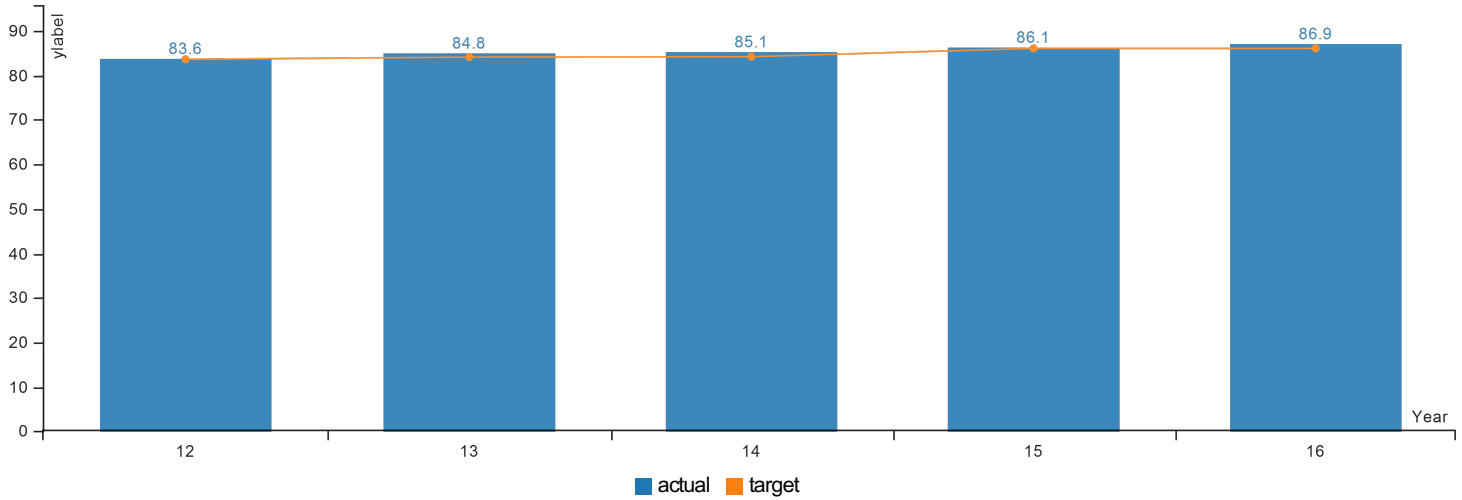
How Are We Doing

In 2015, only 3.09% of Oregonians 65 or older needed assistance with publicly funded long term care. This is a slight uptick from 2015, but remains well below the goals established by the Legislative Assembly.

Factors Affecting Results

Oregon has adopted the Community First Choice Model, also known as the K Plan. This is a big driver in these results as the K Plan has numerous tools that are designed to keep people independent. Additionally, the success of the AAA network administering Oregon Project Independence, Older Americans Act programs and the Aging and Disability Resource Connection contribute towards keeping seniors independent.

KPM #11	LTC RECIPIENTS LIVING OUTSIDE OF NURSING FACILITIES - The percentage of Oregonians accessing publicly-funded long-term care services who are living outside of nursing facilities.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
LTC RECIPIENTS LIVING OUTSIDE OF NURSING FACILITIES					
Actual	83.60%	84.80%	85.10%	86.10%	86.90%
Target	83.50%	84%	84.09%	85.96%	85.96%

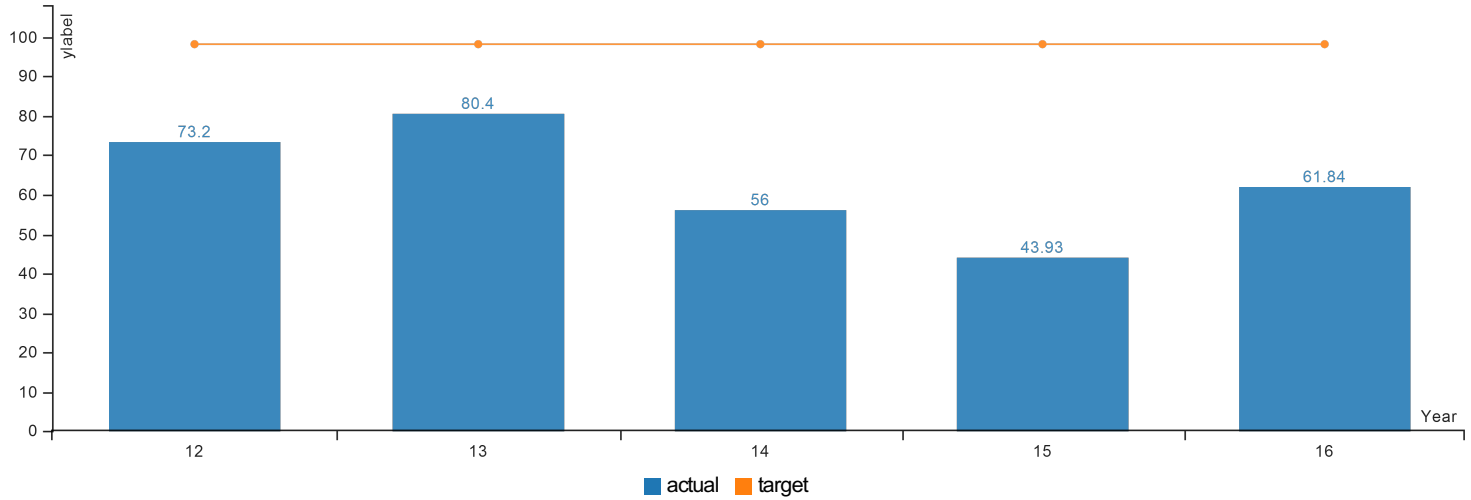
How Are We Doing

APD continues to make steady, continued progress at serving seniors and people with disabilities in settings less restrictive than nursing facilities. APD is pleased it is exceeding targets established by the Legislative Assembly.

Factors Affecting Results

Hospitals continue to discharge patients “sicker and quicker”. In many cases, hospital preference on discharge of a senior who needs additional care is a nursing facility. While institutional care may be appropriate for certain individuals for short periods of time, DHS must continue to aggressively ensure that seniors are appropriately discharged from nursing facilities.

KPM #12	DEVELOPMENTAL DISABILITY SUPPORT SERVICES - The percentage of eligible adults who are receiving adult support services within 90 days of request.
	Data Collection Period: Jun 01 - Jul 31



Report Year	2012	2013	2014	2015	2016
DD Adult Support Services					
Actual	73.20%	80.40%	56%	43.93%	61.84%
Target	98%	98%	98%	98%	98%

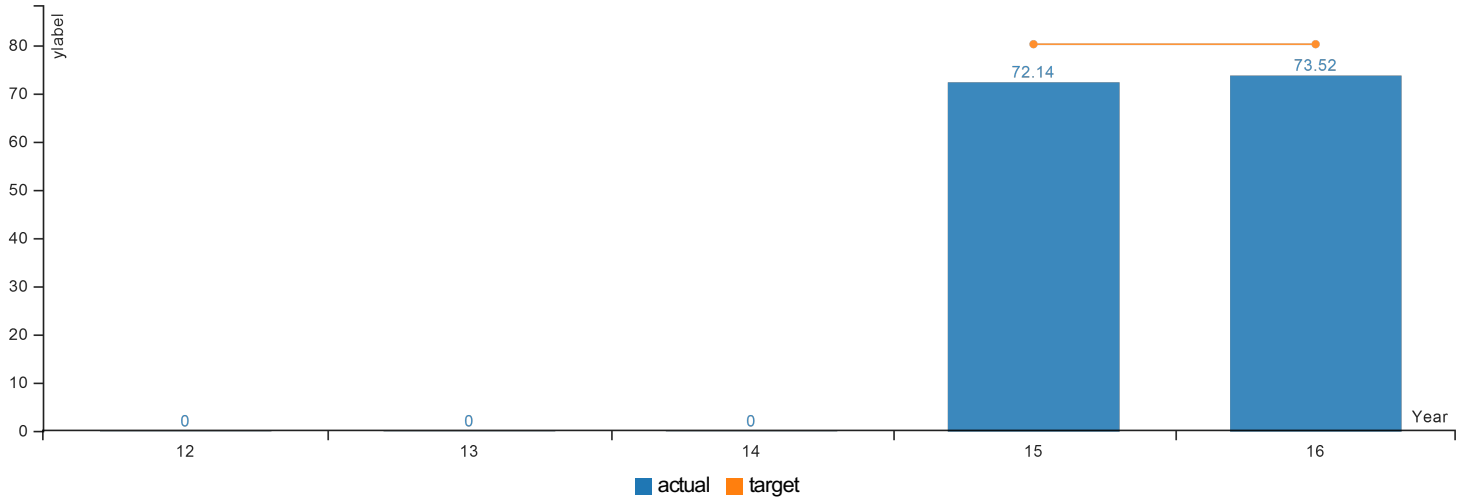
How Are We Doing

The Office of Developmental Disabilities Services continues to add people to services as a result of the state moving to the Community First Choice Option or K plan.

Factors Affecting Results

Moving to the K plan has increased the number of people accessing services which has caused delays in processing at all levels. This is impacting the ability of people to start services within 90 days of request.

KPM #13	PEOPLE WITH DISABILITIES LIVING AT HOME - The percentage of individuals enrolled in the Intellectual/Developmental disabilities program who are receiving services in their own home.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
PEOPLE WITH DISABILITIES LIVING AT HOME					
Actual	No Data	No Data	No Data	72.14%	73.52%
Target	TBD	TBD	TBD	80%	80%

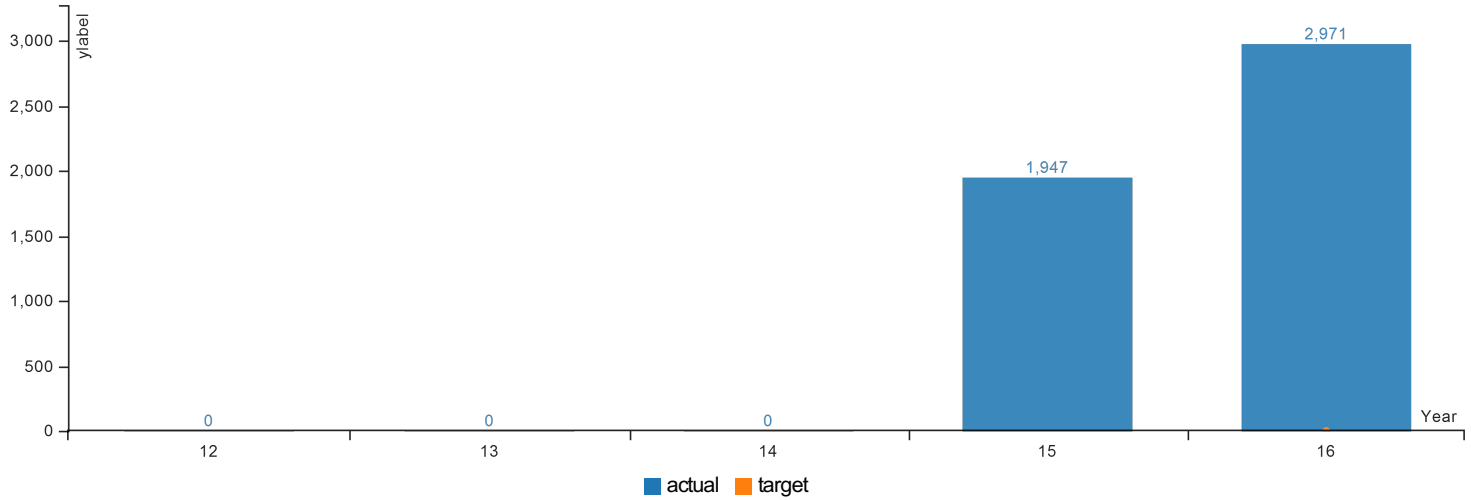
How Are We Doing

The majority of children and adults with intellectual and developmental disabilities continue to live in family homes.

Factors Affecting Results

Implementing the K plan has allowed people with more significant need to receive in-home services if they chose not to move to a residential setting.

KPM #14	SUPPORTED EMPLOYMENT - Increase the number of individuals who receive developmental disability services in supported employment.
	Data Collection Period: Oct 01 - Sep 30



Report Year	2012	2013	2014	2015	2016
INTEGRATED EMPLOYMENT SETTINGS					
Actual	No Data	No Data	No Data	1,947	2,971
Target	TBD	TBD	TBD	TBD	0

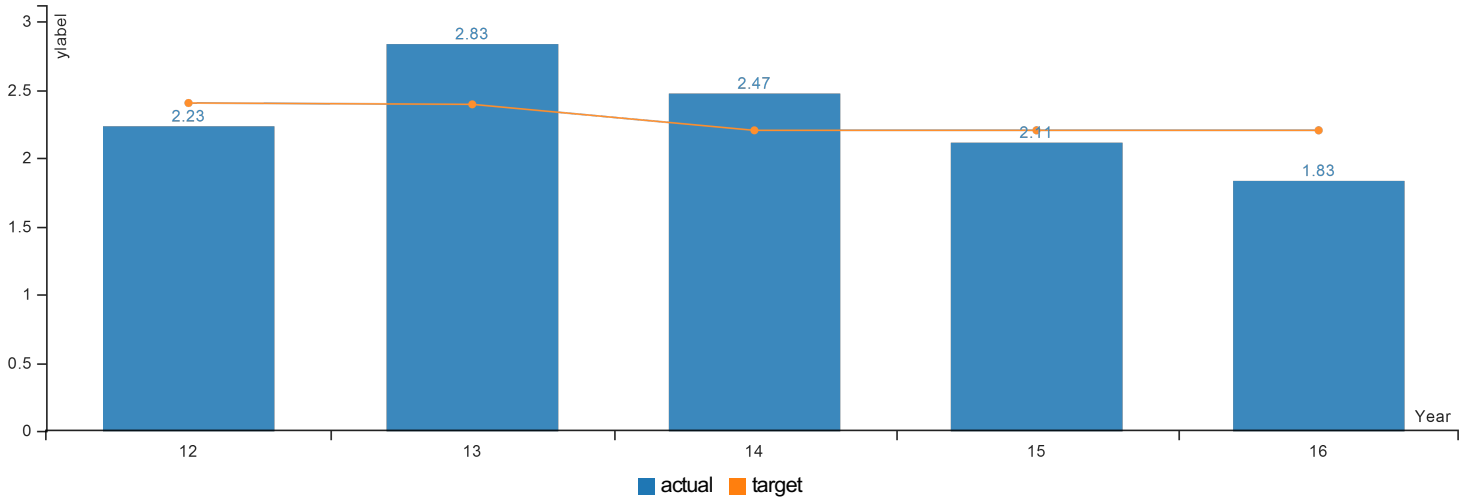
How Are We Doing

For Fiscal Year 2016 we provided employment services to 2,971 individuals and are in compliance with both the Executive Order and Lane Settlement.

Factors Affecting Results

Executive Order 15-01 and the Lane v. Brown Settlement Agreement require DHS to provide employment services to at least 7,000 individuals by 2022. This means that by 2017 at least 3,000 individuals should have received an employment service; by 2018 3,800; 2019 4,600; 2020 5,400; 2021 6,200; and 2022 7,000.

KPM #15	ABUSE OF PEOPLE WITH DEVELOPMENTAL DISABILITIES - The percentage of people with developmental disabilities experiencing abuse.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
ABUSE OF SENIORS AND ADULTS WITH DISABILITIES - b) people with developmental disabilities					
Actual	2.23%	2.83%	2.47%	2.11%	1.83%
Target	2.40%	2.39%	2.20%	2.20%	2.20%

How Are We Doing

As seen in the reporting table above, the abuse rate of adults with intellectual/developmental disabilities enrolled in services has declined slowly over the last four years. In 2015 it was below 2% for the first time, indicating that the current target (2.2%) may be able to be lowered in the future.

The types of services being received by over 15,000 individuals with intellectual/developmental disabilities, as well as the definitions of abuse applied to this population, have changed significantly over the last ten years. Because of these changes, as well as the lack of standardized national abuse data for comparison, it is challenging to develop a target. The approach instead has been to establish a baseline based on historical data, and then pursue a series of incrementally decreasing targets. At this time the target is at 2.2%, based on prior data.

Our strategies for improvement include:

- A renewed focus on monitoring and safety in licensed settings for adults with intellectual/developmental disabilities, including greater coordination between licensing, abuse investigation and program staff to respond more quickly and effectively to areas of concern.
- Development and implementation of a Centralized Abuse Management information system in 2017, to allow for enhanced centralized tracking and monitoring of abuse referrals, outcomes and trends statewide.
- Ongoing outreach to increase public awareness of abuse issues facing individuals with intellectual/developmental disabilities.
- Ongoing collaboration with community partners, including brokerages serving people with intellectual/developmental disabilities living in their own homes.

Enhanced training to abuse investigators, service coordinators, personal agents, direct service providers and facility staff.

Factors Affecting Results

Abuse rates for adults with intellectual/developmental disabilities can be affected by many factors, including:

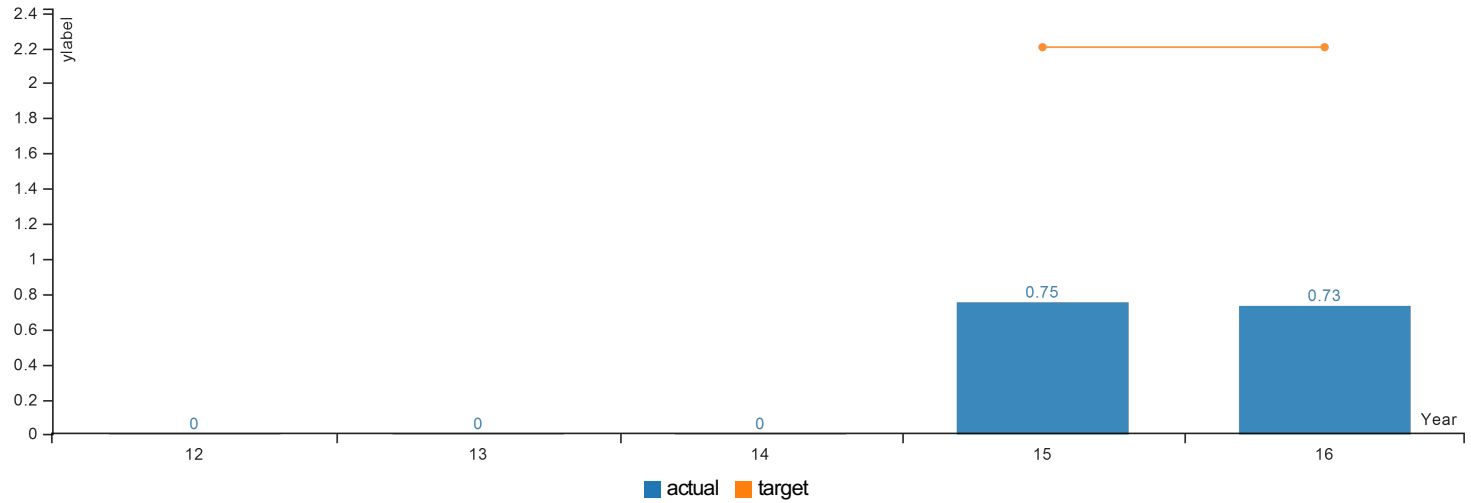
- High turnover of staff in licensed and certified programs.
- An increase in the number of higher-acuity residents being served in community-based care settings.
- An adult's right to make decisions about their living situation, companions, etc.
- Barriers to the reporting of abuse by cognitively impaired clients.
- Lack of resources available to respond and support adults with intellectual/developmental disabilities who are abused (e.g. domestic violence shelters, counseling resources).

What needs to be done in this area includes:

- Ongoing training in recognizing, reporting, and preventing abuse for service coordinators, personal agents, direct service providers and facility staff.
- Research and collaboration with community response system and resources, including domestic violence and sexual assault response services.
- Increased investigator access to experts such as forensic nurses and psychologists.

Improved outreach to clients, their families and the community at large to increase awareness of abuse issues.

KPM #16	ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES - The percentage of seniors and adults with physical disabilities experiencing abuse.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
ABUSE OF SENIORS AND ADULTS WITH DISABILITIES - a) seniors and adults with physical disabilities					
Actual	No Data	No Data	No Data	0.75%	0.73%
Target	TBD	TBD	TBD	2.20%	2.20%

How Are We Doing

Since our Department currently is below the preliminary target of 2.2% for the percentage of older adults and people with disabilities who are abused, it appears that we are meeting the goals of our intervention model described above. However, there are concerns about the accuracy and reliability of the data that we are attempting to resolve. Abuse in the community can be difficult to lower due to the individual's right to make decisions about their own life and the course of action. Additionally, as public awareness of the signs of abuse increases so do the number of abuse reports received by the department resulting in more investigations and interventions. The department wants to encourage individuals to report all suspected abuse.

Strategies to improve the department's performance include:

- On-going Adult Protective Service training including fundamentals of and advanced training for experienced APS workers.
- Continuation of public education efforts;
- Technical Assistance to field offices;

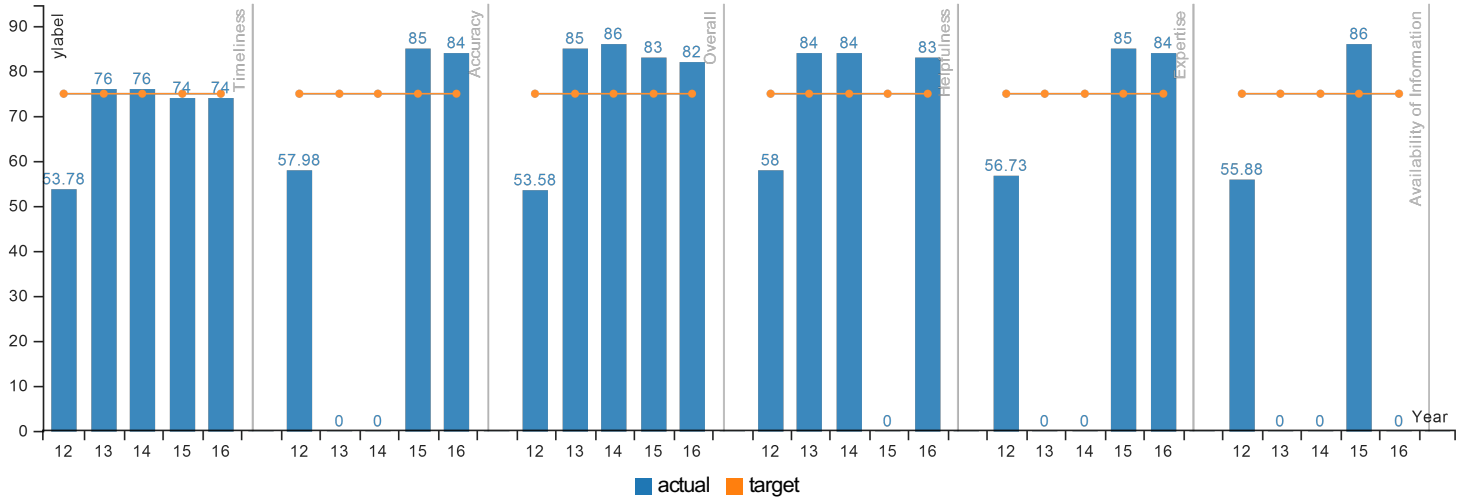
Factors Affecting Results

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

- Right to self-determination;
- Limited resources including state, federal, and community-type(s);
- Additional training and development needed for APS Specialist's;
- Response of the criminal justice system;

- Development and understanding of intra-agency functions;

KPM #17	CUSTOMER SERVICE - Percentage of customers rating their satisfaction with DHS above average or excellent: overall, timeliness, accuracy, helpfulness, expertise, availability of information.
	Data Collection Period: Jan 01 - Jan 31



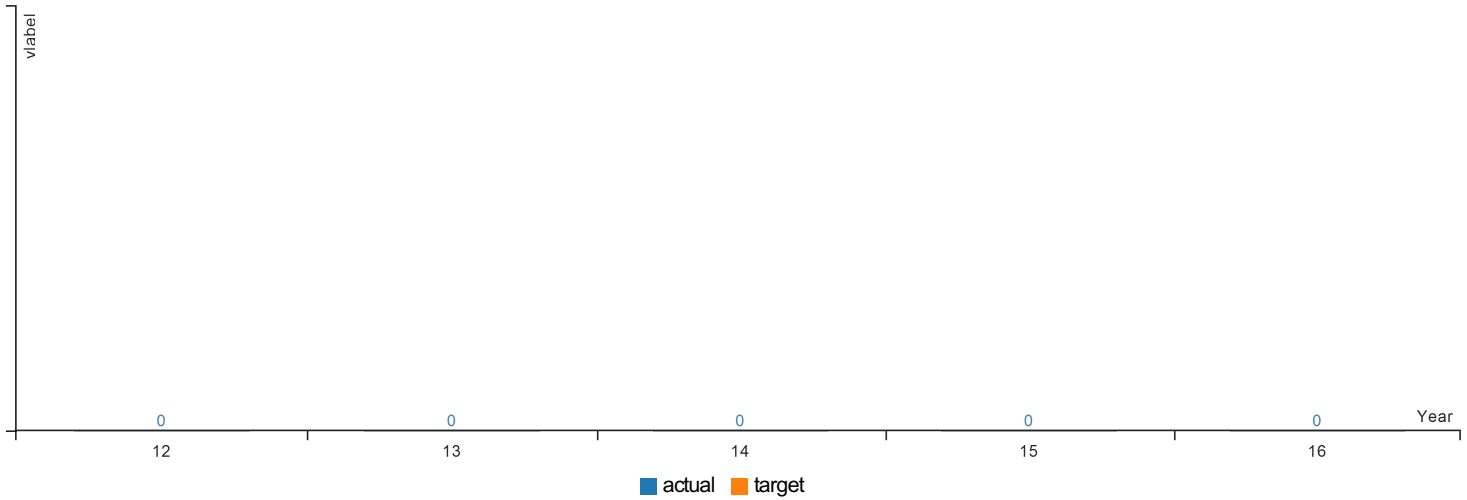
Report Year	2012	2013	2014	2015	2016
Timeliness					
Actual	53.78%	76%	76%	74%	74%
Target	75%	75%	75%	75%	75%
Accuracy					
Actual	57.98%	No Data	No Data	85%	84%
Target	75%	75%	75%	75%	75%
Overall					
Actual	53.58%	85%	86%	83%	82%
Target	75%	75%	75%	75%	75%
Helpfulness					
Actual	58%	84%	84%	No Data	83%
Target	75%	75%	75%	75%	75%
Expertise					
Actual	56.73%	No Data	No Data	85%	84%
Target	75%	75%	75%	75%	75%
Availability of Information					
Actual	55.88%	No Data	No Data	86%	No Data
Target	75%	75%	75%	75%	75%

How Are We Doing

DHS met or exceeded 4 of the 6 submeasures

Factors Affecting Results

KPM #18	PLACEHOLDER: SERVICE EQUITY -
	Data Collection Period: Jan 01 - Jan 01

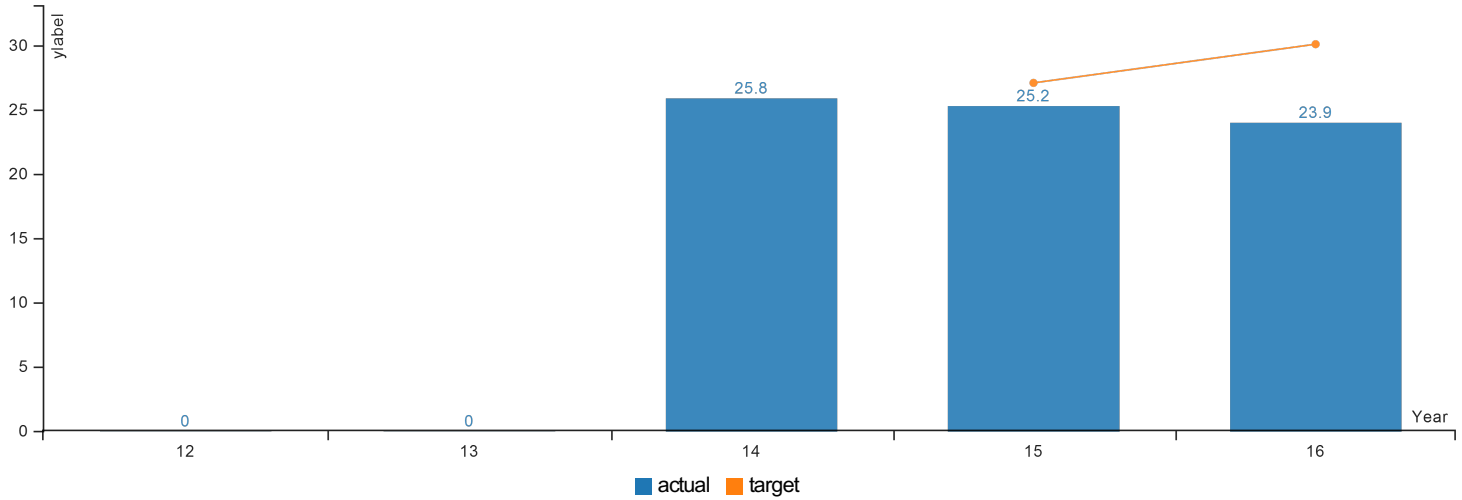


Report Year	2012	2013	2014	2015	2016
SERVICE EQUITY Rate per 1,000 Population					
Actual	No Data	No Data	No Data	No Data	No Data
Target	TBD	TBD	TBD	TBD	TBD

How Are We Doing

Factors Affecting Results

KPM #19	CHILDREN SERVED BY CHILD WELFARE RESIDING IN PARENTAL HOME - The percent of children served in Child Welfare on an average daily basis (In Home and Foster Care) who were served while residing in their parent's home.
	Data Collection Period: Oct 01 - Sep 30



Report Year	2012	2013	2014	2015	2016
CHILDREN RESIDING AT HOME IN LEAST RESTRICTIVE SETTING					
Actual	No Data	No Data	25.80%	25.20%	23.90%
Target	TBD	TBD	TBD	27%	30%

How Are We Doing

From 2014 to 2015, Oregon saw a slight decrease in this performance measure of 0.6 percent. Then a larger decrease from 2015 to 2016 of 1.3%. There are several strategies still in process of implementation during this time. Differential Response has not yet been fully implemented. The state child welfare program has been working toward the vision of Safe Equitable Foster Care Reduction. One way to achieve this vision is through serving children safely in their own home. Several strategies have been involved in helping to achieve this vision.

- Focus on the Oregon Safety Model, which includes child safety assessment, actions and decisions through the life of a case, so DHS Child Welfare staff are making safety decisions consistent with the model across the state, serving children in their homes when safe. Oregon Safety Model fidelity work continues across the state.
- Strengthening, Preserving and Reunifying Families services have been established in every county in the state. These services specifically address needs of children and families who come to the attention of child welfare through a report of abuse or neglect. These services are designed to address gaps in the service array in local communities --specifically, those services aimed at maintaining children safely in the home, reducing the lengths of stay in foster care and addressing re-abuse of children. Performance-Based Contracting is a results-oriented contracting method that focuses on the outputs, quality, or outcomes that may tie at least a portion of a contractor's payment, contract extensions, or contract renewals to the achievement of specific, measurable performance standards and requirements. Each county regularly assesses their Strengthening, Preserving and Reunifying Families service array, to determine gaps in service provision and use of current services. In an effort to understand outcomes associated with implementation of the SPRF program, DHS has implemented the first step toward a system of Performance-Based Contracting, in collaboration with our SPRF contractors. Current SPRF contracts now include performance-based contract language and outcomes. Upon execution of the contracts, the contractor began submitting reports through the invoicing process which identifies one of three outcomes for each client:

1) Achieved

2) Partially Achieved

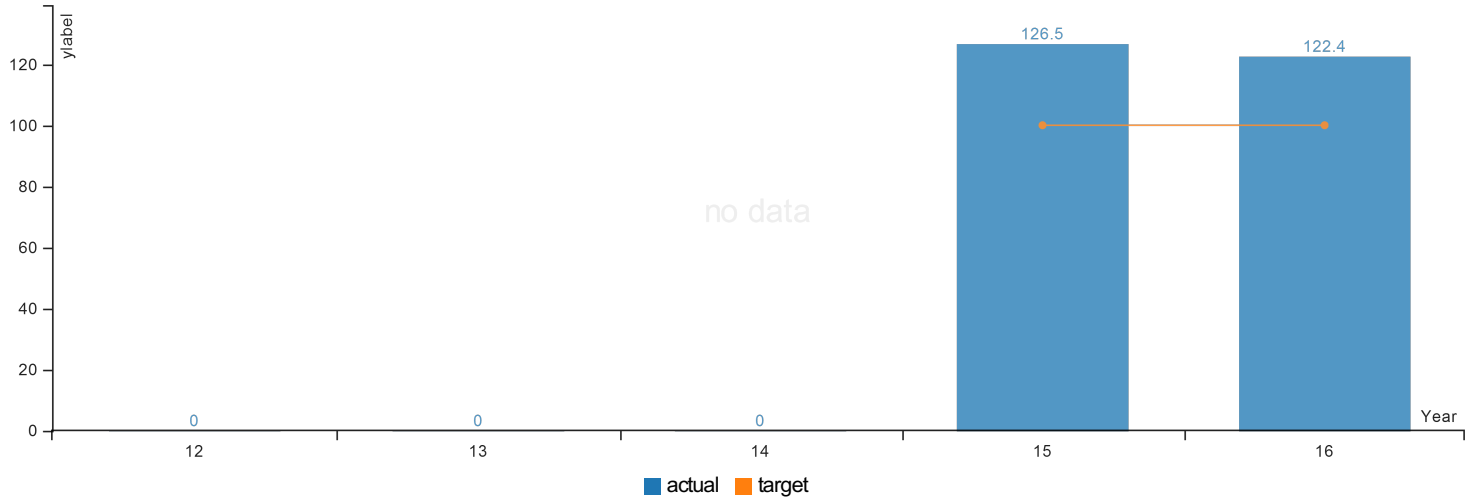
3) Not Achieved

Differential Response provides the route for families to connect to their community and needed services. The families involved with child welfare receive a comprehensive child safety assessment by child welfare staff. However, just as every family is unique, the department's approach needs to be flexible enough to serve the family's needs. Oregon's DR design includes the specific screening criteria to determine the best response to assess families and increase our success in keeping children safely parented at home while the family receives services. Families can more successfully resolve issues when they are viewed as part of the solution and where they partner with child welfare and their community in problem solving and the identification of services and supports needed. Differential Response began in Oregon in May 2014 in 3 counties. It is now being practiced in 12 counties (totaling nearly half the state's child welfare workforce). A 3 year evaluation of Differential Response is being conducted by the University of Illinois.

Factors Affecting Results

The comprehensiveness of child abuse/neglect assessments takes significant resources and workload demand and urgency. The major factors affecting families of abused and neglected children are drug/alcohol abuse, domestic violence, parental involvement with law enforcement, and poverty. Often there are several of these factors co-occurring in families of child abuse/neglect victims.

KPM #20	TANF JOBS PLACEMENTS - The percentage of clients who achieve job placement each month compared to those anticipated to achieve placement.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
TANF JOBS PLACEMENTS					
Actual	No Data	No Data	No Data	126.50%	122.40%
Target	TBD	TBD	TBD	100%	100%

How Are We Doing

Our objective is to increase the percent of TANF participants successfully obtaining employment. Oregon's economy has been recovering, however the recovery has been inconsistent across the state. The results for State Fiscal Year (SFY 2016) show that the agency has surpassed its goal by 22.4 percent.

Factors Affecting Results

This measure may be affected by several things, including the status of the economy, the availability of jobs and other industry factors. It may also be affected by the structure of the Job Opportunity and Basic Skills (JOBS) program and the effectiveness of community and agency partnerships to help TANF participants obtain employment. The effects of the TANF program reinvestment in 2015 likely also impact this measure's goals.

Agency Management Report

KPMs for Reporting Year 2016

Published: 10/7/2016 9:47:02 AM

Human Services, Department of

	Green	Yellow	Red
	= Target to -5%	= Target -6% to -15%	= Target > -15%
Summary Stats:	57.89%	21.05%	21.05%

Detailed Report:

KPM	Metrics	Actual	Target	Status	Management Comments
1. OVRS CLOSED - EMPLOYED – The percentage of Office of Vocational Rehabilitation Services (OVRS) consumers with a goal of employment who are employed.		62.34%	66%	Yellow	
2. TANF FAMILY STABILITY - The percentage of children receiving TANF who entered foster care.		0.67%	0.50%	Red	The Self-Sufficiency programs are intended to provide a safety net, family stability, and a connection to careers that guide Oregonians out of poverty. Part of the TANF service array includes Family Support and Connections which provides supports to prevent children in at-risk TANF families from entering the child welfare system. Home and community based services are used to guide interventions that build on family strengths and address family functioning issues. The services are designed to strengthen and support families by increasing parental protective factors and addressing risk factors related to child abuse. Temporary Assistance for Domestic Violence Survivors (TA-DVS) provides temporary financial assistance and support services to families with children who need to flee and stay free from domestic violence.
3. TANF RE-ENTRY - The percentage of Temporary Assistance for Needy Families (TANF) cases who have not returned within 18 months after exit due to employment.		65.10%	65%	Green	The Self-Sufficiency programs are intended to provide a safety net, family stability, and a connection to careers that guide Oregonians out of poverty. With respect to this KPM measure, the programs will work in partnership with other workforce system agencies and community partners to help Oregonians connected to our programs exit poverty along a career path.
4. SNAP (Supplemental Nutrition Assistance Program) UTILIZATION - The ratio of Oregonians served by SNAP to the number of low-income Oregonians.		94.20%	85%	Green	
5. SNAP (Supplemental Nutrition Assistance Program) ACCURACY - The percentage of accurate SNAP payments		0%	98%	Red	

KPM	Metrics	Actual	Target	Status	Management Comments
6. ENHANCED CHILD CARE - The percentage of children receiving care from providers who are receiving the enhanced or licensed rate for child care subsidized by DHS		63.70%	65%	Green	There has been a steady increase in the percentage of children receiving care from providers who are receiving the enhanced or licensed rate for child care subsidized by DHS. Though we did not quite achieve our targets for past years our numbers continue to increase. Rate increases for all subsidy providers were implemented in the fall of 2013. As a result of HB 2015, provider rates were increased again to the 75th percentile or higher of the 2014 Child Care Market Price Study on January 1, 2016. This brings provider rates more in line with current market rate studies and the continuing goal toward a child care subsidy system that is child-focused, family friendly and fair to providers. The 2016 Oregon Child Care Market Price Study analysis showed rates at the 76th percentile. The Administration for Children and Families, Office of Child Care and HB2015 recommended rates be set at the 75th percentile in order to allow subsidy families sufficient access to care. QRIS provider incentives and reduced copays for families using QRIS providers were implemented in 2016 to help promote subsidy access to high quality care. Other ERDC program enhancements from HB2014 and CCDF Reauthorization will improve access and duration of child care situations. DHS and the Office of Child Care currently track the number of subsidy children being cared for by providers on the QRIS. In the future this KPM may be changed to provide the same measure. This will align with the four priority areas of the Child Care Development Block Grant (CCDBG) Act of 2014: Improving health and safety in child care Improving quality of child care Establishing family-friendly policies Strengthening program integrity
7. ABSENCE OF REPEAT MALTREATMENT - The percentage of abused/neglected children who were not subsequently victimized within 6 months of prior victimization.		94.60%	96%	Green	Oregon continues to train staff in the Oregon Safety Model and has even taken steps to halt other initiatives to ensure succesful understanding and implementation of the safety model. When practice is consistent with the model, the information gathering, decision making and planning requires focus not only on the immediate safety needs of the child, but on the underlying factors that contributed to the abuse or neglect and could continue to result in abuse or neglect in the near future.

KPM	Metrics	Actual	Target	Status	Management Comments
8. TIMELY REUNIFICATION - The percentage of foster children exiting to reunification within 12 months of foster care entry.		66.10%	70.60%	Yellow	The continued and consistent use of the practice of the Oregon Safety Model, embedded in administrative rules, procedure, and reinforced by the permanency consultant staff should result in continued progress in this measure. Oregon has just completed updated curriculum on the Oregon Safety Model post assessment, referring to the Safety Model throughout the life of an open case once it is determined that safety threats exist in the family. This training, which is expected to be completed by the end of this calendar year and is mandatory for permanency workers and their supervisors, solidifies practice in several areas including protective capacity assessments and identifying conditions for return. These two elements of the Safety Model are key in identifying the increased and diminished protective capacities of the parents, delivering the appropriate services that impact these capacities, and being able to know when a family might be reunited on an in-home safety plan. Along with classroom training, workers are receiving group supervision on real cases in order to see the model in practice. Although Oregon's Safety Model can no longer be considered new, working the model throughout the life of an open case can be an ongoing struggle when workloads are high and case management becomes crisis oriented. Keeping the work systematic is a key to knowing when a child or children can be safely returned home. In addition to training, a quality assurance tool that focuses on the practice elements of the Safety Model in ongoing casework has been developed and will be used to assess branch practice and guide consultants in where their technical assistance and training should be focused in each individual branch. In addition to the continued focus on the Oregon Safety Model, Oregon is also using DHS and Juvenile Court data to develop branch improvement plans in the area of timely reunification when a branch is performing below the state average. These written plans summarize the branch's analyzed data, sets goals, specific strategies, measurements for the strategies, accountability to the plan, and what supports are needed to affect the plan. Assigned consultants work with branch leadership in both developing the strategic plans and monitoring their follow through and results. This effort and the continued fidelity to the Oregon Safety Model should continue to impact this key performance measure in a positive direction.
9. TIMELINESS OF ADOPTION ONCE LEGALLY FREE - Percent of Legally free children adopted in less than 12 months		46.10%	48.20%	Green	The child permanency program continues its efforts to use individual branch plans to pinpoint and address insufficiencies in the adoption finalization process. Permanency consultants are in branch offices lending their technical assistance and training and helping with branch processes to keep the cases moving.
10. LTC NEED PREVENTION - Percentage of seniors (65+) needing publicly-funded long term care services.		3.09%	5%	Green	
11. LTC RECIPIENTS LIVING OUTSIDE OF NURSING FACILITIES - The percentage of Oregonians accessing publicly-funded long-term care services who are living outside of nursing facilities.		86.90%	85.96%	Green	
12. DEVELOPMENTAL DISABILITY SUPPORT SERVICES - The percentage of eligible adults who are receiving adult support services within 90 days of request.		61.84%	98%	Red	
13. PEOPLE WITH DISABILITIES LIVING AT HOME - The percentage of individuals enrolled in the Intellectual/Developmental disabilities program who are receiving services in their own home.		73.52%	80%	Yellow	
14. SUPPORTED EMPLOYMENT - Increase the number of individuals who receive developmental disability services in supported employment.		2,971	0	Green	
15. ABUSE OF PEOPLE WITH DEVELOPMENTAL DISABILITIES - The percentage of people with developmental disabilities experiencing abuse.		1.83%	2.20%	Green	The abuse rate of adults with intellectual/developmental disabilities enrolled in services has declined slowly over the last four years. In 2015 it was below 2% for the first time, indicating that the current target (2.2%) may be able to be lowered in the future.
16. ABUSE OF SENIORS AND PEOPLE WITH DISABILITIES - The percentage of seniors and adults with physical disabilities experiencing abuse.		0.73%	2.20%	Green	

KPM	Metrics	Actual	Target	Status	Management Comments
17. CUSTOMER SERVICE - Percentage of customers rating their satisfaction with DHS above average or excellent: overall, timeliness, accuracy, helpfulness, expertise, availability of information.	Timeliness	74%	75%	Green	
	Accuracy	84%	75%	Green	
	Overall	82%	75%	Green	
	Helpfulness	83%	75%	Green	
	Expertise	84%	75%	Green	
	Availability of Information	No Data	75%	Red	
18. PLACEHOLDER SERVICE EQUITY -		No Data	TBD	N/A	
19. CHILDREN SERVED BY CHILD WELFARE RESIDING IN PARENTAL HOME - The percent of children served in Child Welfare on an average daily basis (In Home and Foster Care) who were served while residing in their parent's home.		23.90%	30%	Red	
20. TANF JOBS PLACEMENTS - The percentage of clients who achieve job placement each month compared to those anticipated to achieve placement.		122.40%	100%	Green	The Self-Sufficiency programs are intended to provide a safety net, family stability, and a connection to careers that guide Oregonians out of poverty. With respect to this KPM measure, the programs will work in partnership with other workforce system agencies and community partners to help Oregonians connected to our programs exit poverty along a career path. The program will continue to monitor the measure and targets. The targets this measure compares to are updated as needed during program planning processes.

This report provides high-level performance information which may not be sufficient to fully explain the complexities associated with some of the reported measurement results. Please reference the agency's most recent Annual Performance Progress Report to better understand a measure's intent, performance history, factors impacting performance and data gather and calculation methodology.

IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 17-19 Costs	All biennia total project cost	Base or POP	Project Phase: I=Initiation P=Planning E=Execution C=Close-out	If Continuing project - has it been rebaselined for either cost, scope or schedule? Y/N - If Y, how many times	Purpose L=Lifecycle Replacement; U=Upgrade existing system; N=New System	What Program or line of business does the project support	Comments
Health Systems Division	OHA	MMIS Modularization	This POP requests state funds to secure 90% federal financial participation funds to: align to CMS mandates for states to modularize their medicaid portfolio. These funds will be used to define Oregon's Medicaid Service Delivery strategic plan, assess other states modularization approaches, identify options for modular solutions, define certification requirements as required by CMS, and begin procurement activities to secure modular solution components.	Jan-17	Jun-19	$ -	$ 3,854,917	TBD	POP	P	N	L	HSD	This is a planning POP with an expectation of a follow up for additional funding that will come forward for implementation in AY19-21 or AY21-23
Health Systems Division	OHA	ONE Enhancement and Support Services (ESS) - (MAGI Medicaid Systems Transfer Project Phase II -)	The Centers for Medicare and Medicaid Services (CMS) offers additional enhanced funding for system work for eligibility systems. This policy option package is to request the authority for to fund enhancements to the Modified Adjusted Gross Income (MAGI) Medicaid eligibility determination system (called ONE) that have been identified as necessary to better serve Oregonians. Currently, OHA has a contract with the Systems Integrator that built the ONE system, Deloitte Consulting, to continue to enhance it while maintaining & operating it. The plan is for several builds a year of new functionality, prioritized by Member Services Staff as well as Medicaid policy staff, to be made available inside of ONE. Additionally, this POP will support necessary changes when CMS issues new requirements for MAGI Medicaid eligibility systems such as MARS-E 2.0 Security Compliance.	Apr-16	Jun-18	$ 1,596,629	$ 12,800,000	$ 18,345,775	POP	E	Y,1	U	HSD	IRR
Public Health	OHA	Public Health Modernization	The goal is to ensure basic public health protections for everyone in Oregon. This POP will: • Equip the workforce to respond to emerging health needs: develop an effective and efficient state and local public health workforce; • Fill the 55% health equity service gap: improve health equity by engaging with communities in public health planning; • Provide data needed to monitor public health problems: upgrade outdated information systems needed to collect data on population health and inform decision-making; • Fill the 55% service gap in preventing environmental health hazards, the 37% service gap in communicable disease investigation and the 38% service gap in responding to emergencies: mount timely responses to emerging public health issues.	TBD	TBD	$ -	$ 3,000,000	TBD	POP	I	N	U	Public Health	The project has an IT component, the POP is for the overall project including the IT component.
Aging and People with Disabilities - Oregon Adult Abuse Prevention and Investigations	DHS	Implementing Centralized Abuse Management (CAM) System	The purpose of this project is to develop and implement a comprehensive multi-program centralized abuse management system to capture abuse allegations and investigations from intake and screening through investigation, case closure and referrals, documentation, and to support abuse management oversight and inquiries. House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from nine (9) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations.	Jul-15	Dec-17	$ 550,142	$ 4,010,290	$ 5,237,494	POP	P	Y, 2	U	APD/OAAPI	
Aging and People with Disabilities/ Self Sufficiency	DHS	Integrated Eligibility Determination Project (IE)	Quick, correct and efficient eligibility determinations for Non-MAGI Medicaid, SNAP, TANF, and Child Care	1-Jul-15	30-Jun-19	$ 10,203,716	$ 113,630,759	$ 163,704,603	POP	E	N	N	APD	

IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 17-19 Costs	All biennia total project cost	Base or POP	Project Phase: I=Initiation P=Planning E=Execution C=Close-out	If Continuing project - has it been rebaselined for either cost, scope or schedule? Y/N - If Y, how many times	Purpose L=Lifecycle Replacement; U=Upgrade existing system; N=New System	What Program or line of business does the project support	Comments
Aging and People with Disabilities/ Developmental Disabilities	DHS	Provider Time Capture (PTC)	Implement a shared time capture solution for the APD, ODDS and AMH programs for their Home Care Workers (HCW) and Personal Support Workers (PSW) to include time, attendance and travel. Bring DHS/OHA in compliance with the Department of Labor's FSLA regarding employee record keeping and overtime.	1-Sep-14	31-Mar-18	$ 1,655,792	$ 4,273,077	$ 9,691,664	Base	E	Y, 1	N	APD/DD	New Estimated End Date is tentative, and has not been approved at ESC.
PHD	OHA	HIV-Electronic (HIV-E)	Replace the current CAREAssist and HIVCAT application with the best fit commercial off the shelf solution.	4-Feb-16	1-Dec-18	$ 27,351	3.2 million	TBD	Base	I	N	L	PHD - HIV	
WIC	OHA	TWIST to Web	The purpose of this project is to upgrade from a client server based system to a FNS web based WIC management information system.	3-Jan-17	1-Jul-20	TBD	TBD	TBD	Base	I	N	L	WIC	Prioritized by PH ISMC to move forward
Immunization	OHA	SMILER (School Module Integrating Law and Electronic Reporting)	Oregon Immunization Program (OIP) seeks a technology that will standardize collection and assessment of student immunization records, produce appropriate exclusion orders, and generate timely reports. The solution will also interface with internal and external stakeholder systems, eliminating the need for repeated, manual data entry across the various systems.	1-Jul-17	1-Jun-19	TBD	$ 500,000	$ 950,000	Base	I	N	N	Immunization	Prioritized by PH ISMC to move forward
Maternal and Child Health	OHA	Tracking Home visiting Effectiveness in Oregon (THEO)	Deliver a maternal and child health home visiting data collection, case management and reporting system.	1-Jun-16	31-Dec-17	$ 284,000	$ 1,516,000	$ 1,800,000	Base	I	N	N	MCH	Estimates are high level at this point until solution vendor contract finalized.
Health Systems Division	OHA	MMIS - Social Security Number Removal Initiative	The Medicare Access and CHIP Reauthorization Act (MACRA) went into law April 16, 2015. This legislation requires CMS to remove Social Security Numbers (SSNs) from Medicare cards and replace with a Medicare Beneficiary Identifier (MBI). MACRA's primary goal is to decrease Medicare beneficiaries' identity theft vulnerability by removing SSNs from Medicare cards. Compliance must occur by April 16, 2019 - within four years from enactment of the MACRA legislation.	1-Jul-17	31-Mar-20	$ -	$ 1,500,000	$ 1,500,000	Base	E	N	N	HSD	This effort is eligible for 90% CMS enhanced funds upon approval of an Advanced Planning Document (APD). The level of effort for this initiative is estimated to be significant as impacted systems require remediation to accept and use the MIB number to support business operations. Comparable recent projects include MMIS ICD-10 and Real+D. Business processes will require modifications to support use of the MIB. Business functional changes include those associated with Medicare Buy-in and Medicaid and Medicare Dual Eligible's. Proposed 15-17 Budget 97,102 - having meetings now to figure out the budget for 17-19

IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 17-19 Costs	All biennia total project cost	Base or POP	Project Phase: I=Initiation P=Planning E=Execution C=Close-out	If Continuing project - has it been rebaselined for either cost, scope or schedule? Y/N - If Y, how many times	Purpose L=Lifecycle Replacement; U=Upgrade existing system; N=New System	What Program or line of business does the project support	Comments
The Office of Health Information Technology	OHA	HIT Portfolio	The Office of Health Information Technology (OHIT) Phase 2.0 includes 3 projects with technology components. The name and description of each are: Oregon Common Credentialing Program (OCCP): SB604 requires OHA to implement a credentialing solution mandated for use by practitioners and credentialing organizations. Credentialing organizations currently credential health care practitioners independently, resulting in a duplication of efforts. This comprehensive solution will significantly reduce redundancy, supporting OHA's goal to reduce waste in our health care system. Provider Directory (PD): This will allow healthcare entities access to a state-level directory of healthcare practitioner and practice setting information. It will leverage authoritative data existing in current provider databases and add critical new information and functions. The provider directory can be used across the healthcare continuum to support operations, analytics, and the exchange of health information to deliver key benefits. Clinical Quality Metrics Registry (CQMR): this will enable Coordinated Care Organization (CCO) and Meaningful Use clinical quality metrics to be gathered for quality measurement and incentive payment. It will support the Medicaid Electronic Health Record (EHR) incentive program, which provides federal dollars to Oregon Medicaid providers who achieve meaningful use of EHRs. The CQMR assists OHA meeting its obligations under the Medicaid waiver to lower growth in cost.	TBD	TBD	TBD	TBD	TBD	Base	P	N	N	OHIT	
Health Systems Division	OHA	MMIS Transformed Medicaid Statistical Information System (T-MSIS) Phase 2	CMS recently identified additional Data Elements (DEs) that will be needed for states' files to comply with T-MSIS Phase 2 requirements, as well as deadlines for their inclusion. These DEs cover data fixes, MMIS systems changes, or data fields not currently captured, and may require policy and/or business process changes. Following submission of all previously held files to CMS, OHA will need to initiate T-MSIS Phase 2 efforts, and begin planning for inclusion of the three new DE types. Deadlines for these data are based on DE type (Type 1 – 6 months, Type 2 – 12 months, Type 3 – 18 months).	1-Feb-17	TBD	$ -	TBD	TBD	BAS	P	N	U	HSD	Proposed 15-17 Budget 155,992 - having meetings now to figure out the budget for 17-19

DHS Oregon Department of Human Services

Oregon Health Authority

DHS|OHA

Business Case

Centralized Abuse Management (CAM)

(Formerly Statewide Adult Abuse Data and Report Writing System – SAADRWS)

VERSION LOG

Version	Description	Author	Date
0.1	Initial Draft	N Grengs	3/15/2016
0.2	Initial Draft with Core team feedback from J Thompson, K Wymore, L Stutheit, F King, J Ammon, T Holland and J Telagarapu	N Grengs	3/24/2016
0.3	Executive summary, alternatives and conclusions drafted and questions identified	N Grengs	5/5/2016
0.4	Update to reflect Salesforce as the primary alternative, updated costing models, benefits and risks	N Grengs	5/26/2016
0.5	Reviewed by Executive Steering Committee. Incorporated comments from K Naugle-Wilk, Lea Ann Stutheit, Ian Wilson and John Thompson. Funding still needs alignment.	N Grengs	06/13/2016
0.6	Updated costs for SF licenses, removed indirect costs.	N Grengs	06/15/2016
1.0	Final Draft updates per Business Case Review Team meeting: Lillia Teninty, Lea Ann Stutheit, Don Erickson, Ian Wilson (for Ashley Carson-Cottingham), Marie Cervantes, Paul Ettinger, Kathryn Naugle Wilk, John Thompson	C. Hawkins-Weltz / K. Wymore	06/23/2016
1.1	Updates to Final Draft based on stakeholder review	C. Hawkins-Weltz	6/27/2016
1.2	Continued updates to FD based on stakeholder comments	K Naugle Wilks	6/28/2016
1.3	Minor edits to spelling, grammar and typing corrections: feedback from Gary Brower and Kristi Ivers	C Hawkins-Weltz	7/15/2016
1.4	Edits from QA feedback	K. Wymore	8/25/2016
1.5	Edits from OSCIO feedback	K Wymore	12/1/2016

SIGN-OFF

Name	Role	Approval Signature	Date
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1. Executive Summary

Oregon's Department of Human Services (DHS) and Oregon Health Authority (OHA) are committed to ensuring the safety of vulnerable Oregonians. This business case outlines the purpose and proposed approach to better serve this population, by implementing an integrated solution to investigate, track, and report on incidents of adult abuse

The Office of Adult Abuse Prevention & Investigations (OAAPI) is a DHS/OHA Shared Service that provides abuse-related services to the Aging & People with Physical Disabilities (APD), Intellectual/Developmental Disabilities Services (I/DD) and Child Welfare (CW) programs at DHS, and the Addictions & Mental Health (AMH) program at OHA.

Together with its program partners, OAAPI serves some of Oregon's most vulnerable residents, in their own homes or in licensed care facilities. The approximate numbers served include:

- 500,000 older adults and people with physical disabilities;
- 16,000 adults enrolled in Intellectual and Developmental Disabilities (I/DD) programs;
- 55,000 adults receiving Community Mental Health Services or residing in the Oregon State Hospital (OSH); and
- 3,600 children residing in licensed facilities that provide therapeutic treatment, or children enrolled in I/DD services.

Establishing a centralized abuse management system is of paramount importance to DHS and OHA (herein referred to as "The Agencies".) The Agencies seek to eliminate manual processes as well as the need to utilize legacy systems in order to standardize and centralize adult abuse data collection for The Agencies.

The objective of this effort is to develop and implement a comprehensive web-based multi-program abuse management system. This system will reduce or eliminate manual input/processes, replace legacy systems, standardize and centralize adult abuse data collection across Oregon, and provide a web-based tool for reporting and analyzing adult abuse. This system will capture abuse allegations and investigations from intake and screening through investigation, case closure and referrals, documentation, and will support abuse management oversight and inquiries. A centralized system will enhance DHS and OHA's ability to protect vulnerable Oregonians, by replacing existing manual and disparate processes and systems across the state with a fully integrated system that improves visibility.

1.1 Background

Oregonians will be better served with a centralized adult abuse management system replacing the existing collection of manual process and disparate systems currently used across the state. Currently, State Agencies, partner organizations and local office workers[1], interpret Oregon Administrative rules differently regarding which allegations of abuse to screen in. Most offices lack a consistent, automated mechanism to screen in, investigate, document and report or track the full life cycle of an abuse incident and the parties involved. Implementing a single stable, rules based solution will improve consistency, streamline workflow, increase efficiencies at local offices and reduce gaps in the availability of timely, pertinent information to support abuse investigations

[1] Local office workers include screeners, investigators and supervisors in the offices across the state that are performing the work for any of the programs included in the scope of this project.

throughout the state. The Agencies' goal is to increase awareness of patterns of abuse in licensed settings and in the community.

1.2 Opportunity Definition

The Agencies' are championing this initiative to improve services and support for vulnerable Oregonians through implementation of consistent processes and robust systems.

The outcomes this project will achieve are responsive to challenges identified by multiple studies and legislation including House Bill 4151 (HB4151) and Senate Bill 1515 (SB1515). HB4151 requires DHS to standardize resources and technologies related to abuse investigations. SB1515 requires DHS and OHA to improve communications about abuse investigations with certifying, licensing and authorizing organizations. A centralized abuse management system will also address DHS Elder Abuse Prevention Audit findings, Adult Safety and Protection Team Report recommendations and the Resident Safety Review Council Report from February 2013.

The high-level business objectives driving this effort are to:

- Better protect the individuals we serve.
- Increase productivity and efficiency through automation.
    - Document reports of abuse, screening decisions and investigations centrally and in real-time so local staff, local management, Central Office, OAAPI and others with a need to know have immediate access to information.
    - Reduce duplicate data entry and manual work.
    - Allow mandatory reporters and other reporters of abuse to submit their reports online via the Internet.
- Support program variation and frequent changes.
- Support the growing abuse management workload.
- Identify and track abuse across the lifespan of a person (victim and/or perpetrator).
- Identify and track abuse and abuse history at DHS-licensed facilities across programs.
- Produce standardized information for auditing and analysis.
- Implement an easy-to-use, web-based, system.

The Agencies' vision is to have at least a minimally viable solution of core functionality across all programs in scope implemented in a first release with a second release to follow with the remaining requirements and enhancements. Core functionality is currently defined as the functionality to support intake and screening through investigation, case closure and referrals, documentation and reporting processes. However, the Agencies intend to enlist the assistance of a System Integrator (SI), to propose implementation options for the Agencies' consideration that will include the suggested scope, functionality, programs included and release dates for the implementation of the CAM system. Therefore, success criteria for the project's planned releases will be determined in the execution phase in collaboration with the System Integrator.

1.3 Alternatives Analysis

After a preliminary business case proposed the development of a custom solution, the Agencies

Department invested significant efforts to assess other alternatives. A team comprised of program and technology members conducted in-depth market research. The market research included in-depth interviews with 18 states to discover their abuse management solutions. This market research yielded two viable solutions utilized by other states and two used in Oregon. The team did further in-depth analysis of capabilities of these four options against functional and technical requirements, and conducted customer demos and on-site visits. The Agencies concluded that building a custom Centralized Abuse Management System introduced much higher risk and cost compared to pursing a different alternative.. Detailed information from the in-depth analysis and site visits are in the Alternatives Analysis, Section 5.0, of this document and in the supplemental documents. Information gained during customer demos and site visits eliminated some alternatives under consideration identified from the project's initial market research. These eliminated options include Commercial off the Shelf (COTS) solutions and transfer solutions used by other entities resulting in the following remaining alternatives.

Alternative 1: Purchase Software as a Service Solution; leverage another state's use of that SaaS

Under this alternative, a Software as a Solution (SaaS) CRM solution would be purchased, configured and customized to meet the CAM Project's detailed requirements. This approach allows relatively quick design, build and implementation plus ongoing flexibility to meet the continuously changing business/regulatory environment at a reasonable cost.

Oregon has the opportunity to leverage requirements for Colorado's Adult Protective Services (CAPS) solution implemented in June 2015 as a starting point for a SaaS solution. Colorado implemented CAPS in June 2015 using Salesforce, a Customer Relationship Management (CRM) SaaS solution. Oregon can leverage CAPS' foundational capabilities, substantially reducing the time to deliver, the cost of implementation, and the exposure to risk for Oregon. DHS and OHA Executive Leadership believe this synthesized approach represents the best fit for Oregon's needs. More details regarding Colorado's solution and the proposed implementation approach are outlined later in sections 5.1.1 and 6.2 of this document.

Under this alternative, Oregon will leverage Colorado's solution as foundational requirements for Oregon's abuse management toolset, using the services of a Systems Integrator to configure and/or customize the software to meet Oregon's needs. The estimated cost of this alternative through implementation is ~4.7 million dollars with at total estimated cost through 2023 of approximately ~8.4 million dollars.

Alternative 2: Implement a Custom Build System

Under this alternative, the Agencies would design, develop, test and deploy a custom solution for The Agencies' Centralized Abuse Management needs. This alternative would allow a tailor-made solution that would meet all of the functional, technical, and organization requirements. The cost, risks, and timeline to implement are substantially higher than implementing a SaaS solution leveraging Colorado's foundational requirements. The total estimated cost for this alternative through implementation is ~11.9 million dollars with a total estimated cost through 2023 of approximately ~$17.0 million dollars.

Alternative 3: Maintain the Status Quo

Under this alternative Oregon would maintain the current status quo with disparate, disconnected systems and highly manual processes and there would be no additional investment in abuse tracking system automation. The requirements and recommendations made by HB4151, SB1515, and various reports and audits would not be met in the foreseeable future. The Agencies' fragmented approach would continue and improvements to current processes would be limited to

those that arise naturally through the Agencies' continuous improvement program. The Agencies would continue with ineffective, disconnected, automated and manual systems, which are increasingly difficult to oversee and analyze. The total estimated cost of this alternative through 2023 of approximately ~$5.2 million dollars.

In light of the settlement that was reached with Oracle in September of 2016, the Agencies were asked to evaluate the appropriateness and feasibility of implementing the CAM solution using Oracle products contained in the negotiated User License Agreement (ULA). The settlement offers Oracle's catalog of products free of charge for the next 5 years and 10 months. However, use of Oracle products would not allow the Agencies to leverage the foundational capabilities of the Colorado CAPS solution due to the fact that Colorado's code is specific to the Salesforce platform. The Colorado solution is the only proven implementation of an Abuse Management System on a CRM platform. An approach using Oracle products would substantially increase the time to deliver a solution, and expose Oregon to additional risk as the Agencies would be unable to leverage the work done in Colorado and would be required to develop a solution on an unproven platform from the ground up. Implementation costs would increase to support additional requirements, design and development efforts. A transfer approach of Colorado's solution will establish a collaborative relationship with Colorado and enable Oregon to continue to benefit from any new developments that Colorado makes to their solution. This continuous collaboration, allowing Oregon the option to use those enhancements free of charge, is dependent on the transfer and use of the CAPS code on the Salesforce platform and could not be utilized with an approach including Oracle products.

1.4 Conclusions and Recommendations

Based on the analysis of the alternatives, DHS and OHA intend to pursue Alternative 1: Implement a SaaS Solution and leverage another state's capabilities with that SaaS. This strategy will help accelerate Oregon's implementation efforts, while reducing risk and shortening the implementation timeline.

Section 6.2, Table 5 (5) of this document sets out a preliminary schedule to implement the Centralized Abuse Management system in two releases. To support the commitments made to the Legislature of an implemented solution within the 2015-2017 biennia and in response to HB4151 and SB1515, the project's scope will be implemented in two releases. Afirst release is projected to complete by June 2017 and the second release by December 2017. The high-level estimated cost of implementing the system and operating it through December 2017 for both releases is approximately $4.7 million. The project has been funded for a total of $5,632,037 which includes $1,437,494 of general funds, $3,300,000 of Q bonds and $894,543 for Qbond issue and debt service for a total of usable project funds of $4,737,494. Funds for issue and debt service will not be reported in the funding. Ongoing operating costs post-implementation through June 2023 are estimated at another $3.0 million, for a total 7-year investment of approximately $8.4 million. Actual costs may differ depending on per user licensing costs and vendor responses to the planned Request for Proposal (RFP) for System Integrator (SI) services.

2. Background & Purpose

2.1 Current State of Abuse Management Operations

The Office of Adult Abuse Prevention & Investigations (OAAPI) is a DHS/OHA Shared Service that provides abuse-related services to the populations served by The Agencies and provides services for some of Oregon's most vulnerable residents, in their own homes or in licensed care facilities.

Many different methods are used by The Agencies to support screening, investigations, referrals, and other abuse management processes. At their core, these processes have very similar steps. They vary depending on: 1) The population served; 2) If the intake/screening/investigating organization is a state organization or contracted party and; 3) Which computer applications and end user tools they have available for their use. There are seven (7) key systems, six (6) of which are state owned and one (1) owned by a local county, and more than 120 local databases and Microsoft (MS) Excel spreadsheets in use at this time. These systems are not integrated nor do they provide all the essential information required for local workers, local managers, and Central Office oversight.

In 2014, almost 750,000 Oregonians were in one of the nine populations supported by the Agencies. During that same year, the Agencies received over 38,000[2] allegations of abuse of these individuals, resulting in 18,185[1] investigations of which 4,544 were substantiated. This number does not account for an unknown number of allegations screened out at the local office level due to the lack of visibility caused by disconnected processes and systems.

According to the 2014 OAAPI Annual Report dated July 2015, "In 2014, there was a 10% overall increase in the number of investigations conducted (compared to 2013)." Over the next ten years, the number of allegations received and screened by The Agencies is expected to increase nearly 60%. This assessment increases the projected 50,414 allegations in 2015 to over 78,500 allegations in 2024, due to predicted growth of vulnerable populations. OAAPI is projecting 30,800 investigations by 2024, a nearly 63% increase from the 2015 level of 19,000 investigations.

In 2014, the Oregon State Legislature passed House Bill 4151 (HB4151). Section 4 of HB4151 mandates that for adults 65 and older and for residents of Office of Licensing and Regulatory Oversight (OLRO) licensed facilities, DHS "shall adopt policies and guidelines to plan for the development and standardization of resources and technologies" related to abuse. In summary it mandates the following: 1) Capture of key adult abuse incident and management data; 2) Standardization of procedures and protocols for making and responding to reports of abuse; 3) Standardization of procedures and protocols for investigations of reports of abuse and; 4) Promoting and coordinating communication and information sharing with law enforcement agencies regarding reports and investigations of abuse.

There are five main program areas involved in this project: 1) DHS' Aging & People with Disabilities (APD) Adult Protective Services (APS); 2) OHA's Health Systems (HS) Division; 3) DHS' Developmental Disabilities (DD); 4) DHS' Child Welfare (CW) and; 5) OHA's Oregon State Hospital (OSH) Division. For a comprehensive list of stakeholders, see the Business Case Supplemental Documents Package.

There is a long list of Oregon Revised Statutes (ORSs) and Oregon Administrative Rules (OARs)

[2] OAAPI Annual Report 2014 – Published July 2015.

for the program areas and populations served by this project.[3] Some overarching statutes drive consistent rules for multiple populations and program partners. However, there are also specialized rules depending on the population served. A full analysis of the similarities and differences in these rules has not been performed. It is important to note that many factors impact these ORSs/OARs resulting in frequent changes. In the future, there will be one standard process for all populations served. This standard process will allow for the nuances between the ORSs/OARs in place today.

Federal and State legislation, program rules, processes, terminology, reporting and coding requirements are evolving at a quick pace. The different agencies within the US Department of Health and Human Services (HHS) are working toward more standardization in the adult abuse discipline.[4,5] The disconnected tools in use by DHS and OHA are not modern, sophisticated, or flexible enough to evolve with the changing regulatory environment within the state or across the nation.

2.2 Current State of DHS Aging and People with Disabilities Abuse Management Operations

The DHS Aging & People with Disabilities APS program serves two Oregon population groups: APS Community and APS Facility.

- APS Community consists of approximately 620,000 adults age 65 and older and adults 18-24 with a physical disability who live in their own homes in the community.
- APS Facility consists of approximately 46,000 individuals living in DHS-licensed facilities.

Screening and investigation of these reports of abuse are performed by Aging and People with Disabilities (APD) Field Offices and certain Area Agencies on Aging (AAAs).

In 2014, there were approximately:

- 12,100 allegations of APS Community abuse resulting in approximately 3,300 substantiated abuse cases.
- 4,400 allegations of APS Facility abuse resulting in approximately 950 substantiated abuse cases.

[3] A complete list of ORSs and OARs by population served can be found in Business Case Supplemental Documents Package.

[4] In September 2013, recognizing the lack of consistent national data on adult maltreatment, HHS, the Administration for Community Living (ACL), in partnership with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), began a 2-year effort to design and pilot test a national reporting system based on data from state adult protective services (APS) agency information systems. The project is currently designated as the National Adult Maltreatment Reporting System (NAMRS).

[5] The CDC's National Center for Injury Prevention and Control, Division of Violence Prevention has published "Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements" in January 2016. They indicate in their paper "Longstanding divergences in the definitions and data elements used to collect information on Elder Abuse (EA) make it difficult to measure EA nationally, compare the problem across states, counties, and cities, and establish trends and patterns in the occurrence and experience of EA."

The number of allegations supported is difficult to ascertain because the two APS systems in use lack screening capabilities.

The major computer systems used by APS are: 1) Oregon ACCESS, which is a case management system for APS Community Clients, and; 2) Web723, which is a tool for documenting an APS Facility abuse investigation report. These two systems have poor search capabilities making it difficult for workers to find historical abuse information. As a result, offices must resort to tracking key information on spreadsheets and in Microsoft (MS) Access databases.

Other than Oregon Access and Web 723 for Lane Council of Governments (LCOG), there is no key system screening functionality. This means local screeners and investigators are not able to see statewide abuse screening information, and central program management is unable to monitor local screening activity or track historical screening trends. Additionally, the search capability in these systems does not support the sophisticated and time-sensitive needs of the program to respond to queries about specific allegations or overall trends. All notices are manually created in MS Word resulting in considerable duplicate data entry and the potential for human error. LCOG has their own MS Access computer system, which allows for LCOG-wide documentation of intake, screening decisions, investigations and the generation of notices.

2.3 Current State of OHA Health Systems Abuse Management Operations

The OHA Health Systems Division serves two abuse population groups (within the scope of this project). They are: 1) Individuals in State Operated Secure Residential Treatment Facilities and; 2) Individuals receiving Community Mental Health services.

- State Operated Secure Residential Treatment Facilities serve approximately 120 people.
- Community Mental Health Programs (CMHP) are County based and serve approximately 57,200 people.

Screening and investigations involving adults receiving CMHP services are performed by County CMHP staff, with technical assistance and consultation provided by OAAPI. Exceptions include when the alleged abuse involves CMHP staff or occurs in a state-operated Secure Residential Treatment facility; in those cases, OAAPI staff perform the screening and investigation.

In 2014, there were approximately:

- 15 allegations of abuse for individuals in State Operated Secure Residential Treatment Facilities resulting in about seven substantiated abuse cases.
- 395 allegations of abuse for individuals receiving Community Mental Health services of which approximately 134 were substantiated.

Allegations and investigations for State Operated Secure Residential Treatment Facilities and Community Mental Health that are received by OAAPI, are entered into the OAAPI Abuse Database. Not all Community Mental Health allegations that are screened out (not needing investigation), are tracked as there is not a centralized database supporting these programs. Technology tools depend on what tools a particular County CMHP has in place. The key computer system used is the OAAPI Abuse Database, which is MS Access and is not accessible to the Oregon Counties. All data entered into the OAAPI Abuse Database is after the fact, duplicate data entry, and currently used to capture the investigation data electronically for future analysis.

Investigations for these populations are all performed manually and then typed into MS Word. All

notices are manually created in MS Word resulting in considerable duplicate data entry and the potential for human error.

2.4 Current State of DHS Office of Developmental Disabilities Services Abuse Management Operations

The DHS Office of Developmental Disabilities Services (DD) program serves two Oregon abuse population groups directly: Community DD Program individuals and In Home Program individuals.

- County-based Community DD Programs (CDDP) and the Stabilization and Crisis Unit (SACU) serve approximately 5,800 adults enrolled in (or previously eligible for) CDDP services. These adults live and receive services in either DHS-licensed settings such as provider group homes, state run group homes or private foster homes. CDDP (County) staff perform screenings and investigations of allegations involving CDDP clients. Screening and investigation of allegations in SACU facilities are performed by OAAPI investigators.

- The Community DD Programs (CDDP) and Brokerage Operations serve approximately 13,000 adult individuals with Intellectual/Developmental Disabilities (I/DD) living in their own homes or family homes, or DHS-licensed residential facilities. CDDP (County) staff perform screenings and investigations of allegations involving CDDP clients.

Allegations involving individuals with I/DD living in non-DD licensed facilities are screened by either DD or APS, and are generally investigated by APS as indicated above in APS Facility.

In 2014, there were approximately:

- 1,400 allegations of abuse for Community DD individuals resulting in about 675 substantiated abuse cases.

- 70 allegations of abuse for individuals in Stabilization and Crisis Unit facilities of which approximately 20 were substantiated.

Investigations for these populations are all performed manually and then typed into MS Word. Additionally, all notices are manually created in MS Word, resulting in considerable duplicate data entry. The number of reports of abuse that are reported and subsequently screened in for investigation can only be estimated as they are not all tracked in a key computer system. The key computer systems used are Serious Event Review Team (SERT), Combined On-call Intake (COIN) and the OAAPI Abuse Database. SERT is old and ineffective. COIN is used by OAAPI for tracking allegations, and the OAAPI Abuse Database is used by OAAPI for all SERT allegations referred to OAAPI for investigation. The number of reports that are screened out for further investigation are also unknown as these are tracked only at each individual CDDP.

2.5 Current State of DHS Child Welfare Abuse Management Operations with OAAPI Oversight

The Child Welfare (CW) program serves children with intellectual/developmental disabilities living in DHS-licensed 24-hour residential settings and children in DHS-licensed 24-hour residential facilities that are part of the Child Caring Agencies (CCAs). These Oregon abuse population groups are included within the scope of this project.

County Child Welfare staff at the various CW hotlines perform initial screening of all child abuse

referrals. When children identified in an allegation live in a licensed setting, the referral is sent to OAAPI (using OR-Kids) for additional screening. After screening, investigations for both of these populations are performed by OAAPI.

In 2014, there were approximately:

- 85 allegations of abuse for children with intellectual/developmental disabilities living in DHS-licensed 24-hour residential settings resulting in about 46 substantiated abuse cases.
- 131 allegations of abuse of children in DHS-licensed Children's Care Provider Programs with approximately 24 substantiated.

Investigations for these populations are all documented manually and then typed into MS Word. Key information is entered into OR-Kids when the investigation is completed. All notices are manually created in MS Word resulting in considerable duplicate data entry. The computer systems used to process these cases are OR-Kids and the OAAPI Abuse Database. All allegations for CW are initially captured in OR-Kids and then entered into the OAAPI Abuse Database after the fact. The OAAPI Abuse Database is MS Access, therefore it is not available to the County CW screeners across the state.

In 2016, the Oregon State Legislature passed Senate Bill 1515 (SB1515). SB1515 adds young adults aged 18 to 21 years old in Child-Caring Agencies (CCAs) to be included in the age definition of "child in care" and expands the definition of CCA. This additional young adult group is estimated to be less than 250 individuals at this time and are included in the CAM Project as part of the population of children in DHS-licensed Children's Care Provider Programs.

The requirements of SB1515 will also likely lead to a much higher percentage of allegations of abuse in CCAs resulting in an investigation, doubling or tripling the number of CCA-related investigations conducted and documented by OAAPI.

2.6 Current State of OHA's Oregon State Hospital Abuse Management Operations

The OHA Oregon State Hospital (OSH) serves one abuse population group (within the scope of this project). Approximately 1,220 individuals live at the Oregon State Hospital.

When alleged abuse occurs in the Oregon State Hospital, OAAPI staff perform the screening and investigation.

In 2014 there were approximately 78 allegations of abuse for individuals living at the Oregon State Hospital, of which approximately 19 were substantiated.

Allegations and investigation outcomes for the Oregon State Hospital are entered into the key computer system, OAAPI Abuse Database, which is an MS Access application. All data entered into the OAAPI Abuse Database is after the fact, duplicative data entry, used to capture the investigation data electronically for future analysis.

Investigations for this population are performed manually and then typed into MS Word. All notices are manually created in MS Word resulting in considerable duplicate data entry.

2.7 Current Business Process

In 2014, seven (7) abuse management process were documented. At a high level, all seven processes involve screening, investigating, referring, and closing allegations, with associated documentation and notifications. Each of these processes are based on a particular program or

group of programs, as well as the individual program OARs, which define and guide them. Detailed information about these current processes can be found in the Business Case Supplemental Documents Package, Document F.

Table 1 – Key Current Business Processes

Process	Process Description	Process #
OAAPI-Led Investigation	This process documents the intake, screening, investigation, report creation, report distribution, and closure of non-CCP investigations completed by OAAPI staff.	BP-100
CCA Investigation	This process documents the intake, screening, investigation, report creation, report distribution, and closure of investigations completed by OAAPI staff for the CCP Program.	BP-200
County DD Investigation	This process documents the intake, screening, investigation, report creation, report distribution, and closure of investigations completed by the county CDDP abuse investigator.	BP-300
County MH Investigation	This process documents the intake, screening, investigation, report creation, report distribution, and closure of investigations completed by the county Mental Health (MH) Program.	BP-400
APS Community Investigation	This process describes the intake, screening, investigation, report creation, report distribution, and closure by APD and AAA staff for the APS Community Program.	BP-500
APS Facility Investigation	This process describes the intake, screening, investigation, report creation, report distribution, and closure by APD and AAA staff for the APS Facility Program.	BP-600
Lane Council of Government (LCOG) APS Investigation	This process describes the intake, screening, investigation, report creation, report distribution, and closure for the Lane Council of Government Community and Facility APS investigations.	BP-700

The Agencies' have identified and drafted a standardized future state business process with the assistance of the user community across all in scope programs. This process will be used in the fit gap analysis performed by the SI during execution.

3. Problem or Opportunity Definition

3.1 The Business Problem

The lack of a centralized abuse system in place today creates obstacles and challenges for The Agencies' work efforts to support vulnerable Oregonians.

The Agencies are committed to the protection of vulnerable Oregonians and are hampered by abuse data that is often fragmented, incomplete, and/or inaccessible. Additionally staff are required

to utilize multiple disparate systems to make determinations about allegations of abuse slowing response and increasing risk of error. A centralized system that provides cross program abuse information and supports intake, screening, and investigation activities is critical to increase the efficiency and effectiveness of the staff performing those functions and to further protect Oregon citizens. The limitations of the current environment; lack of coordinated systems and data, gaps in visibility and the lack of a unified tracking and reporting process all lead to the imperative for The Agencies to address this situation by implementing a centralized abuse system to establish a clear and complete picture of abuse.

APS receives staff based on workload and the calculations to determine staff needs depend on forecasting future workload projections. The tools and information available today are challenging, requiring APS to use a workload calculation from four (4) years ago. This means the additional workload to support the increase in population over that time is not being reflected today's calculation. There was an increase in population of approximately 10% last year alone. Lack of up to date information and the inability to forecast have resulted in a lower than necessary staff count, negatively affecting the APS key performance metrics. Visibility in to the activity and movements of alleged and substantiated perpetrators across programs or counties is limited. This lack of information across the state opens the door for potential risk to persons served by the DHS and OHA.

Lack of unified processes has resulted in potential risk of clients falling "through the cracks" as local offices follow inconsistent screening practices and vary in their interpretation of Oregon rules and statues. Further complicating the challenges, for staff that are performing intake, screening, and investigations is that they lack systems to help them perform their jobs effectively and efficiently. Information such as addresses, screening and investigation data is cut and pasted into: 1) Multiple systems; 2) Multiple MS Word letters and; 3) MS Excel spreadsheets and; 4) MS Access databases.

The current intake process may be documented in one of many different systems around the state, and referrals that do not result in investigation are not always tracked with automated tools. As a result, it is difficult to review these referrals for quality control, screening related trends and workload trends. Law enforcement agencies send police reports to field offices in such a volume that staff find it hard to review and screen in/out all of the reports in a timely manner. When intakes and referrals are not all documented it's difficult to measure if there are sufficient staff to cover the workload and to measure the true quality of the work being performed including that all reports of abuse are being processed properly without falling "through the cracks".

Recent legislation has increased the number of mandatory reporters and hence the workload for intake and screening of reports of abuse. HB4151, passed in 2014, requires that DHS/OHA send a copy of its letter of determination and investigation report to the state agency responsible for certifying/licensing a substantiated perpetrator in a health occupation. The consistency with which this is done is not known since the processes and systems do not allow for tracking of this information. This increases the workload of the already overloaded investigators doing the work today.

As Oregon's population ages, DHS and OHA are seeing an increased interweaving of clients in community and facility settings. This means clients of one program are often placed in facilities licensed by other programs, or clients are transitioned from one system to another as they age and their health conditions or behavioral needs change. Establishing a centralized abuse management system enables DHS and OHA to integrate abuse data across programs, ensuring critical information in one system is retained helping keep clients safe by providing access to a client's history of abuse.

3.2 Current Technology Limitations

There are seven (7) primary data systems[6] used in Oregon today to collect reports of abuse and/or generate investigation reports. There are three (3) key data systems[7] used to analyze investigations and create data analysis reports related to protective services and abuse investigations with OAAPI oversight. These systems run on different software, collect different data points, and do not provide a comprehensive centralized data repository for abuse data. Investigation reports for seven of the nine populations are written using MS Word. In addition, more than 120 simple applications and spreadsheets are used in local offices to support abuse processes and manage workload, from receipt of an allegation through completion of an investigation.

The mix of old legacy systems and desktop software makes it difficult for employees and management to ensure all allegations are documented and processed appropriately. In most local offices, physical paper files are the only source of complete information about an investigation. This creates the potential for an allegation to go uninvestigated because there is no tool for unassigned referrals***.***

Following is a summary of the key systems used to collect, report or analyze abuse or generate investigative reports. Each system has limitations, which make them poor candidates for modifying to meet centralized abuse investigation or reporting. The limitations in many cases are due to the technology platforms lacking the robustness necessary to support large-scale use or they are an aging technology with limited ability to sustain and support. For example, MS Access lacks a robust structured query language, all information is saved into one file, which limits options, slows down reports, queries and forms and security controls are limited. As the volume of user's increases, performance degrades rapidly. Although technically, a MS Access system can support 255 concurrent users, the real world limit is 10-80 concurrent users.

The Oregon Access ***(OR Access)*** system's APS module for abuse tracking contains the largest number of investigations (~36,000) of all the systems listed above. ***It does not have intake or screening functionality and has poor search capabilities making it difficult or impossible to determine if a person has an in-progress or past investigation.*** This results in duplicate information as many allegations/investigations are entered multiple times. The system is capable of collecting information that helps support unique identification of people such as Social Security Number, birth date and client master identifier. Less than seven percent of alleged and substantiated perpetrators are uniquely identified with a Social Security Number or date of birth. None has a reference to a person or client master identifier. This makes it impossible to find repeat offenders of abuse. End-users cannot attach documents and/or evidence to the investigations in OR Access. Investigation reports cannot be sent electronically from the system and must be printed, scanned and attached to an email to send notices. The system does not provide statistics, trends, or other tracking data to local office management to help assess and manage to target quality outcomes. OR Access is not web-based, so it is not available away from the office unless it is downloaded to the investigator's computer or the investigator remotely accesses the system using emulation software (Citrix). OR Access is written in PowerBuilder and has a Sybase backend. PowerBuilder is an older development environment with a very small population of users. This makes it very difficult to find PowerBuilder developers, so supporting OR Access requires in-house training on the technology by OIS. Due to the aging nature of this

[6] Oregon Access (OR Access), Lane Council of Government (LCOG) Client Tracking System (CTS), Web723, SERT (Serious Event Response Team), COIN (Combined On Call and Intake), OR-Kids and the OAAPI Abuse Database.

[7] DHS Data Warehouse, COIN and the OAAPI Abuse Database.

technology and the current issues it carries, OR Access is not a good candidate for future central abuse management use or extensibility.

Web723 contains the next largest number of investigations (approximately 32,000). It ***does not have intake or screening functionality***. As with OR Access, DHS is not documenting all the reports of abuse in this system; only the reports of abuse assigned to investigate are entered. There is a high level of frustration by local office staff with this system as it frequently "crashes" or times out while documenting an investigation and all the data entered is lost. This system does not have the ability to locate past/historical information so all information has to be manually entered for each investigation. Many hours of re-entry of information are required due to the instability of this system. End-users cannot attach documents or evidence to the investigations. Only at the conclusion of an investigation, after a supervisor has reviewed the report and all notices have been sent out, an electronic notice is sent to the APD Central Office of Licensing and Regulatory Oversight (OLRO) in Salem confirming that the investigation is complete. Considerable time is spent manually preparing and mailing documents to all the appropriate parties. There are no statistics, trends, or other tracking data available to local office management to help ensure desired quality outcomes are achieved. This application is written in Cold Fusion, an aging technology, and has a DB2 backend. Due to Web723's instability issues, old technology and limited functionality, it is not a good candidate to extend.

Lane Council of Government's (LCOG) ***Client Tracking System (CTS)*** is used for all LCOG APS reports of abuse (~12,700) and investigations (~7,200). LCOG transfers files of information to DHS that are then loaded into the DHS Data Warehouse. Due to periodic issues with these imports, the DHS Data Warehouse does not contain a full set of LCOG data for analysis. LCOGs CTS has relatively good APS functionality but, being designed for a single AAA office, it ***does not provide for the statewide 360-degree view of a person needed by DHS and OHA***. It has an MS Access front end with a MS SQL Server backend and hence is not extensible or scalable.

Serious Event Review Team (SERT) is used by the DHS Office of Developmental Disabilities Services Community DD programs to notify OAAPI that an investigation is needed (approximately 57,000 serious events are stored in the system some of which are reports of abuse). CDDPs use this system to analyze trends such as type of abuse, providers and clients with high numbers of incidents. The County Investigator fills out the form and it is transferred to OAAPI. Data from this system is manually re-entered into the OAAPI Abuse Database. ***Known issues with this system include: It is not user friendly; not searchable or search criteria/results are inconsistent and; the database model is out of date, as it has not been updated in over three years.*** Because of the complexities of using this system, not all CDDPs are inputting data here. SERT is currently supported by the Office of Business Intelligence (OBI). It has a ColdFusion frontend and a MS SQL Server backend. It is not extensible or scalable.

OR-Kids is used by DHS Child Welfare to notify the OAAPI Investigations Unit of allegations of child abuse initially screened by Child Welfare workers that require OAAPI screening and investigation (~88 in 2014). This system has substantial functionality. It is a complex system that is not end-user friendly, partially due to the significant level of pop-ups, which frustrate the end-users. The search feature does not work well; standard searches for a person can return hundreds of names resulting in staff not finding the person they really need or want. ***The online user interface and data relationships between case, abuse report, people, assessments, allegations and associated notes are not intuitive from an abuse management perspective.*** The OAAPI investigation process for children in licensed settings is handled outside of OR-Kids and final information is posted back in OR-Kids upon completion of the investigation. The investigation itself is written independently in MS Word. The front-end application primarily uses JBoss, Java and COBOL. The backend uses MS SQL Server. This system architecture is

designed specifically to manage child protective services cases, it does an inadequate job displaying information about abuse incidents related to OAAPI investigations. This system is not a good candidate to extend for centralized abuse management. With a core focus on child protective services, modifications to accommodate the requirements of the Agencies would require significant and expensive modification and could negatively impact the core functionality and purpose of existing system.

Combined On-Call Intake (COIN) is used to track reports of abuse made directly to OAAPI (~5,000) and screening decisions for many of the populations investigated by the OAAPI Investigations Unit. It does not support the investigation process. This system was created internally with MS Access and is not extensible or scalable.

The ***OAAPI Abuse Database*** is used to track key information about investigations (~23,368) for Community DD, Community MH, and OAAPI investigators. These investigators use a separate MS Word template to write their investigation reports. Although OAAPI offers a recommended format, reports vary somewhat from county to county. CDDP and CMHP investigators send their reports to OAAPI via e-mail, where they are reviewed, approved and "data-mined" manually by OAAPI staff to populate by re-entering information into OAAPI's Abuse Database. All OAAPI-led investigations are also data-mined manually and entered into this database. ***This system is filled with duplicated data from other systems and tools (MS Word). This system does not have role-based security, allowing anyone to change any data in the system.*** The OAAPI Abuse Database is a Microsoft Access database developed internally in 2001. This system is not extensible or scalable for statewide use.

Currently, the Agencies rely on these disconnected data systems to store abuse-related data and to produce reports. Challenges and risks are pervasive because these systems are often unable to provide the critical information being asked for by internal and external partners, including: accurate metrics for Quarterly Business Reviews (QBR), requests for statewide abuse data from media, and sufficiently granulated data reports for the Legislature. The table below illustrates the distribution of the systems by the population served that are used to support abuse management by the Agencies.

Table 2 – Systems Used by Population Served[8]

		Screener / Investigator	
Nbr	**Population**	**Tools**	**OAAPI Tools**
1	I/DD Individuals Living in DHS-Licensed Stabilization & Crisis Units	SERT (notice of report), MS Word (Investigation Report)	COIN (doc screen in) OAAPI DB (doc from MS Word Report)

[8] Additional statistics by population type can be found in the Business Case Supplemental Documents Package.

Nbr	Population	Screener / Investigator Tools	OAAPI Tools
2	I/DD Children Living in in DHS-Licensed 24-Hr Residential Settings	OR-Kids (notice of report, outcomes), MS Word (Investigation Report)	OAAPI DB (doc from MS Word Report)
3	Children in DHS-Licensed Children's Care Provider Programs	OR-Kids (notice of report, outcomes), MS Word (Investigation Report)	OAAPI DB (doc from MS Word Report)
4	Adults at the Oregon State Hospital	MS Word (Investigation Report)	COIN (doc screen in), OAAPI DB (doc from MS Word Report)
5	Adults in State Operated Secure Residential Treatment Facilities	MS Word (Investigation Report)	COIN (doc screen in), OAAPI DB (doc from MS Word Report)
6	Adults Receiving Community Mental Health Services	MS Word (Investigation Report)	OAAPI DB (doc from MS Word Report)
7	Individuals Living in DHS-Licensed Facilities	Web723 (Investigation Report) or LCOG's CTS (Screen In/Out & Investigation Report)	Web723, DHS Data Warehouse
8	Adults 65+ & Adults 18-64 with a Physical Disability	OR Access (Investigation Report) or LCOG's CTS (Screen-In/Out & Investigation Report)	OR Access, DHS Data Warehouse
9	Adults Enrolled or Previously Eligible for a Community DD Program	SERT (notice of report), MS Word (Investigation Report)	COIN (doc screen in), OAAPI DB (doc from MS Word Report)

Consultants and Task Forces have looked numerous times at the abuse management technology issues for the populations served by The Agencies. The many challenges associated with the current systems are evident not only to individuals within DHS, OHA and OAAPI, but have been brought to the attention of the Agencies by external entities as well, most notably in the following instances:

- DHS Consultant Public Knowledge report dated 2005.
- McKinsey Study Recommendation dated 2008.
- Oregonian Article dated March 26, 2011.
- Adult Safety and Protection Team Report dated August 4, 2011.
- Resident Safety Review Council Report to Legislature dated February 2013.
- DHS Elder Abuse Prevention Audit (12-013).

3.3 The Opportunity

DHS and OHA share an imperative of keeping vulnerable adults safe by investigating allegations of abuse in a timely manner and remediating as needed. Implementing a centralized web-based data system to collect all reports of abuse; screen, refer and investigate those reports of abuse; and ensure all appropriate agencies/parties are notified of the investigation outcome directly supports DHS's commitment to "improve systems,

processes and culture to ensure that safety is our number one priority."[9] This will significantly improve DHS' ability to achieve its mission to assist Oregonians in achieving safety, health and independence.

3.3.1 Alignment with 2014's Oregon House Bill 4151 (HB4151)

Development of this system is in direct alignment with HB4151 which states "The Department of Human Services shall adopt policies and guidelines to plan for the development and standardization of resources and technologies" related to abuse of vulnerable adults age 65 and above or living in an DHS-licensed facility. The CAM Project will address HB4151 through the following capabilities:

1) Create a centralized system that standardizes data for the nine (9) population groups served by OAAPI and its program partners called out in HB4151.
2) Create a centralized database of reports of abuse.
3) Provide storage of photographs for purposes of preserving evidence of the condition of the resident at the time of the investigation.
4) Create a centralized method of notice management (sending and receiving notices) to improve communications with law enforcement.
5) Create a centralized and standardized method of sending notices to health care licensing/certifying agencies.
6) Create a centralized and standardized method for the DHS Background Check Unit (BCU) to augment their background checks by viewing information in the new system for persons who present a risk of harm to another person.
7) Create a centralized and standardized method for DHS and OHA organizations that do not utilize the Background Check Unit (BCU) to view information in the new system for persons who present a risk of harm to another person.

3.3.2 Alignment with 2016's Oregon Senate Bill 1515 (SB1515)

Development of this system is in direct alignment with SB1515. This Senate Bill specifies approximately 16 types of abuse related notices, some of which result in multiple notices depending on the situation. A robust notice management system will support generation, tracking, storage, management and quality control of notices. The planned system's flexibility will support screeners and investigators to comply with changing mandatory requirements more efficiently.

3.3.4 Alignment with the Strategic Technology Plan

The DHS/OHA Strategic Technology Plan (STP) includes a number of strategies that the Centralized Abuse Management Project will support.

The table below summarizes the various components of the STP that a centralized abuse system will satisfy.

[9] Clyde Saiki, DHS Director's email February 8, 2016.

Business Automation	• Work queues to improve work management at all levels in the organization. • Sophisticated searches to research abuse history. • Unification of processes and activities across programs by providing one tool to document reports of abuse, screening decisions, investigations and notices. • Allow for easy transfer/referring out of reports of abuse between programs and program partners. • Reducing dependency on paper processes by allowing for electronic document storage and electronic notices. • Electronic document storage. • Reduce duplication of work. • Capture data once and reuse it. • Provide real-time, statewide, centralized data for reporting.
Comprehensive View of our Clients	• Supports the use of a master person record.
Enable Connectivity Anytime, Anywhere, in Multiple Ways	• Provide workers a real-time portal to perform their work anytime, anywhere, 24/7. • Provide the public a portal to report abuse anytime, anywhere, 24/7.
Trusted Source for Health & Human Service Data	• Reduce data duplication and entry into multiple systems through the use of a single system for the Agencies for abuse management. • Trusted source for verified person data. • Trusted source for reports of abuse, screening decisions and abuse investigations. • Improve data access and sharing across programs. • Role based data access and security to improve data protection and compliance.
Dynamic Needs Supported by Seamless Technology Services	• Industry best practices and standards based modular architecture and design (e.g., Service Oriented Architecture (SOA), Enterprise Service Bus (ESB) etc.) to leverage existing functionality and also expose functionality through web services. • Highly configurable platform that is responsive to evolving business needs. • Extensible platform allows for standard interfaces with other modern enterprise applications.

3.4 Project Objectives

<u>High-Level Goals of the new system are to:</u>

1) **Reduce abuse risk to vulnerable Oregonians and reduce liability abuse exposure for the State:** Improve DHS, OHA, and OAAPI visibility into all cases for which they have oversight regardless of program, facility, population, policy or location thus reducing risk to Oregonians, who may have otherwise fallen through the cracks. Provide a 360-degree

view of a person so trends in victims and/or perpetrators can be found and uniquely identified statewide across programs. Improve victim safety by improving communications between stakeholders[10] including Oregon State health certification/licensing agencies.

2) **Increase abuse case investigations productivity and efficiency:** Increase staff productivity through improved processes that minimize duplication of data entry. Move away from the need for paper files to a new paperless system, which allows information sharing with the right people at the right time. Provide staff tools for proactive self-management of workload and outcomes by staff and management in local offices and each program's central office. Provide abuse reporters the ability to enter their allegations of abuse through the Internet.
3) **Support program variation and frequent changes:** Accommodate similarities and differences in programs and respond quickly to frequent legal and policy changes.
4) **Develop capacity for projected increases in abuse-related workload:** Improve the ability to handle and support the anticipated high volume of abuse allegations, referrals, investigations, notices and related data over the next ten years.
5) **Identify and track abuse across a person's lifespan:** Identify abuse statewide across programs, connect abuse across the lifespan of a person regardless of their role in the incident (victim, perpetrator, witness etc.), and ensure that protective services are informed by a client's past history of abuse.
6) **Implement a web based and easy-to-use technology system:** Implement a system that will: 1) Support and integrate the screening, investigation, review, reporting and notice processes regardless of the DHS/OHA program that is being administered and; 2) Function well regardless of the supported desktop browser technologies used by the state and their program partners (counties, AAAs, brokerages etc.).
7) **Produce standardized auditing and analysis information:** Standardize the collection of all abuse-related data for purposes of auditing, analysis, reporting and forecasting. This will be achieved through use of common terminology and definitions that will be determined through a cooperative effort of OAAPI and its partners and aligned with developing national abuse data collection methodologies.
8) **Provide accurate data and reporting:** Create the ability to report on core data and metrics in order to provide effective services and measurable outcomes to program partners, and to assure that abuse investigations are being conducted effectively and prevention efforts are being targeted appropriately.
9) **Enable mobile technology:** Enable the use of mobile technology in the investigation process to improve efficiencies, especially related to safety and response times when investigators are in the field.

3.4.1 Key Benefits of the Centralized Abuse Management System

Key benefits of the new system include:

- Provides The Agencies with one comprehensive multi-program system for abuse management documentation and inquiries so that risk to the safety of Oregonians and liability to the State are reduced.

[10] See Business Case Supplemental Documents Package for a comprehensive list of key stakeholders.

- Real-time, online documentation of initial reports of abuse and the resulting screening decisions to ensure all reports of abuse that need investigation are screened in and the rationale and other steps taken (such as referring to others) can be supervised and monitored.
- Real-time, online documentation of all investigations including notices, and storage for that information in a centralized database so that the information is safe and accessible by local office staff and management, program Central Office, OAAPI and the DHS Background Check Unit.
- Increases productivity and efficiency through reduction in duplicate data entry, manual work, and by allowing reporters of abuse the ability to submit reports online through the Internet 24 hours a day 7 days a week.
- Improves decision making and preventive actions because, over time there is one place to find a:
    - Perpetrator and their history of abuse for one or more programs across the entire state of Oregon.
    - Victim and their history of abuse for one or more programs across the entire state of Oregon.
    - DHS-Licensed Facility and the history of abuse at that facility for one or more programs across the entire state of Oregon.
- Standardizes methods and data allowing for improved oversight and analysis.

Key functionality of the new system includes:

- Dashboards for workers that enhance their ability to self-manage their work within mandated response times.
- A business rules engine that allows for easy modifications by The Agencies for specific needs and new mandates.
- Evidence, photos and other document attachments.
- Integration with the ONE's Master Client Index.
- Mailing address validation.
- Automated notice generation.
- Public online report of abuse submittal.
- Role based security.
- Single sign-on with OHA's Active Directory.

4. High Level Requirements and Key Assumptions

Following is a brief overview of the high-level requirements and some key assumptions for this initiative.

4.1 High Level Requirements

Following are the most critical requirements for a centralized abused management solution:

Online Abuse Complaint: Provide the public - including mandatory reporters - an Internet page to submit complaints 24 hours a day – seven (7) days a week.

Worker Dashboard: Provide screeners, investigators, supervisors and reviewers dashboards listing incidents and investigations that can be filtered and sorted to fit their needs. For example: to filter by the incidents needing response today or to sort for the last incident that the worker updated.

Comprehensive Search: Provide users of the system sophisticated, comprehensive search, filter and sort capability to assist in finding past victims, perpetrators and/or incidents. For example: searches for people across program by name and/or address and/or social security number.

Portals: for Screeners, Investigators, Supervisors and Reviewers. Provide screeners the ability to accept online abuse complaints and route them to the appropriate location, enter abuse complaints received in other manners (phone, email, mail…), update complaints, which could not be completed in a contiguous timeframe. Provide investigators the ability to enter and track required information for an investigation. Provide Supervisors and Reviewers the ability to review and comment on screening decisions and draft investigation reports.

Business Rules Maintenance: Provide System Administrator(s) the capability to maintain business rules separate from system code. For example: allow the System Administrator to update Oregon Administrative Rules and definitions viewed and selected by workers along with field selection values.

Interfaces: Integrate with the existing Master Client Index including inbound Interfaces from OLRO-licensed facilities; provider demographics from the APD provider database and a regularly scheduled data export to the DHS data warehouse and QMDB/Q2.

Historical Data: Load Historical Abuse Management Data into the new solution from multiple feeder systems including OR Access, Web723, LCOG CTS and OAAPI Abuse Database.

Data Warehouse: Provide a data warehouse for running queries, mandated reports, and performing data analysis without impacting performance of end users. Provide a full set of data for running extracts to be used by others systems such as QMDB for DHS.

Workload Management: Support for monitoring and projecting workload by worker, by program, by local office, and by program within an office. Support for assigning, pausing, and restarting work on individual and groups of reports of abuse and/or investigations.

Document Management: Support for capturing, storing and retrieving images and other electronic documents related to reports of abuse and investigations. Support for scanning paper documents. Support for uploading of documents through the online abuse complaint and the worker portals. Support the use of template documents for communications.

Notice Management: Support for worker-driven and system-driven notices to Complainants, Perpetrators, Providers, Various Law Enforcement Agencies, Oregon State Health Occupation

licensing/certifying/authorizing organizations, and referral partners. Support the use of templates for notices that can be sent via secure email, fax and/or the United States Postal Service.

Reporting: Support for the creation of reports required for investigation reporting, protection and intervention process measures, and analysis of service equity in abuse investigations.

Identity and Access Management: Support for the integration with DHS's Active Directory for authenticating workers who are state employees or program partners such as Area Agency on Aging staff and Counties who access the system on the behalf of a DHS program.

Data Security: Protection of data, whether at rest, in transmission, in display, or in reports consistent with federal, state and agency data privacy, security and retention laws, rules and policies.

Disaster Recovery: Ensuring that no data is lost is critical to the safety of our clients. The Recovery Point Objective (RPO) for this project is zero data loss in the event of a disaster. The Recovery Time Objective (RTO) is a maximum of 24 hours that the system can be unavailable in the event of a disaster or system problem.

4.2 Detailed Requirements

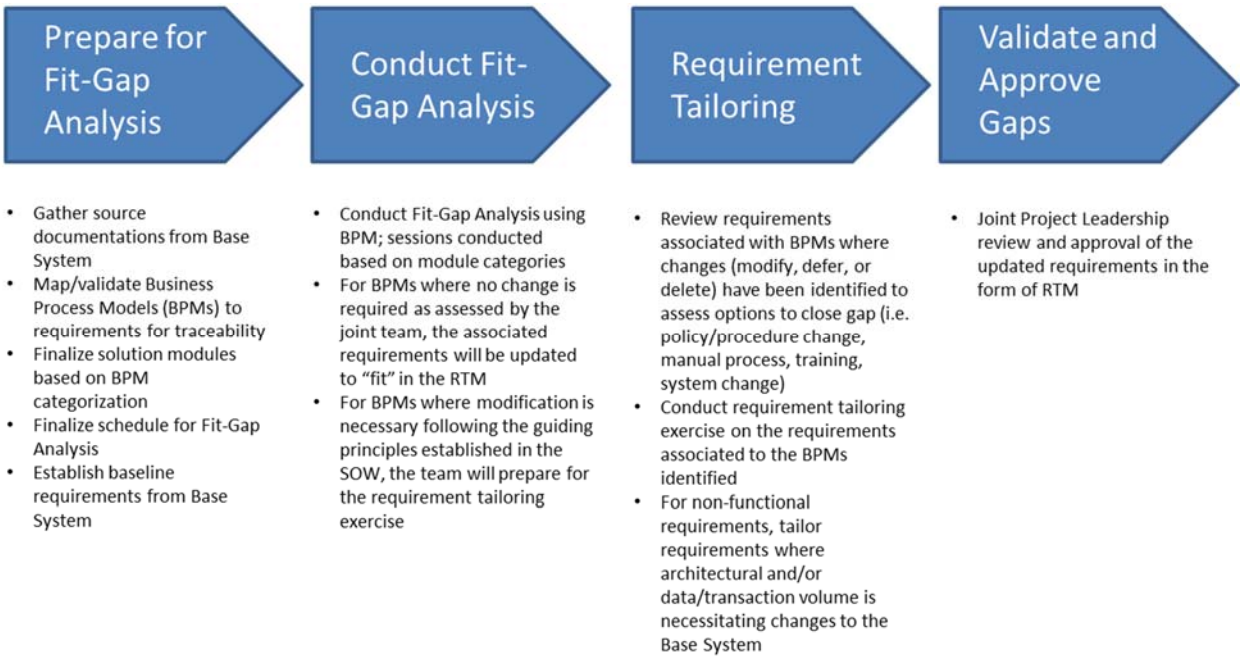
The project team developed both high-level business requirements and detailed business requirements. These two requirements documents will provide a Systems Integrator (SI) sufficient context regarding Oregon's business needs to respond to Oregon's planned Request for Proposal (RFP) for a SI. The selected SI's expertise will be leveraged to help refine Oregon's preliminary detailed business requirements, which will increase the probability of project success. Oregon will align requirements as closely as possible to Colorado's design while still addressing Oregon's unique, mission-critical business needs. The detailed business requirements will be reviewed with subject matter experts including DHS/OHA field staff to ensure they are complete and correct.

The Systems Integrator will use Oregon's detailed requirements to conduct a Fit-Gap Assessment with the potential solution to establish additional functional and technical design specifications. This approach leverages the proven model implemented in Colorado to guide Oregon's efforts.

4.3 Fit-Gap Analysis

Fit-Gap analysis will compare Oregon's rules, policies and procedures to the Colorado System and identify how the Colorado System meets respective functionality for Oregon out of the box. The goal of analysis is to identify how the Colorado Solution meets the respective needs of the Agencies. Gaps where system functionality is not present and cannot be resolved through a change to process or policy will be prioritized along with a defined approach to address them. This fit-gap effort identifies the gaps that will identify the need for process changes, software configuration changes and/or customizations required.

The following diagram describes the activities to be conducted during the Fit-Gap Analysis. This information is more fully documented in the planned RFP.



4.4 Assumptions and Constraints

The following constraints are factors in the Alternatives Analysis:

- Project funding was approved in SB5507A Enrolled comprised of:
  - $1,437,494 in General Funds (GF);
  - $3.3 million in Q Bonds;
  - $894,543 for Q Bond issuance and debt service.
- Core functionality for adult abuse report intake, screening and investigation must be implemented by June 30, 2017. The initial release of the Centralized Abuse Management solution will not automate all tasks, so duplicate data entry will not be resolved until Release 2.
- HB4151 requires Oregon have one central statewide solution for APS.

The following assumptions are factors in the Alternatives Analysis below:

- The Oregon Legislature, which approved dollars in SB5507A for this project, will unschedule funds to proceed with this project.
- Population growth is expected to average 10% per year for the populations served in this project.
- The solution will meet 80% or more of agency functional requirements and 90% of non-functional (technical and security) requirements.
- The solution must be easily adaptable to satisfy ongoing process and requirement changes such as those driven by HB4151 and SB1515.
- The selected alternative must support the DHS/OHA Strategic Technology Plan.
- Historic abuse information will be accessible to the DHS data warehouse sometime after the core system is implemented.
- The project will issue a competitive bid Request for Proposal (RFP) for a Systems Integrator (SI) to plan, design, implement and maintain the new system.
- Training will be provided by the System Integrator (SI) to OAAPI Program area trainers who will then train staff statewide.

- Solution implementation and ongoing maintenance and operations will be provided by a 3rd party vendor with oversight from state employees.
- Risk tolerance for this project is moderate based on the timeline, volume of work, and funding available.
- The system can be used and supported in all required locations including but not limited to:
  - DHS and OHA programs, offices, county and local partners.
  - DHS's Background Check Unit.
  - Long-Term Care Ombudsman (LTCO).
  - The Public.

5. Alternatives Analysis

5.1 Alternatives Identification

After a preliminary business case proposed development of a customized solution, the Agencies invested significant efforts to assess other alternatives to compare against custom development. A team comprised of program and technology members conducted in-depth market research. The market research included detailed interviews with 18 states to discover their abuse management solutions. This market research yielded two potentially viable solutions utilized by other states and two used in Oregon. The team did further in-depth analysis of capabilities of these four options against functional and technical requirements, and conducted customer demos and on-site visits. Detailed information from the in-depth analysis and site visits can be found in the Business Case Supplemental Documents.

Information gained during customer demos and site visits eliminated some alternatives under early consideration identified from the project's initial market research including Commercial off the Shelf (COTS) solutions and transfer solutions used by other entities.

COTS solutions available in the marketplace such as Harmony, which could address Oregon's requirements primarily, accommodate only one program - Adult Protective Services. The relevant vendor supported COTS solutions require significant customization, including underlying architecture modification, in order to meet the Agencies' needs. A primary benefit of COTS solutions is that the licensing vendor provides regular regulatory and business functionality updates/upgrades to meet changing needs. The extent and complexity of Oregon's level of required modifications to a COTS negates those benefits, as each release would require re-customization for Oregon. The viable COTS solutions reviewed were only supported by the vendor that owns and licenses the software. In this situation, if the state were not satisfied with the licensing vendor, there would not be options to utilize an alternate vendor to support the system. Many states reported issues getting modifications made to their vendor-licensed software that involved many months of delay to get vendors to address their legal, regulatory and efficiency improvements. Oregon must be able to respond to effectively to the rapidly changing regulatory and business environment. This makes the use of the relevant COTS solutions high risk for Oregon.

Transfer solutions used by other states consist primarily of large, monolithic systems such as the Statewide Automated Child Welfare Information Systems (SACWIS), outdated home grown state systems used for Adult Protective Services over the last 10-20+ years, or small County/AAA applications that cannot accommodate the number of statewide users required by the CAM Project. SACWIS systems have high implementation costs - $50 million and up, with ongoing annual support costs of $20 million or more. Abuse tracking and management is a small piece of functionality in the SACWIS systems. Removing this functionality represents significant expense, leaving it in makes modifications and maintenance cost prohibitive. The general architecture of SACWIS reviewed by the team is old and focuses on the family rather than the abused person. For these reasons, SACWIS transfer solutions were removed from consideration.

Smaller, custom developed solutions such as the Lane County (LCOG) solution were determined not to be viable options for Oregon to consider transferring as a starting point for its statewide solution as they lacked the scalability and functionality necessary to meet Oregon's functional and technical requirements. Most are built using MS Access or other software that is not designed to support the level security or the number of concurrent users that Oregon requires.

As part of Oregon's due diligence, alternate CRM solutions, including MS Dynamics were considered at the request of the Agencies. MS Dynamics was a late emerging option brought forward after robust analysis of other solutions had already been completed. After consideration, the project team did not find MS Dynamics offered substantial capabilities beyond those in more thoroughly assessed alternatives and the cost model was not as viable as other options. Ultimately, The Agencies' Executive Leadership determined Salesforce to be the preferred CRM alternative over MS Dynamics as it enables Oregon to build upon existing foundational capabilities established by Colorado's adult protective services system.

The following alternatives emerged from the analysis completed by the project team and based off the recommendations of The Agencies' Executive Leadership.

1. Purchase a Software as a Service Solution; leverage another state's use of the SaaS.
2. Implement a Custom Build Solution.
3. Maintain the Status Quo.

Project analysis of these alternatives are as follows:

Alternative 1: Purchase Software as a Service Solution; leverage another state's use of that SaaS

Under this alternative, a SaaS CRM solution would be implemented, configured and customized to meet the CAM Project's detailed requirements. This approach allows relatively quick design, build and implementation plus ongoing flexibility to meet the continuously changing business/regulatory environment at a reasonable cost.

Oregon investigated two CRM options – Microsoft Dynamics and Salesforce. While each of these CRM solutions have capabilities that can meet Oregon's needs; Salesforce is considered the front-runner option as it provides Oregon the opportunity to leverage Colorado's proven Adult Protective Services (CAPS) which was configured using the Salesforce SaaS solution and implemented in June 2015. The Colorado capabilities can be utilized by Oregon as a foundational requirements reducing implementation time substantially. This strategy, in concert with procuring a SaaS and services of a Systems Integrator will help accelerate Oregon's implementation efforts, while reducing risk and shortening the implementation timeline. DHS and OHA Executive Leadership believe this synthesized approach represents the best fit for Oregon's needs. More details regarding Colorado's solution and the proposed implementation approach are outlined later in this document.

Alternative 2: Implement a Custom Build System

Under this alternative, the Agencies would design, develop, test and deploy a custom solution built from the ground up for APS, HS, DD, CW and OSH Centralized Abuse Management needs. This alternative would allow a tailor-made solution that would meet all the functional, technical and organization requirements. The costs to develop a custom system are substantially higher than procuring a SaaS solution and carry significantly higher risks and a much longer timeline to implement compared to Alternative 1.

Alternative 3: Maintain the Status Quo

Under this alternative Oregon would maintain the current status quo with disparate, disconnected systems and highly manual processes and there would be no additional investment in abuse tracking system automation. Improvements to current processes would be limited to those that arise naturally through the Agencies' continuous improvement program. The Agencies would continue with ineffective, disconnected automated and manual systems, which are difficult to oversee and analyze. The centralized abuse tracking needs of HB 4151 would not be met.

The chart below outlines the estimated Total Cost of Ownership for alternatives:

TOTAL·COST·OF·OWNERSHIP·ANALYSIS¶

Comprehensive·Cost·Model·for·all·Scenarios¶

¤	¤	Project·and·Implementation¤	Operations,·Maintenance,·Ongoing·Support¤
Personal·Services¤	Salaries·&·Benefits¤	¤	• → State·Perm·Staff¶ • → State·Temp·Staff¶ • → State·LD·Staff¤
Services·&·Supplies·&¤	State·Data·Center¤	¤	• → Consulting·Services¶ • → Hosting¶ • → Storage¶ • → Network¤
	Software¤	• → Software·Purchase·/·Upgrade¤	• → Software·License·Maintenance¤
	Hardware¤	• → Hardware·Purchase/·Upgrade¤	• → Hardware·Ongoing·Maintenance¤
	IT·Professional·Services¤	• → Project·Devel/Implementation¤	• → Project·Devel/Implementation¤

5.1.1 Alternative 1 – Implement a Software as a Service Solution and leverage another state's proven capabilities with that SaaS

Cost

The total cost of implementing and supporting this alternative and operating it the proposed solution starting July 2016 through June 2023 is estimated to be ~$8.4 million. (See details of this estimate in Appendix A.) Compared to the Custom Build alternative, this alternative minimizes costs of Fit-Gap analysis, design, configuration, customization, testing, training, and rollout by using a Customer Relationship Management platform based on the successful Colorado APS abuse management solution. This alternative requires a per-person and/or per device Salesforce licensing cost over the life of the solution.

Alternative 1 - Salesforce CRM
Totals include FY 2016-17 through FY 2022-23

		Through Dec 2017 Project and Implementation	Jan 2018 through June 2023 Operations, Maintenance, Ongoing Support	Total	%
Personal Services	Salaries & Benefits	$1,554,538	$80,303	$1,634,840	19.4%
Services & Supplies & Capital Outlay	State Data Center	$0	$0	$0	0.0%
	Software	$1,157,814	$3,089,932	$4,247,746	50.5%
	Hardware	$20,000	$0	$20,000	0.2%
	IT Professional Services	$1,479,500	$614,499	$2,093,999	24.9%
	Contingency	$421,185	$0	$421,185	5.0%
	Total	$4,633,037	$3,784,733	$8,417,770	
	%	55.0%	45.0%		100.0%

Benefits

Alternative 1 supports the functional and non-functional requirements associated with Centralized Abuse Management for the Agencies. The system will implement much faster, with lower risk and less cost than building a custom solution. This is demonstrated Colorado, who implemented their

initial release of the Salesforce SaaS within 6 months. Colorado's current system provides a proven APS model for Oregon to leverage as a starting point for the centralized abuse management solution. Oregon's plan is to pursue procurement of Salesforce as the SaaS as its capabilities and the ability to leverage Colorado's requirements will accelerate Oregon's initiative.

Salesforce provides an easy-to-use capability for the business to administer templates, list values, and perform ad hoc reporting. This SaaS allows for program-specific uniqueness through configuration of program specific data integrity rules. Configuration capability of Salesforce will allow program variations when necessary and the ability to make frequent changes quickly to accommodate the rapidly changing regulatory environment. Configuration supports the use of templates and rules for distribution of notices making it easier to generate and distribute notices. Salesforce has interface/integration tools, which will quickly and easily interface the new system with legacy extracts and systems such as the Agencies' provider information and client master index.

All reports of abuse, response times and screening decisions will be entered in real-time into the system. Reporters of abuse will be able to submit their reports on-line via the Internet. Screeners, investigators and others with a need to know will be able to research past screenings and investigations (including historical system investigation data created prior to implementation) to assess if ongoing or past reports of abuse and investigation outcomes play a role in the current situation. Screeners, investigators, supervisors, reviewers and others will have dashboards to assist them in managing their work/workload. All data about an investigation will be kept online rather than in field office files making management, oversight and prevention planning more effective.

In "Magic Quadrant for the CRM Customer Engagement Center" May 2016, Gartner reports Salesforce to be the leader in both their Ability to Execute and Completeness of Vision for their CRM.[11] They also said that Salesforce "appeared as the leading vendor on shortlists for Business to Business (B2B) customer service and support solutions seen by Gartner six times as often as the nearest rival." "Salesforce's enormous influence in the market has attracted a global list of key system integrators and over 600 complementary software providers."

Risks

The top risks of this alternative are:

1) Implementing an enterprise information technology solution within a relatively short timeline that spans multiple programs and agencies located across the state.

2) Significant policy and procedure changes will be required for the Agencies as more standardization is put in place.

3) Integration may be more difficult between Salesforce and legacy systems than anticipated.

4) Acquisition of funding to ensure reductions in manual work arounds and duplicate data entry beyond the 2015-17 biennium may be a challenge.

5) System will need to adhere to security requirements for Level 3 data. Project will need to ensure that all these requirements are met utilizing a SaaS solution.

[11] Critical capabilities and features included: "Case management/problem/service resolution (and control of customer master data); A knowledge management solution; a full customer self-service suite, with support for Web and mobile channels; Real-time decision-making and predictive analytics support for agents; an adaptive business rule engine; Enterprise feedback management."

6) This alternative is dependent on the acquisition of the code/configuration of Colorado's system.

5.1.2 Alternative 2 – Implement a Custom Build Solution

Cost

The total cost of implementing this alternative and operating it through June 2023 is estimated to be ~$17 million. (See Appendix A for details.) This alternative incurs the full cost of analysis, design, development, testing, training, and rollout. The cost is unknown for Enterprise Technology Services/State Data Center (ETS/SDC) to develop and implement a process to ensure no data loss in the event of a disaster or event causing the production server/system to go down. This alternative will typically require only server-based software and developer tool licensing as opposed to user or end user device licensing costs.

Alternative 2 - Build
Totals include FY 2016-17 through FY 2022-23

		Through June 2019 Project and Implementation	July 2019 through June 2023 Operations, Maintenance, Ongoing Support	Total	%
Personal Services	Salaries & Benefits	$3,326,881	$258,998	$3,585,879	21.2%
Services & Supplies & Capital Outlay	State Data Center	$139,056	$86,400	$225,456	1.3%
	Software	$70,000	$10,000	$80,000	0.5%
	Hardware	$20,000	$0	$20,000	0.1%
	IT Professional Services	$5,056,789	$4,052,172	$9,108,961	53.7%
	Contingency	$1,722,545	$0	$1,722,545	10.2%
	Indirect	$1,550,291	$661,135	$2,211,426	13%
	Total	$11,885,562	$5,068,705	$16,954,267	
	%	70.1%	29.9%		100.0%

Benefits

This alternative could achieve all of the Agencies functional, technical and organizational requirements.

Risks

The top risks of Alternative 2 - Build are:

1) Implementing an enterprise information technology solution that spans multiple programs and agencies located across the state in a longer timeframe than suits the State's sense of urgency. This alternative is estimated to be designed and implemented in a 2 ¼ to 2 ½ year timeline.

2) Significant policy and procedure changes will be required for the Agencies as more standardization is put in place.

3) Availability of funding at the level required to support completion of the project.

4) Creation of a new ETS/SDC custom process/design/implementation to ensure there would not be any loss of data during a disaster or event causing the production server/system to go down. This is not a proven ETS/SDC capability for non-mainframe applications so the costs to establish are unknown and the desired results could take longer than expected.

5) Setup disaster recovery for zero data loss with an outside vendor, then test for potential cut over to should a disaster occur at ETS/SDC.

5.1.3 Alternative 3 – Maintain the Status Quo

Cost

Maintaining the status quo and not implementing an integrated solution will cause DHS and OHA to incur additional expenses over time. That estimated total cost through June 2023 is approximately ~$5.2 million (see Appendix A for details). This additional cost will be driven by increasing workloads due to aging populations and increased regulatory requirements leading to the need to add more staff to manage the demand in the field and meet key performance measure goals.

Alternative 3 - Do Nothing

		Through Dec 2017 Project and Implementation	Jan 2018 through June 2023 Operations, Maintenance, Ongoing Support	Total	%
Personal Services	Salaries & Benefits	$1,047,589	$4,136,675	$5,184,264	100.0%
Services & Supplies & Capital Outlay	State Data Center	$0	$0	$0	0.0%
	Software	$0	$0	$0	0.0%
	Hardware	$0	$0	$0	0.0%
	IT Professional Services	$0	$0	$0	0.0%
	Total	$1,047,589	$4,136,675	$5,184,264	
	%	20.2%	79.8%		100.0%

Benefits

There is no up-front investment required to continue maintaining the status quo.

Risks

The top risks of Alternative 4 – Maintain the Status Quo are the continuation of current state risks:

1) Safety risks to Oregonians that are reported as abused. The reports of abuse may be hand written (if documented at all) and stored in paper/personal computer files in 140 or more locations across the state. This fragmentation of data makes it difficult to oversee the quality of screening decisions regarding reports of abuse and hence leaves Oregonians at risk.
2) Safety risks to Oregonians when an alleged or substantiated perpetrator applies for certification, licensing or authorization from an Oregon state, DHS or OHA organization. Communications from investigators to the certification, licensing and authorization organizations are inconsistent so the certification, licensing or authorization organization may not be aware they are approving an alleged or substantiated perpetrator.
3) Safety risks to Oregonians when an alleged or substantiated perpetrator requests employment from a DHS, OHA, and program partner or provider organization. Communications from investigators to the Background Check Unit (BCU) are inconsistent across all the programs and program partners so BCU may not be aware they are approving an alleged or substantiated perpetrator to work with Oregonians.

4) Risks that field staff are unable to effectively manage their own workload and for staff/management to prevent cases from being lost or potentially left unresolved due to insufficient tools for tracking work.
5) Risk of increasing field staff frustration as they spend more time on duplicate data entry, manual creation and distribution of notices instead of performing actual investigations because both population sizes and requirements for additional notices increase the workload.
6) Risk of expensive lawsuits resulting from the risks to Oregonians.

5.2 Cost Comparison

The Oregon Legislature has approved the use of ~$1.4 million in General Funds and ~$3.3 million in Q Bonds (plus issuance and debt service) to be used during the 2015-17 biennium.

The following Table summarizes the cost information from the preceding section.

Table 3 – Cost Summary

Alternative	Cost
Alternative 1 – SaaS	~$ 8.4 Million
Alternative 2 – Build	~$17.0 Million
Alternative 3 – Maintain the Status Quo	~$ 5.2 Million

5.3 Benefit Comparison

The following table summarizes the benefits information from the preceding section.

Benefit Area	Alternative 1 Salesforce	Alternative 2 Build	Alternative 3 Status Quo
Comprehensive multi-program system	Good	Good	n/a
Proven Model	In Colorado	No	Yes
Meets functional and non-functional requirements	Good	Good	Poor
Speed to implement	Fast	Slow	n/a
Speed to integrate with legacy data	Fast-Moderate	Moderate	n/a
Up-front investment	Low	High	n/a
Maintenance & operations investment	Medium	Medium	n/a
End user ad hoc reporting	Easy	Somewhat Difficult	Very Difficult
Supports DHS/OHA Strategic Technology Plan	Yes	Yes	No
Reduce risk to Oregonians & liability for State	Good	Good	Poor
Increase productivity and efficiency	Good	Good	Declines over time as expectations increase
Support program variation & frequent changes	Good	Average	Poor
Support growing workload	Good	Good	Poor
Identify & track abuse across lifespan	Good	Good	Poor
Identify & track abuse at facilities	Good	Good	Poor
Produce standardized info for audit and analysis	Good	Good	Poor
Web-based & easy-to-use	Good	Good	Poor

Benefit Area	Alternative 1 Salesforce	Alternative 2 Build	Alternative 3 Status Quo
Supports HB4151	Good	Good	Poor
Supports SB1515	Good	Average	Poor
Decommissions Systems	COIN, LCOG CTS, OAAPI Abuse Database, SERT, Web723	COIN, LCOG CTS, OAAPI Abuse Database, SERT, Web723	None

5.4 Risk Comparison

Below is a high-level risk comparison table. Please see "CAM Project Risk Assessment – Stage Gate 2" for a more detailed description of the principal risks facing the project.

Risk Area	Alternative 1 Salesforce	Alternative 2 Build	Alternative 3 Status Quo
Technology	Low	High	Medium
Policy	Low	Medium	High
Operational	Low-Medium	High	High
People	Medium	Medium	High
Overall	Low-Medium	High	High

Each of the active alternatives has the risks associated with multi-Program (enterprise) information technology projects involving complex state program and partner relationships.

- Alternative 1 (SaaS) is the least risky because it leverages Colorado's APS system built using Salesforce, and utilizes a platform which allows for rapid configuration and customization as needed.
- Alternative 2 (Build) is a larger project with inherently higher risks than Alternative 1. Risk is driven in part by the significantly longer duration and the higher demand over that duration on Program participation than Alternative 1.
- Alternative 3 (Status Quo) has the highest risk of all the alternatives. It continues the current state where statewide centralized oversight is very difficult and workers continue with paper files and severely inadequate or no application system to support their needs.

6. Conclusions and Recommendations

6.1 Conclusions

Both Alternative 1 and 2 would address the opportunity described in Section 3.2 above and they fulfill the objectives listed in Section 3.3. The cost to implement Alternative 1 is less than half of Alternative 2 with significantly lower risks and a much shorter implementation timeline.

Table 4 – Cost, Benefits, Risks Summary

	Project Cost	Project Benefits	Overall Risk
Alternative 1 SaaS	~$ 8.4 Million	All requirements, quick to implement	Low - Medium
Alternative 2 Build	~$17.0 Million	All requirements	High
Alternative 3 Status Quo	~$ 5.2 Million		High

6.2 Recommended Action and Schedule

The Agencies recommend Alternative 1 – Purchase Software as a Service Solution; leverage another state's use of that SaaS. This approach will procure Salesforce, a SaaS CRM solution and leverage Colorado's APS solution's capabilities as the basis for Oregon's solution. Colorado's solution is built on the Salesforce platform.

To support this approach, the state will need to ensure that security standards adhere to Oregon's SaaS Cloud Policy requirements and the terms and conditions contract will reflect those standards.

The recommended approach is significantly lower risk and approximately half the cost of Alternative 2 – Build, while still providing equivalent benefits.

The recommended alternative aligns well with the DHS/OHA Strategic Technology Plan including progress in pursuit of automating workflows, decision-making, and business rules while reducing manual, paper-based processes. It moves the state closer to the "360 degree view of a person" goal.

DHS requests Stage Gate 2 approval. Stage gate and legislative approval was received by DHS in 2014 for project initiation. In 2015, DHS received approval for additional research on solutions currently in use by other States for abuse management. DHS plans to seek approval to move to the detailed project planning phase (Stage Gate 3) in order to procure the Systems Integrator for implementation of the selected SaaS.

Funding for this initiative is provided by the legislatively approved use of ~$1.4 million in General Funds and ~$3.3 million in Q Bonds (plus issuance and debt service) to be used during the 2015-17 biennium. DHS is pursuing several funding options to close the financing gap between currently earmarked funds and the total expected cost. These include 1) Obtaining grant funding through ACL12; 2) Obtaining approval for a Policy Option Package (POP) for future

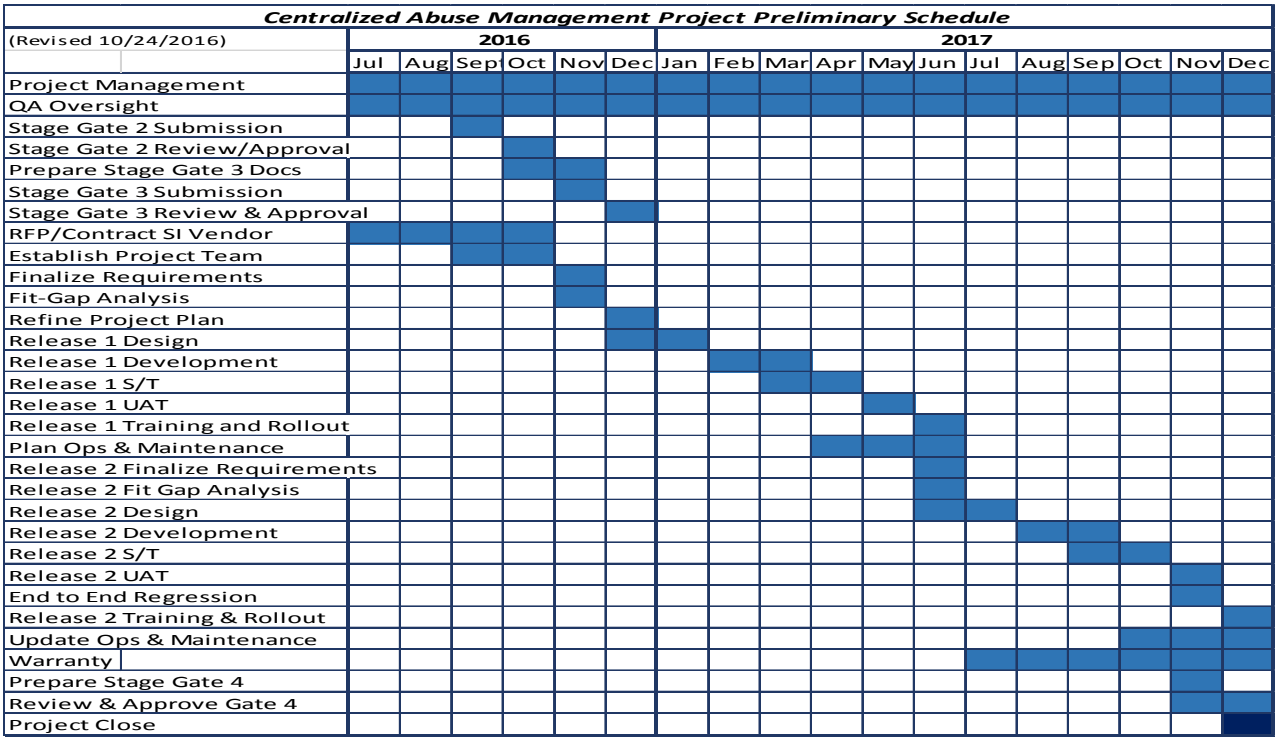
[12] APD has applied for but not received approval for grant funding. The US Department of Health and Human Services (HHS) Administration for Community Learning (ACL) released a Funding Opportunity Announcement for grants to states to strengthen their Adult Protective Services (APS) systems statewide. Due date for applications is 05/31/2016 and APD intends (pending approval) to

enhancements and to also cover the first two years of licensing for maintenance and operations of the new system.

The table below reflects the high level proposed project schedule for Alternative 1 – a SaaS including the reuse of Colorado's Salesforce code set and functionality. If Alternative #1 is approved, all core requirements are planned to implement by December 2017.

Table 5 – Tentative Project Schedule

The following chart lays out a preliminary schedule for the project. A more detailed project schedule will be prepared during the project planning phase and the project schedule will require re-baselining after the Fit/Gap Analysis. The chart is duplicated in Appendix B, where it is more legible.



6.3 Consequences of Failure to Act

Given the current degree of manual processing and the projected growth in work, failure to act will result in continued poor program performance with regard to key performance measures including timeliness of screening decisions and response times for investigations. Doing nothing will continue to grow the problems that impact the safety of Oregonians, including: 1) Workloads of screeners and investigators in the field; 2) Communications between investigators and certifying, licensing and authorizing organizations; 3) Client and other interested party discontent, and; 4) The potential for new lawsuits.

Failure to act on this effort means that the eventual satisfaction of the needs of the Programs and OAAPI will come at higher risk to Oregonians and liability to the State.

apply for the full amount of this grant to support the costs of this project. This grant opportunity is for approximately $412,000 over two years.

7. Business Case Checklist

7.1 Checklist for the Completed Business Case

☒ Has the case clearly defined what the case is about, the purpose for the proposed solution, what business problems the proposed solution attempts to solve, and the scope of the proposal?

☒ Has the cash flow, the flow expenditures, and the intake of financial benefits been presented over a common time period for the case, for each alternative action considered (including the “status quo”/current state alternative).

☒ Are the assumptions and methods for assessing the proposal’s impacts clearly defined, understandable, and acceptable? Do not forget risk impacts!

☒ Does the business case include the non-financial costs and benefits?

☒ Are the factors critical to the success of the proposal clearly defined?

☒ Are there critical success factors that can be managed? Is there a risk analysis that identifies and measures the relevant risks to the proposal?

☒ Are recommendations and conclusions based on a clear comparison of alternatives in terms of contributions to business objectives, problems solved, financial outcomes, and risks?

☒ Does the case clearly identify the estimated timeframes, costs, and implementation strategy required to successfully deliver the recommended solution?

☒ Does the case clearly express to consequences of failure to act on the recommended alternative?

8. Appendixes and References

8.1 Appendix A Cost Worksheets

8.1.1 Cost Worksheet for Alternative 1 – Salesforce

PROPOSAL CASH FLOW

							Discount Rate:	3%
	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	TOTAL
BENEFITS / GAINS								
Notification/Distribution	$0	$97,430	$198,756	$202,732	$206,786	$210,922	$215,140	$1,131,766
Duplicate Data Entry	$0	$211,066	$430,574	$439,186	$447,969	$456,929	$466,067	$2,451,791
Reporting	$0	$26,830	$54,734	$55,828	$56,945	$58,084	$59,246	$311,667
System Limitations	$0	$10,413	$21,243	$21,668	$22,102	$22,544	$22,995	$120,965
TOTAL BENEFITS/GAIN	$0	$345,739	$705,308	$719,414	$733,802	$748,478	$763,448	$4,016,189
Personal Services Costs (Salaries & Benefits)								
Perm Employees								
Total Personal Service Costs	($893,125)	($693,174)	($9,143)	($9,417)	($9,700)	($9,991)	($10,290)	($1,634,840)
Services & Supplies/Capital Outlay Costs								
State Data Center Costs								
None	$0	$0	$0	$0	$0	$0	$0	$0
Software Costs								
Licensing ($900/full user/year x 429 Users)	($386,100)	($393,822)	($401,698)	($409,732)	($417,927)	($426,286)	($434,811)	($2,870,377)
Licensing ($450 /casual user/year x 288 Users)	($129,600)	($132,192)	($134,836)	($137,533)	($140,283)	($143,089)	($145,951)	($963,483)
Administrator Licenses (5 ea. at $1000/yr.)	($5,000)	($5,100)	($5,202)	($5,306)	($5,412)	($5,520)	($5,631)	($37,171)
Middleware for Integration (1 @50K)	($50,000)	($51,000)	($52,020)	($53,060)	($54,122)	($55,204)	($56,308)	($371,714)
Miscellaneous Software for 10 computers	($2,500)	($2,500)	$0	$0	$0	$0	$0	($5,000)
Hardware Costs								
10 computers @ $2000 each	($20,000)	$0	$0	$0	$0	$0	$0	($20,000)
IT Professional Services								
SI Consulting Services	($570,000)	($380,000)	$0	$0	$0	$0	$0	($950,000)
SI Consulting Services - Ongoing Maint. & Support	$0	($95,000)	($97,850)	($100,786)	($103,809)	($106,923)	($110,131)	($614,499)
QA Consulting Services	($353,000)	($176,500)	$0	$0	$0	$0	$0	($529,500)
Contingency Cost @ 10%	($240,933)	($180,253)	$0	$0	$0	$0	$0	($421,186)
TOTAL COSTS	**($2,650,258)**	**($2,109,541)**	**($700,749)**	**($715,834)**	**($731,253)**	**($747,013)**	**($763,122)**	**($8,417,770)**
Accumulated Total Costs	($2,650,258)	($4,759,799)	($5,460,548)	($6,176,382)	($6,907,635)	($7,654,648)	($8,417,770)	($8,417,770)
Cash Flow Summary								
Benefits/Gains	$0	$345,739	$705,308	$719,414	$733,802	$748,478	$763,448	$4,016,189
Costs	($2,650,258)	($2,109,541)	($700,749)	($715,834)	($731,253)	($747,013)	($763,122)	($8,417,770)
Net Cash Flow	($2,650,258)	($1,763,802)	$4,559	$3,580	$2,549	$1,465	$325	($4,401,581)
Cumulative Net Cash Flow	($2,650,258)	($4,414,059)	($4,409,501)	($4,405,921)	($4,403,372)	($4,401,906)	($4,401,581)	($4,401,581)

8.1.2 Cost Worksheet for Alternative 2 – Build

ALTERNATE PROPOSAL CASH FLOW

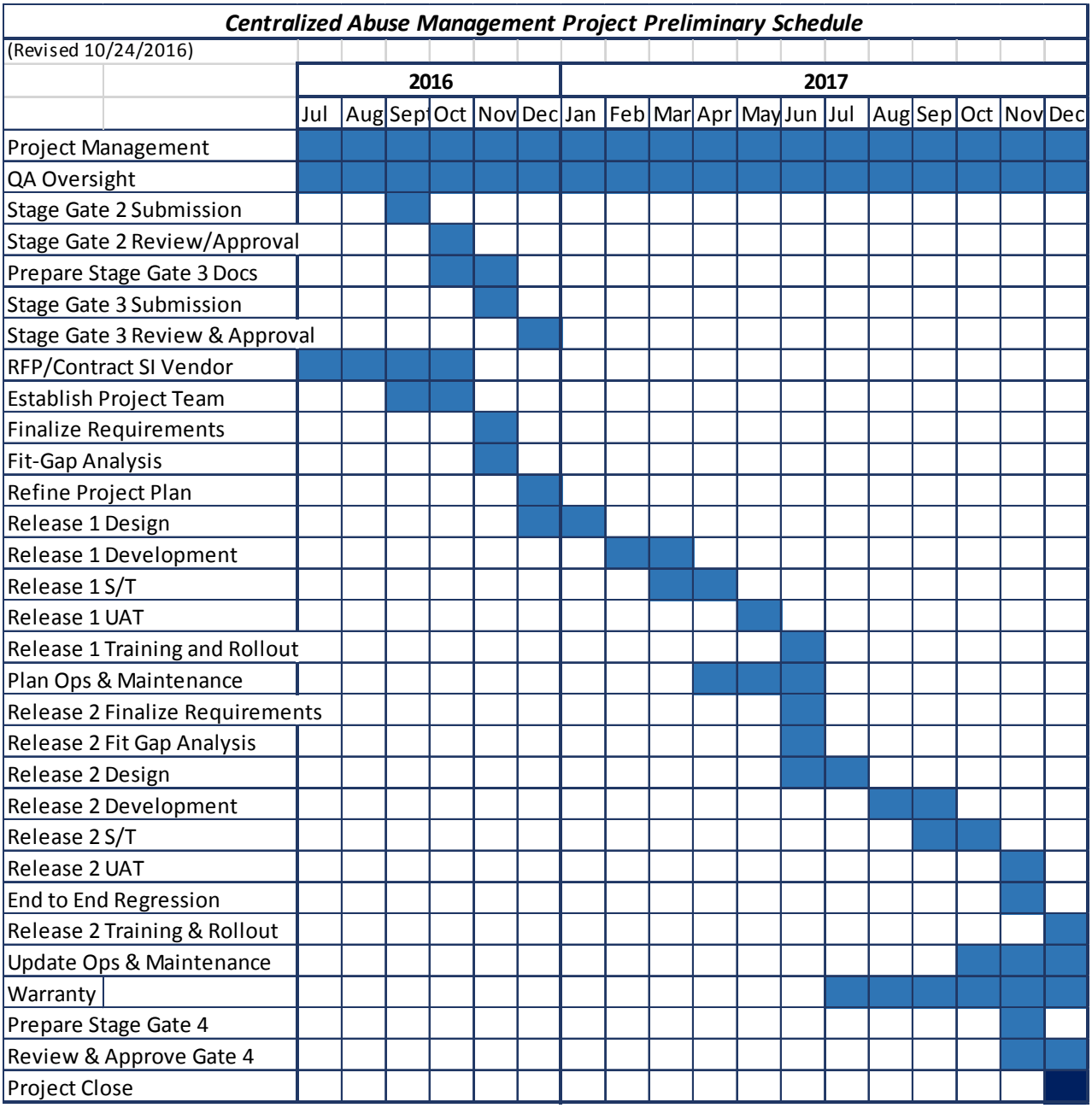
Discount Rate: 3%

	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	TOTAL
BENEFITS / GAINS								
Notification/Distribution	$0	$0	$194,859	$198,756	$202,732	$206,786	$210,922	$1,014,055
Duplicate Data Entry	$0	$0	$422,132	$430,574	$439,186	$447,969	$456,929	$2,196,790
Reporting	$0	$0	$53,661	$54,734	$55,828	$56,945	$58,084	$279,251
System Limitations	$0	$0	$20,827	$21,243	$21,668	$22,102	$22,544	$108,384
TOTAL BENEFITS/GAIN	$0	$0	$691,478	$705,308	$719,414	$733,802	$748,478	$3,598,480
Personal Services Costs (Salaries & Benefits) Perm Employees								
Total Personal Service Costs	$ (1,200,121)	$ (1,214,536)	$ (912,224)	$ (63,234)	$ (64,244)	$ (65,255)	$ (66,265)	(3,585,879)
Services & Supplies/Capital Outlay Costs								
State Data Center Costs								
Consulting Services: 5 servers @ $,2500 ea	($7,500)	($2,500)	($5,000)	$0	$0	$0	$0	($15,000)
Consulting Services for Disaster Recovery	$0	$0	($77,256)	$0	$0	$0	$0	($77,256)
Hosting: $300/month per server	($10,800)	($14,400)	($21,600)	($21,600)	($21,600)	($21,600)	($21,600)	($133,200)
Network	$0	$0	$0	$0	$0	$0	$0	$0
Software Costs								
SW Purchase/Upgrade - Development Tools	($50,000)	$0	$0	$0	$0	$0	$0	($50,000)
SW License Maintenance (10% during Impl and half that after)	($5,000)	($5,000)	($5,000)	($2,500)	($2,500)	($2,500)	($2,500)	($25,000)
Miscellaneous Software for 10 computers	($5,000)	$0	$0	$0	$0	$0	$0	($5,000)
Hardware Costs								
10 computers @ $2000 each	($20,000)	$0	$0	$0	$0	$0	$0	($20,000)
IT Professional Services								
SI Consulting Services	($1,128,250)	($1,974,099)	($483,691)	$0	$0	$0	$0	($3,586,039)
SI Consulting Services - Ongoing Maint. Support	$0	$0	$0	($358,604)	($369,362)	($369,362)	($369,362.05)	($1,466,690)
Independent Quality Assurance	($353,000)	($353,000)	($264,750)	$0	$0	$0	$0	($970,750)
3rd Party for Disaster Recovery Services Build*	$0	$0	($200,000)	$0	$0	$0	$0	($200,000)
Disaster Recovery Services ($50,000 per mo.)	$0	$0	($300,000)	($618,000)	($636,540)	($655,636.20)	($675,305)	($2,885,481)
Contingency @ 20%	($555,934)	($712,707)	($453,904)	$0	$0	$0	$0	($1,722,545)
Indirect Costs (15%)	($500,341)	($641,436)	($408,514)	($159,591)	($164,137)	($167,153)	($170,255)	($2,211,426)
TOTAL COSTS	**($3,835,946)**	**($4,917,678)**	**($3,131,938)**	**($1,223,529)**	**($1,258,383)**	**($1,281,506)**	**($1,305,287)**	**($16,954,267)**
Cash Flow Summary								
Benefits/Gains	$0	$0	$691,478	$705,308	$719,414	$733,802	$748,478	$3,598,480
Costs (w /Indirect)	($3,835,946)	($4,917,678)	($3,131,938)	($1,223,529)	($1,258,383)	($1,281,506)	($1,305,287)	($16,954,267)
Net Cash Flow	($3,835,946)	($4,917,678)	($2,440,460)	($518,221)	($538,970)	($547,704)	($556,809)	($13,355,787)
Cumulative Net Cash Flow	($3,835,946)	($8,753,624)	($11,194,084)	($11,712,305)	($12,251,275)	($12,798,978)	($13,355,787)	($13,355,787)

8.1.3 Cost Worksheet for Alternative 3 – Maintain the Status Quo

	FY 2016-2017	FY2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	Grand Total
COST OF INEFFENCIES								
Notification/Distribution	$194,859	$200,705	$204,719	$208,813	$212,990	$217,250	$221,595	$1,460,930
Duplicate Data Entry	$422,132	$434,796	$443,491	$452,361	$461,409	$470,637	$480,049	$3,164,875
Reporting	$53,661	$55,270	$56,376	$57,503	$58,653	$59,826	$61,023	$402,312
System Limitations	$20,827	$21,452	$21,881	$22,318	$22,765	$23,220	$23,684	$156,147
TOTAL COSTS	$691,478	$712,223	$726,467	$740,996	$755,816	$770,933	$786,351	$5,184,264

8.2 Appendix B – Tentative Project Schedule



DHS
Oregon Department
of Human Services

DHS

Business Case

Department of Human Services
Integrated Eligibility Determination Project

VERSION LOG

Version	Description	Author	Date
1.0	Initial Draft	Karl Olmstead	11/24/2015
1.1	Revised based on feedback from Ed Arabas	Karl Olmstead	12/15/2015
1.2	Revised Draft preparing for Stage Gate 3 Submission Incorporated changes from Sarah's review	Karl Olmstead Karl Olmstead	07/05/2016 7/9/2016
1.3	Updated high-level requirements language. Finished M&O strategy section	Karl Olmstead	7/10/2016
1.4	Swapped in high-level requirements language to align with final SOW; expanded risk section and revised M&O strategy per SM	Karl Olmstead	7/12/2016
1.5	Added financial table attachment; revised cost numbers and narrative elsewhere; cleaned up for submission for QC review	Karl Olmstead	7/13/2016
1.6	Final edits; labeled final draft; awaiting final financial numbers only.	Sarah Miller	7/21/2016
2.0	Version for Stage Gate 2 Submission	Karl Olmstead	7/22/2016

SIGN-OFF

Version	Role	Name	Comments	Date

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1 Business Case Summary

1.1 Overview

Oregon's Department of Human Services (DHS) is preparing this business case as the foundation for determining whether and how to extend the Oregonligibility, or ONE system to include eligibility determinations for the Non-Modified Adjusted Gross Income (Non-MAGI) Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Employment Related Day Care (ERDC) programs.

This version of this business case is being prepared for consideration by the Office of the State CIO (OSCIO) and the Legislative Fiscal Office (LFO) in advance of their authorization to proceed from the planning phase of the project to project execution (Stage Gate 3). An earlier version of this business case (version 1.1, 12/15/2015) was reviewed and approved by OSCIO and LFO as they authorized the project to move from the initiation phase to the planning phase.

1.2 Background

Oregonians do not currently have the ability to apply for Non-MAGI Medicaid through a self-service portal via an on-line application. Additionally, while individuals currently may use an on-line application for Oregon's Supplemental Nutritional Assistance Program or with manual process supplementation for Temporary Assistance to Needy Families or Employment Related Day Care, the system supporting the application does not link to a benefit authorization system. DHS eligibility workers must engage in manual application processing activities, with little to no automation. Changes to regulations from federal agencies present challenges for eligibility workers when applying those regulations to each applicant's unique situation. DHS seeks to eliminate manual processing and the need to use legacy systems in support of Non-MAGI Medicaid, SNAP, TANF and ERDC eligibility determinations.

1.3 Opportunity Definition

The Oregon Health Authority (OHA), the state's designated Medicaid agency, recently implemented a new system for MAGI Medicaid eligibility determinations. That system is called Oregonligibility, or ONE, and is the result of transferring the State of Kentucky's Affordable Care Act compliant state-based marketplace solution (*kynect*) for use in Oregon.

In early 2016, Kentucky rolled out an extension to the system that OHA has transferred to Oregon. That extension will support eligibility determinations for the following programs:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance to Need Families (TANF)
- Low Income Home Energy Assistance Program (LIHEAP)
- Medicaid Waiver Management Applications
- Kentucky's Child Care Program

Given those system implementations, and given that the federal Centers for Medicare and Medicaid Services (CMS) has directed Oregon that it will only provide a 90/10 federal funding match for extending the ONE system, the time is clearly right to pursue extending ONE to

support Non-MAGI Medicaid eligibility determinations and eligibility determinations for other DHS Human Service programs too.

The high-level business objectives driving this effort are:

- Allowing applicants to apply for benefits on-line, reducing the need to travel to local offices and reducing the need to provide duplicate information when applying for benefits from more than one program
- Automating manual processes in order to:
    - Reduce the amount of time that elapses between completing an application and making an eligibility determination
    - Reduce the amount of time that staff must spend creating, reviewing, and acting on each application
    - Reduce the rates of errors in making eligibility determinations
- Allowing for seamless sharing of information and transfer of cases among program staff
- Compliance with federal funding program requirements to support programmatic operations.

On August 10, 2011, three federal agencies (Centers for Medicare and Medicaid Services (CMS), Food and Nutrition Services (FNS) and the Administration for Children & Families (ACF)) announced a time-limited, specific exception to the cost allocation requirements set forth in Office of Management and Budget (OMB) Circular A-87. These provisions generally require the costs associated with building shared state-based information technology systems to be allocated across all benefitting programs. The exception reflected a federal focus on streamlining enrollment in health and human services programs while leveraging funding efficiencies at the state-level. On July 20, 2015, the three agencies extended the exception for an additional 3 years, through December 31, 2018, and provided additional guidance on how states may take advantage of it to leverage these investments to better serve consumers' multiple programs and needs.

1.4 Alternatives Analysis

An earlier version of the business case for this project, which was prepared in advance of the state's Stage Gate 2 review, explored four broad alternative project approaches. They were:

1. Implement Non-MAGI Medicaid Eligibility Determination into the ONE System
   Under this alternative, the ONE system would have been extended to support Non-MAGI Medicaid eligibility determinations and service authorization to community-based care programs only.
2. Implement Integrated Eligibility Determination into the ONE System
   Under this alternative, the ONE system would be extended to support Non-MAGI Medicaid eligibility determinations and SNAP, TANF, and ERDC determinations, as well as service authorizations for community-based care programs.
3. Acquire External Eligibility Determination Services from another State
   Just like Alternative #1, this alternative would have extended ONE to support Non-MAGI Medicaid eligibility determinations only. Like Alternative #2, it would have supported eligibility determinations for the SNAP, TANF, and ERDC programs. However unlike Alternative #2, that support would have been outside of ONE. In this alternative, DHS would have contracted with another state to support SNAP, TANF, and ERDC eligibility decisions.

4. Do Nothing
   Under this alternative, there would be no additional investment in the ONE system and no acquisition of eligibility services from another state. Improvements to current processes would be limited to those that arise naturally through the DHS's continuous improvement program.

A full analysis and comparison of the costs, benefits, and risks of those alternative approaches is contained in that older version of the business case. Based on that analysis, DHS's executives selected Alternative #2.

This newer business case contains updated information about the costs and risks of the selected alternative, focusing specifically on developing a more complete and accurate estimate of the costs of designing, developing, implementing, maintaining, and operating the proposed system and the business processes that will depend on it. Those costs, benefits, and risks are compared only against the Do Nothing alternative.

The four-year total cost of ownership is estimated at $177.1 million, which includes $14.1 in maintenance and operations costs and a $163.0 million project cost. That project number includes certain additional operations costs that will occur between the time that the project begins rolling out the system to users and the end of warranty period. When these operations costs are characterized as part of the project, they become eligibile for a more attractive federal funding match rate.

This version of the business case explores alternative strategies for support of post-project maintenance and operations activities and recommends pursuit of a model wherein the system is initially supported primarily by vendor staff with a subsequent transition to a shared support model.

1.5 Conclusions and Recommendations

Development of an Integrated Eligibility Determination system continues to appear to be a desirable investment for Oregonians, for DHS and OHA, and for eligibility workers, particularly in light of the looming expiration of the OMB Circular A-87 cost allocation exception and the active support of our CMS and FNS partners.

Between December 2015 and July 2016, project planning activities and the Fit/Gap Analysis work has:

- Completed the identification and documentation of a complete set of system requirements to support the work of DHS's administration of Non-MAGI Medicaid, SNAP, TANF, and ERDC eligibility and OHA's administration of MAGI Medicaid eligibility.
- Documented the architecture, infrastructure, and security changes that will be required to extend ONE to support eligibility determination for Non-MAGI Medicaid, SNAP, TANF, and ERDC
- Developed a Business Transition Plan that establishes a roadmap for the policy, process, procedure, and organizational change that will be required to implementent and opereate the new system.

- Negotiated a tentative statement of work with the system integrator for design, development, and implementation services at a fixed price.
- Identified a post-project maintenance and operations strategy and developed cost estimates for that work.
- Developed a tentative work plan and schedule integrating both vendor and state tasks.

With those things in place, DHS has a more fully developed understanding of the scope, costs, benefits, and risks of undertaking the project. The project team continues to support extending ONE to support eligibility determinations made by DHS for its major programs. And it supports the model for Maintenance and Operations proposed in Section 4. The DHS leadership team concurs.

2 Background

2.1 Current State of DHS Eligibility Work

Most of the systems supporting DHS eligibility determination processes were designed and built in the 1970s and early 1980s. Many of these systems have been modified repeatedly to address the vast number of eligibility, service authorization, and payment rule and policy changes that have occurred since then.

One of the most common complaints from both clients and workers is the lack of integration between and across DHS systems, resulting in the need for the same information to be provided and entered into multiple DHS systems. Even though DHS offices are committed operationally to the overarching theme of “No Wrong Door,” that vision is difficult to realize due to the lack of system interoperability. Clients are frequently frustrated with having to provide the same demographic and financial information over and over when applying for different program benefits. Caseworkers are frustrated by the lack of client and case visibility across programs. That forces them to open many systems and juggle many views into those systems simultaneously as they interview clients and process cases. Oftentimes, they don’t have access to systems or parts of systems that are needed to support clients effectively.

2.2 Non-MAGI Medicaid Eligibility Operations

Department of Human Services (DHS) and Area Agencies on Aging (AAA) staff make more than 150,000 Non-MAGI Medicaid eligibility determinations every year. The Oregon Health Authority’s (OHA’s) Spring 2016 Forecast for the 2017-2019 Biennium forecasts these caseloads:

- Clients of Aged, Blind, and Disabled programs (83,738 cases during 2017-2019)
- Clients of the Old Age Assistance program(45,522 cases during 2017-2019)
- Clients of the Qualified Medicare Beneficiaries program (24,784 cases in December 2016)

Roughly half of those determinations are made by DHS staff in local offices of the department’s Aging and People with Disabilities (APD) program. The remainder are made by AAA staff in Marion, Polk, Yamhill, Tillamook, Clatsop, Multnomah, Lane, Linn, Lincoln and Benton counties. (Area Agencies on Aging are typically county-chartered organizations that provide assistance

and services for people over the age of 65 and people with disabilities who need assistance. In the Oregon counties listed above, the AAA delivers DHS's APD Medicaid program under contract with the department, including making initial and ongoing financial eligibility determinations.)

The Non-MAGI Medicaid eligibility caseload is projected to grow about 9 percent over the next four years. Without any improved efficiency in making eligibility determinations, the added case load will require at least 25 more eligibility workers to be hired, trained, and deployed across the state.

The process of taking applications, reviewing them, and making Non-MAGI Medicaid eligibility determinations is often expensive, slow, and error-prone. For example, recent measures of Non-MAGI Medicaid cases found workers spending an average of 28 minutes screening each application and taking another 110 minutes to make the eligibility decision. The department's 2013-2015 Statewide Review found error rates ranging from 4 percent to 44 percent for these cases.

2.3 Integrated Eligibility (SNAP, TANF, ERDC) Operations

DHS and AAA staff make approximately 130,000 Supplemental Nutrition Assistance Program (SNAP) eligibility determinations every year for APD program clients. (Those 130,000 households include roughly 155,000 individuals.)

DHS's Self-Sufficiency Program (SSP) staff make the remainder of the eligibility determinations for SNAP, and also make eligibility determinations for the Temporary Assistance to Needy Families program (TANF) and the Employment-Related Day Care program (ERDC). The SSP caseload for those programs is:

- SNAP: ~305,000 households (~620,000 individuals)
- TANF: ~30,000 cases
- ERDC: ~7,700 cases

The Spring 2015 DHS | OHA Caseload Forecast predicts a modest decline in SNAP cases for 2015 to 2017 (from roughly 435,000 households to 420,000 cases). It notes continuing growth in the proportion of SNAP cases that are managed in APD/AAA offices. It projects a similar rate of decline in the number of TANF cases and small increase in the number of ERDC recipients.

Errors occur in these programs, too. The most recently available internal quality control review data for the SNAP program found that in a sample of cases where applicants were determined to be ineligible, that decision was wrong more than 19 percent of the time. In a sample of SNAP-eligible cases, the difference between the benefit amount awarded and the correct amount averaged a little less than 3 percent of the benefit amount. (Some errors were overpayments. Others were underpayments.) In the TANF program, the difference between the amount awarded and the correct amount exceeded 28 percent of the benefit amount.

2.4 Technology Limitations

The DHS technology environment is laden with risks due to the age of these systems, their limited interoperability, and the difficulty of maintaining them to keep up with federal policy changes. Eligibility data are often duplicated in multiple, unintegrated systems and are not

readily shared among the many programs and systems that process service authorizations and provider payments resulting in additional errors or delays in case processing. A good example of this is cases where a worker in an APD/AAA office evaluates a client's eligibility for medical assistance and SNAP and determines the client is SNAP-eligible only. This case will be referred from the APD/AAA office to an SSP office for ongoing case management. The information system used in the APD office (OregonAccess) does not have an interface to the system used in the SSP office (TRACS) so data must either be transferred with a cut-and-paste operation, re-entered from a paper application, or collected from the client all over again.

Case transfers in the opposite direction (from an SSP office to an APD or AAA office) are also problematic. Anecdotal reports include times where these transferred cases went unnoticed for three to six months. Other reports noted that the likelihood of fraud increases when a household is split between an SSP branch and an APD/AAA branch due to the absence of connections between the systems.

Similar, and often more complicated, coordination problems arise for clients of the Intellectual and Developmental Disabilities (IDD) program. The case managers who provide case coordination for long term care or support in the IDD program are predominantly employees of local county-run Community Developmental Disabilities Programs (CDDP) and Adult Support Service Brokerages. While these offices are under contract with the Department to provide case coordination for IDD services, they do not manage the Medicaid financial eligibility case for their clients. This leaves clients and their families in a position of having to contact and work with the APD or AAA branch closest to their home location. Because service cases are managed in multiple legacy systems, which differ from the systems in which the medical eligibility cases are managed, complex and time-consuming human intervention is required to assure both medical and long-term service benefits are maintained and managed correctly.

Additionally, the retirement age of legacy system staff is nearing or has past, and the ability to recruit qualified resources to replace them is quite difficult. This resource constraint makes it difficult to maintain legacy systems on a go-forward basis and increases the risk of inability to recover from a catastrophic failure of the legacy system.

2.5 Lessons Learned from Previous Attempts at Integrated Eligibility Determination System Development

In recent years, DHS tried more than once to develop an on-line, automated eligibility system. The approach in those attempts included purchasing technology for a rules-based eligibility system, and building that system from the ground up, specific to Oregon's unique eligibility and business process requirements. Those attempts were unsuccessful.

Through those failed attempts and through the successful experience at the current OHA MAGI Medicaid Transfer Project, DHS has learned that transferring a system that is already working in another state, and making only mandatory functionality changes will significantly increase the likelihood of project success. The process being proposed for the Integrated Eligibility Determination Project will capitalize on the lessons learned from successful and unsuccessful eligibility determination automation projects, including, but not limited to, the following:

- Establish clear, defined governance process

  - Ensure appropriate information is available for Executive Leadership decision making
  - Define a process for collaborative decision making inside of DHS (APD vs SSP) and define an issue escalation process
  - Define a process for overall system governance in collaboration with OHA
  - Define a governance process between business program areas and IT
  - Ensure right people are at the table for project – from decision makers down to project staff (best people for project are vital resources to other parts of the agency)

- Spend sufficient time planning in support of project objectives
  - Define a shared vision of the project's objectives from Agency Leadership
  - Remember to focus on customer needs; when choice exists between meeting an agency need and providing a customer benefit, choose the customer
  - Balance the number of voices for initial decisions with buy-in by others later; keep the requirements definition group lean and establish vetting sessions with broader audiences

- Architecture & Technology
  - Use technology already in place whenever possible
  - Limit the number of technical changes to base system in a transfer project

- Change Management
  - Follow a defined methodology for organizational change management; use experts to supplement business expertise and experience
  - Ensure business leaders own change management and act as translator between project, IT, and operations, focusing on getting users ready for system

- Communication Management
  - Dedicate communication professionals to the project

- Financial Management
  - Develop accounting procedures that align with the cost allocation methodology

- Scope Management
  - Minimize changes to the transfer system; be willing to change policy & business process before making technology change
  - Set scope & stick to it; use a defined scope management process for changes

- Schedule Management
  - Balance timely decision making with substantive analysis
  - Set realistic expectations for project staff workloads; the project should be a marathon, not a sprint

- Vendor Management
  - Define partnership between vendor & business in order to get project accomplished using defined roles & responsibilities
  - Remember the business has ultimate authority in places of conflict with the vendor

3 Opportunity Definition

3.1 OHA's MAGI Medicaid Eligibility System

3.1.1 Transfer System from Kentucky

The Oregon Health Authority (OHA), the state's designated Medicaid agency, recently implemented a new system for MAGI Medicaid eligibility determinations. That system is called Oregoneligibility, or ONE, and is the result of transferring the State of Kentucky's Affordable Care Act compliant state-based marketplace solution (*kynect*) for use in Oregon. Originally built in Kentucky by Deloitte Consulting, *kynect* operated as the MAGI Medicaid eligibility determination system of record for more than a year before OHA signed an agreement with the Kentucky Cabinet for Health & Family Services to transfer the code and associated documentation to Oregon. The code has been installed on servers at Oregon's State Data Center and is operated as a production system from that location. The ONE system will be used by OHA to make approximately 900,000 individual MAGI Medicaid eligibility determinations and redeterminations each year.

OHA accepted the *kynect* production system as meeting the bulk of its business needs and therefore made very few technical changes to the system, instead focusing on making policy and process changes to its business wherever feasible in order to minimize the risk with the initial system implementation in Oregon.

3.1.2 Phased Implementation

OHA implemented the ONE system in phases. First, in December 2015, it enabled the Worker Portal for use by eligibility workers to determine MAGI Medicaid eligibility for applicants who submit an application by mail, fax, phone, or through the Federally Facilitated Marketplace (FFM) at the federal Healthcare.gov.

In February 2016, it implemented a customer facing Applicant Portal, initially limiting access to certain community partners that help Oregonians for MAGI Medicaid benefits and report changes in circumstance. The Applicant Portal will be made broadly accessible to Oregonians late in the summer of 2016. The Applicant Portal allows Oregonians and community partner assistorsto enter and update income, family composition, address and other eligibility-related information, upload documents, communicate with workers assigned to their cases, and participate in re-certification activities, all without having to fill out paper forms, visit a field office, or contact a call center.

3.1.3 ONE Benefits & System Functionality

Key benefits of the ONE System include:

- Better coordination of care for mixed household families because applicants complete a single application through the HealthCare.gov website or within the ONE system to receive an eligibility determination for MAGI Medicaid/CHIP or private health insurance
- Oregonians can set-up an account, report changes and receive real-time eligibility determinations via the user-friendly Applicant Portal
- Simplified OHA eligibility workload via an automated process that generates tasks for case management

- Centralized and verified enrollment data available for Coordinated Care Organizations
- Consistent high quality data source for reporting CMS-mandated operational statistics

ONE System Functionality includes:

- Workflow automation using task queues inside the Worker Portal
- Automated business rules using Corticon Rules Engine – including real time eligibility determination to support the Applicant Portal
- Automated notice generation using HP ExStream
- Address validation service using Melissa Data
- Automated verification interfaces with the Federal Data Services Hub, the state Medicaid Enrollment System (MMIS), and the Oregon Employment Department
- Automated Bi-Directional Account Transfer with the FFM & Minimum Essential Coverage check for Medicaid benefits
- Integration with the existing document management service provided by DHS Imaging and Records Management System
- Integration of Computer Associates Identity & Access Management Solution to provide single sign-on integration with OHA's Active Directory

3.2 Federal Partnership

3.2.1 A-87 Cost Allocation Exception

On August 10, 2011, three federal agencies (Centers for Medicare and Medicaid Services (CMS), Food and Nutrition Services (FNS) and the Administration for Children & Families (ACF)) announced a time-limited, specific exception to the cost allocation requirements set forth in Office of Management and Budget (OMB) Circular A-87 (Section C.3) and Section 200.405 of the superseding "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards" (2 CFR 200 issued December 19, 2014). These provisions generally require the costs associated with building shared state-based information technology systems to be allocated across all benefitting programs. The exception reflected a federal focus on streamlining enrollment in health and human services programs while leveraging funding efficiencies at the state-level.

3.2.2 Timeline Extension

The original timeline allowed human services programs to benefit from investments in the design and development of state eligibility-determination systems for state-operated Marketplaces, Medicaid, and the Children's Health Insurance Program (CHIP), through December 31, 2015. On July 20, 2015, the three agencies extended that timeline for an additional 3 years, through December 31, 2018, and provided additional guidance on how states may take advantage of the exception and the extended timeframe to leverage these investments to better serve consumers' multiple programs and needs.

The underlying premise for the waiver remains the same: to maintain the progress states have made, and to promote further integration. This will enable states like Oregon that experienced unanticipated delays with the development of the Medicaid Modified Adjusted Gross Income (MAGI) functionality in their eligibility systems, procurement challenges, and other unforeseen barriers to complete that work and then effectively use the waiver extension to streamline their

eligibility systems, improve access to health and human service programs, and maximize efficiency.

The extension of the exception to certain OMB cost allocation requirements, along with a proposed indefinite extension of enhanced Federal funding for Medicaid systems, will enable states to fund the initial development costs needed to retire their legacy eligibility determination systems and integrate their functionalities into improved systems. Moreover, the extension will provide states more time to develop, refine, or test integrated systems to fully comply with Affordable Care Act requirements.

3.2.3 Oregon's Discussion with Federal Partners

In 2015, CMS approved moving ahead with the development of automated Non-MAGI Medicaid eligibility determination capability. In that approval, CMS directed DHS to extend the ONE system, saying CMS would not provide enhanced funding for the development of more than one eligibility determination system.

Since that time, DHS has held discussions with all three federal partners. Each has indicated that it is on board supporting the development of a fully integrated eligibility determination system. In support of DHS' Integrated Eligibility Determination Project, CMS will fund all system components necessary for Medicaid eligibility determinations, including those components that also serve other programs, at its 90/10 match rate. FNS will fund SNAP-only components at its 50/50 match rate, and ACF will allow the state to devote TANF and ERDC funds to support the development of components that were confined to those programs.

CMS and FNS approved federal fiscal year 2016 funding for project planning work and the beginning of design, development, and implementation work. CMS and FNS also approved contracts associated with a Fit/Gap Analysis on which project planning depended. DHS has begun monthly status reports and status meetings with its federal partners.

3.3 Kentucky's Integrated Eligibility/Service Delivery System

3.3.1 Overview

Kentucky's Cabinet for Health & Family Services (CHFS) embarked on an ambitious Information Technology modernization program to replace a collection of legacy systems that supported Health and Human Services programs. The cabinet's goal was to modernize Information Technology (IT) solutions to improve delivery of services and increase worker productivity, through maximizing the funding opportunities available from Affordable Care Act and CMS 90/10 funding. The modernization program included implementation of a state-based Health Insurance Market place, an integrated eligibility and enrollment system, and several other enterprise IT capabilities. The cabinet is poised to achieve the following as a direct result of the modernization program:

- **Streamlined Field Operations**– Increased worker productivity, simplified process steps, reduced case processing cycle times, and reduction in total administrative costs of delivering benefits.

- **Transformed Service Delivery** – Transformed service delivery, providing multiple channels of access (walk-in, online, mail, call centers, fax, mobile, imaging, etc.), and interactive processing across geographic units.
- **Program Compliance and Monitoring of Fraud and Error** – Flexibility for worker performance while maintaining strict adherence to program mandated compliance through checkpoints and controls for measurement and proactive response.

3.3.2 Medicaid and Human Services Eligibility and Enrollment Release Summary

The table below describes the evolution of the non-state based marketplace functions in the *kynect* system to become an integrated eligibility determination system that extends the current production functionality to support all Human Services programs.

Release	Functionality	Go-Live Date
3	• Worker Portal: Case Management Module • Admin Module supporting MAGI Medicaid	December 16, 2013
4	OHA transferred the Release 4 code, the foundation of the ONE system, in March 2015 • E&E System supporting all remaining Medicaid programs • Quality Control • Quality Assurance • Redetermination • Renewals • Appeals • Complaints & Fraud	June 30, 2014
4A	• Registration and Assessment, Eligibility and Enrollment, Individual Service Plan, Case Management, Interim Provider Management, Operational Reports – Part 1, Integration with Kentucky's security solution, Master Client Index and Document Management System • Integrated Rules Driven Assessment, Consumer Self Service, Consumer Directed Option, Waiver Eligibility Integration, Interest List, Incident Management Portal, Operational Reports – Part 2	April 17, 2015

Release	Functionality	Go-Live Date
5	Kentucky calls its Release 5 "*benefind*" rather than *kynect* • New Human Services Programs o SNAP o TANF o Low Income Home Energy Assistance Program (LIHEAP) o Medicaid Waiver Management Application (MWMA) Integration o Kentucky's Child Care Program • New supporting functionalities o Managed Care Enrollment management o Quality Assurance & Quality Control o Business Intelligence o Comprehensive Task Management	February 2016

3.3.3 kynect becomes benefind

The Kentucky state-based marketplace preferred to have *kynect* have the look and feel of searching for private insurance rather than state programs, so it developed a separate applicant portal for other human service programs and called it benefind. Key application components in the *kynect/benefind* system for integrated eligibility determination are described in the following table.

Title	Description
Worker Portal	Module used by the State Agency workers to collect individual/family information to process SNAP, TANF, and/or Medicaid applications. Individuals can apply for one or more programs in a single application, and the module has a capability to interactively ask questions during the interview process based on the programs applied. Throughout the interview process, the modules call interfaces to verify information, as needed.
Eligibility Determination (Rules engine)	Rules base eligibility determination module to determine eligibility for main program and the sub programs to provide best possible benefits for the applicants. For example, when an individual applies for Medicaid, the rules engine cascade down through the Medicaid program hierarchy to provide best Medicaid coverage for the individual.
Benefit Issuance	This module manages daily or monthly issuances for SNAP/TANF/ERDC programs that are issued to individuals/vendors to support initial, monthly or supplemental payments.

Benefit Recovery	This module provides end to end management of SNAP, TANF, ERDC claims. It computes discrepancy, establish claim and start recoupment either through the benefit reduction process or other processes such as tax intercept.
Correspondence	This module manages generation of consolidated correspondences that are issued to the applicants and other stakeholders like vendors.
Task Management	A comprehensive task management module that supports key business processes. The module allows management of human services case management functions as a coordinated set of tasks.
Quality Assurance and Quality Control (QA/QC)	Module to create Random/Targeted sample universes for worker to review SNAP, TANF and Medicaid cases
Hearing/Appeals	Implements end-to-end work flows to support the hearings and appeal process. This module is also integrated with task management module.
Business Intelligence/Management Reports	This module implements operational reports, analytical reports and provides the framework and infrastructure required for several adhoc reporting needs.
Authentication and Identity proofing service	System for authorization and authentication services for users requesting access to various modules of the system.
Document Management Services	Implements electronic case files functionalities where all documents submitted to the agency are indexed and filed for easy access.
Mobile and Tablet Application	Mobile app with full application features for citizens, community partners (application assisters) to apply for health coverage
Self Service Portal for Human Service programs	Self Service Portal for citizens to apply for SNAP, TANF and Medicaid programs.
Medicaid Waiver Management Application (MWMA)	A complete waiver workflow management module to determine eligibility for Medicaid waiver programs and enrollment into waiver services.
Master Client Index module (MCI)	Master client index module which uniquely identifies citizens. It also provides a 360 degree view of citizen enrolled in public assistance program(s).
Interfaces	Implements all required State & Federal Interfaces. Interfaces module also implements an integration framework that supports several integration patterns.
Medicaid Managed Care Enrollment Management	Module for auto assignment and management of Medicaid enrollees in managed care plans (MCOs)

3.4 Oregon's Department of Human Services' Opportunity

Given the implementation of Kentucky's benefind system and Oregon's ONE system, and given that CMS has directed Oregon that it will only provide a 90/10 funding match for extending the ONE system, the time is clearly right to pursue extending ONE to support Non-MAGI Medicaid

eligibility determinations and eligibility determinations for other DHS Human Service programs too.

3.4.1 Citizen Expectations

Today's consumers increasingly communicate in real time via web-based services accessed from virtually anywhere. Technological advances and experiences in consumer marketplaces have resulted in DHS customer expectations that are much higher than they were just a few years ago. Citizens expect to be able to access information about government programs simply and quickly. They expect to be able to find information and connect with programs without needing to first figure out which programs and benefits are administered by which agencies and levels of government. Some are beginning to demand virtual "one stop shops" where they can connect with government programs from all of the agencies that serve people in circumstances like theirs. They expect to access benefits and services without having to report physically to a field office or having to fill out paper forms. And they expect on-line government services to set and meet the highest possible standards for security, confidentiality, and data privacy.

In a 2013 survey, 88 percent of DHS customers indicated they would apply for services on-line if that option were available. Another 10 percent said they were somewhat likely to apply on line. In the same survey, respondents rated accuracy and clear communications as high priorities, and did not prioritize talking with a specific worker or another worker who knew their specific case.

Recent DHS surveys of customer satisfaction reveal that DHS customers are satisfied with the services they receive 83 percent of the time. This satisfaction score could increase by providing DHS customers with an on-line, one stop portal for access to DHS services. Additionally, this project will result in the ability for customers to self-serve not only in the initial application process, but also for information updates throughout their certification period and at re-certification. Customers will be provided with an alternate way to communicate with their eligibility case workers without having to stand in line at a field office, or wait on-hold on the phone.

3.4.2 Human Service Eligibility Program Comparison – Kentucky to Oregon

As part of evaluating the feasibility of transferring an integrated eligibility system, DHS compared Kentucky's and Oregon's SNAP, TANF, and ERDC programs. As evident in the tables below, the programs are similar in their overall business requirements.

3.2.2.1 Supplemental Nutrition Assistance Program

Program Eligibility Comparison for Supplemental Nutrition Assistance Program

Eligibility Criterion	Kentucky Supplemental Nutrition Assistance Program	Oregon Supplemental Nutrition Assistance Program
Family Composition and Residency	• Recipients must live in Kentucky • Recipients must be U.S. citizens or certain legal foreign residents of the United States • A household is any person, family or group of people who live and buy and eat food together • The following people must be included in one household account, regardless of whether they purchase and prepare meals separately: o A spouse of any household member o Parents living with their natural, adopted or stepchildren who are age 21 or younger o Children younger than 18 who are dependents of an adult household member	• Recipients must live in Oregon; does not require intent to remain to establish residency • Recipients must be U.S. citizens or certain legal foreign residents of the United States • Filing group consists of members of a household group who choose to apply together or customarily purchase and prepare meals together • The following people must be included in one household account, regardless of whether they purchase and prepare meals separately: o A spouse of any household member o Parents living with their children who are under the age of 22 o Children younger than 18 who are financially dependent of an adult household member
Income	• Less than 130% of FPL for most households; 165% for elderly/disabled	• Less than 185% of 2015 FPL
Resources	• A household may have no more than $2,000 in assets OR $3,250 if a member of the household is 60 or older • Cash and bank accounts are counted; the dwelling, its contents and personal belongings, and vehicles are excluded	**Non-Categorically eligible households** • Have a resource limit of no more than $2,250 in resources OR $3,250 if a member of the household is 60 or older or disabled • Checking accounts, saving accounts, cash on hand, stocks and bonds, equity in vehicles, real property, etc., are counted. **Categorically eligible households** • Have a resource limit of $25,000 in liquid assets (checking accounts, savings accounts, cash on hand)
Employment	• Anyone in a household who is 16 to 60 years old and can work must register for, look for, and accept work. There are some exceptions to this requirement.	**OFSET (Employment and Training)** • Clients deemed mandatory because they do not meet an exemption must participate in a jobs activity for an eight week period every 12 months • Must accept bona fide offers of employment, even if it's part-time

		ABAWDS (Abled Bodied Adults without Dependents) • Only applicable in Multnomah and Washington counties, as the rest of the state is under a waiver • Requires those aged 18-49 without a filing group member under the age of 18, who do not meet an exemption, to participate a minimum of 20 hours a week, an average of 80 hours a month of special work requirements
Benefits	• Benefits are issued on an Electronic Benefit Transfer (EBT) card • The benefit amount depends on income and household size. • Benefits may be used to purchase almost any food item, except ready-to-eat hot foods • Benefits may be used to buy seeds and plants to grow fruits and vegetables • Benefits may not be used to buy tobacco, alcohol, pet food, soap and other household products, medicines, and other non-food items	• Benefits are issued on an Electronic Benefit Transfer (EBT) card • The benefit amount depends on income, household size and minus any applicable deductions • Benefits may be used to purchase almost any food item with a nutrition label, except ready-to-eat hot foods • Benefits may be used to buy seeds and plants to grow fruits and vegetables • Benefits may not be used to buy tobacco, alcohol, pet food, soap and other household products, medicines, and other non-food items • There is a cash out program in Multnomah, Washington, Columbia and Clackamas Counties for seniors and people with disabilities
Certification Periods	• Varying lengths of certification periods depending on household characteristics • Periodic reports required at least once every six months, except for elderly or disabled (12 months)	• Varying lengths of certification periods depending on household characteristics • Periodic reports required at least once every six months, except for elderly or disabled (12 months)
Deductions	• Utilizes Standard Utility Allowance (SUA) instead of actual utility costs.	• Utilizes Standard Utility Allowance (SUA) instead of actual utility costs

Other	• Students are ineligible unless working 20 or more hours per week or have a child under age 6 or are a single parent of a child under age 12 and going to school full time • Must meet with a worker or do interview over the phone. Must be able to provide identification, social security numbers for everyone applying, proof of who lives in your home (can be written statement), proof that you live in Kentucky, proof of child care costs or child support paid, proof of living expenses, and proof of money you have received in the past 60 days, including pay stubs. • For ineligible non-citizens, income and deductions are prorated for both groups, which includes counting all income and deductions, or a prorated share. As well as, counting none of the income and deductions (with the allotment capped at the level that an all-eligible household would get), or a prorated share. • May disqualify applicants or recipients who fail to perform actions required by other means-tested program, primarily TANF.	• Students aged 18 to 49 attending a higher education program that requires a diploma or GED at least half time must meet additional special criteria • Must meet with a worker or do interview over the phone. Must be able to provide identification, social security numbers for everyone applying, verification of income for recent representative month, and for non-citizens proof of lawful immigrant status of each household member seeking benefits • For ineligible non-citizens, income and deductions are prorated for both groups, which includes counting all income and deductions, or a prorated share. As well as, counting none of the income and deductions (with the allotment capped at the level that an all-eligible household would get), or a prorated share. • May disqualify applicants or recipients who fail to perform actions required by other means-tested program, primarily TANF.

3.2.2.2 Temporary Assistance for Needy Families

Program Eligibility Comparison for Temporary Assistance for Needy Families

Eligibility Criterion	Kentucky Temporary Assistance for Needy Families	Oregon Temporary Assistance for Needy Families
Family Composition and Residency	• Recipient must be a US citizen • Family must have a child under 18 living in the home OR Pregnant woman must be within one month of her due date • Children must be citizens or have eligible alien status • Children must be 18 years old or younger OR Children must be full time student with expected graduation date before age 20	• Recipient must be a US citizen or have qualified non-citizen status (may be waived temporarily if domestic violence is a factor) • Family must reside in Oregon • Family must have a caretaker relative and a child under 18 living in the home OR Pregnant woman must be within one month of her due date (may be earlier if domestic violence is a factor) • Caretaker relative must meet certain blood, adoption, marriage relationship requirements • Children must be citizens or have qualified non-citizen status • Children must be under 18 years old OR 18 years old and a full-time student in HS or GED • Until March 2016, a child must be deprived of parental support due to continued absence, incapacity, or under/unemployment
Income	• Your family must earn less than a certain amount of money per month	• To qualify for TANF, families must have very few assets and little or no income. • Your family must earn less than a certain amount of money per month
Resources	• Countable assets must be $2,000 or less and licensed vehicles needed for individuals subject to the work requirement may not exceed $8,500	• Countable assets must be $2,500 or less for applicants, for individuals in sanction status, and for families with no caretaker relative in the need group • Countable assets must be $10,000 or less for all other recipients • Exclude up to $10,000 equity value of all motor vehicles; remaining equity counts toward asset limit • Applicants and recipients must pursue alternative assets available to them • Applicants and recipients must assign their support rights to, and cooperate with, child support

Employment	• Adults in families receiving cash assistance must work or participate in work related activities for a specified number of hours per week depending on the number of work-eligible adults in the family and the age of children	• Adults in families receiving cash assistance must work or participate in work-related activities for a specified number of hours per week depending on the number of work-eligible adults in the family, the age of children, and the family situation • Caretaker relatives must not be separated from their most recent employment due to discharge without good cause, or due to voluntarily quitting without good cause • Needy caretaker relatives must complete an employability screening
Benefits	• The current maximum monthly benefit for a family of 3 with a monthly gross income of $974, is $262	• The current maximum monthly benefit for a family of three is $506.
Certification Limits	• A family may receive benefits for no more than 60 total months. The 60 months needs not be consecutive	• Eligibility must be recertified every 6 months for families who have an open JOBS plan and are not participating or an active JOBS disqualification OR Eligibility must be recertified every 12 months • Recertification may be done earlier if deemed necessary by the case manager or to align with SNAP benefits • Heads of household may receive benefits for no more than 60 total months. The 60 months need not be consecutive. There are hardship exemptions that can stop the clock or extend benefits beyond 60 months. Children are not subject to the time limit.
Other	• Recipient must have a social security number	• Recipient must have a social security number

3.2.2.3 Employment-Related Day Care

Program Eligibility Comparison for Employment-Related Day Care

Eligibility Criterion	Kentucky Child Care Assistance Program	Oregon Employment-Related Day Care Program
Family Composition and Residency	• Recipient must be resident of KY • Child must be a U.S. citizen or a qualified alien • Child must be under 13 or be 13-19 and physically or mentally incapable of self-care • Recipient must be parent by blood, by marriage, or by adoption, or recipient must be the legal guardian or standing *in loco parentis* in relationship to child	• Recipient must be a resident of OR • Child must be a U.S. citizen or qualified non-citizen (includes non-citizens who are at risk for, or currently the victim of domestic violence, and victims of severe trafficking) • Child must be under 12 or be 12-17 and receiving care due to special circumstances and needs • Recipient must be a parent or caretaker who has care, control, and supervision of the dependent child (not required to be a relative)
Income	• Less than 150% of 2011 FPL (On-line calculator considers earned income, net child support, social security, TANF, and "other sources")	• (At initial certification) Less than 185% of 2015 FPL (Application asks for all sources) • (On-going and at recertification) Less than 250% of FPL and less than 85% of the state median income
Resources	• No requirement	• No requirement
Employment	• Must be employed and average at least 20 hours per week for a single parent or average 40 total hours per week for a couple OR A teen parent attending high school or pursuing a GED OR Participating in the Kentucky Works Program OR Have a child protective or preventive services authorization	• Must be employed (no minimum number of hours) and if a couple, both must work and schedules must overlap (unless one parent cannot provide care due to a verified medical condition) Oregon does not cover teen parents attending high school or pursuing a GED, participants in an Oregon employment program, or parents who have children in protective or preventive services authorizations.
Benefit	• The program pays the provider's bill—less a copay—up to a maximum rate that depends on the age(s) of the child and the provider type • Recipient pays a copay that depends on income plus any part of the provider's rate that exceeds the maximum rate	• The program pays the provider's bill—less a copay--up to a maximum rate that depends on the age(s) of the child, provider type, location, and special care needs • Recipient pays a copay that depends on family size and income plus any part of the provider's rate that exceeds the maximum rate

Other	• Must use a provider that is licensed, certified, and registered	• Must use a provider that meets DHS requirements (includes licensed and licensed exempt providers)

3.4.3 HB 2219 – Single Streamlined Application for Human Service Programs

HB 2219 requires DHS to convene a work group consisting of "human service agencies" to study how to create a consolidated application process. This consolidated application will allow people to apply for and obtain assistance in accessing food, housing, medical care, education, employment services, child care and other social services. A consolidated application process is expected to: 1) decrease the time an applicant spends filling out similar paperwork for different programs, 2) decrease the time agency staff spends processing paperwork, and 3) reduce the burden on applicants to navigate their own way through an often complex system of programs.

HB 2219 names these agencies as "human service agencies":

- Department of Human Services
- Housing and Community Services
- Oregon Health Authority
- Department of Education
- Office of Child Care
- Higher Education Coordinating Commission

The bill goes on to say that DHS will convene a work group with staff from these agencies, the Office of the State Chief Information Officer, and others whom the department deems necessary to study how to create a consolidated application process. HB 2219 also directs the work group to submit recommendations to the Legislative Assembly. The recommendations must include proposals ensuring that all human service agencies have necessary access to client records, while ensuring that the information is used only by authorized persons and only for the purpose of facilitating the client's access to needed services. The report to the Legislature is under development and due by September 15th, 2016.

An integrated eligibility system will better position DHS for the likely recommendations of that work group.

3.4.4 DHS Field Operations Efficiencies

A fully integrated eligibility system will extend gains in efficiency and accuracy to the SNAP, TANF, and ERDC programs. It will improve integration between DHS's Non-MAGI Medicaid program and OHA's MAGI Medicaid program, and it will improve integration and the case transfer process among DHS programs. Simplifying these handoffs will help to maintain continuity of benefits and prevent client needs from slipping through the cracks.

Eligibility decisions will occur in a more timely fashion with the delivery of an integrated eligibility system. Workers will not be downloading paper applications, manually entering information into multiple screens from paper, and performing manual verification checks in multiple systems,

resulting in fewer processing errors and greater integrity of the data in the system. Accuracy of eligibility decisions and benefit amounts will also increase with automation of these activities.

A new system will better meet client expectations about speed, accuracy, and ease of use, based on their experiences with other on-line services. The system will give Oregonians the flexibility to apply for benefits in the manner most appealing to them, and they will be able to make immediate, real-time changes to information about their circumstances, completing these actions either on-line, via telephone, or in person in a field office in their local community. They will have 24-hour access to information about the status of their eligibility cases. The ability for customers to update their own personal information, with automated processing of those updates, will save worker time in the DHS offices. It will also allow for more efficient communications between workers and their assigned customers, with the ability for customers to email their worker at any time a day with information or questions about their case.
Staff in DHS and AAA offices will be able to get back to spending more time with people, assisting them with their needs, and less time with paper processes and files. Additionally, DHS staff who are serving customer needs in their own homes, or places of residence, will be able to access information from those locations and update information. This allows for the worker to save time once they are back in the office, as the updates will already be complete. They will no longer have to upload and update information upon returning to the office.

3.4.5 Alignment with DHS/OHA Strategic Technology Plan

The DHS/OHA Strategic Technology Plan (STP) includes a number of strategies that the Integrated Eligibility Determination Project will support. Strategy #1 in that plan is titled Business Automation and calls for the automation of workflows, decision-making, and business rules while reducing manual, paper-based processes. This project will automate workflows and the application of business rules in each of the programs within its scope. Strategy #2, Dynamic Needs Supported by Seamless Services, is well supported if the project includes a number of programs in its “one stop shop” for citizens. Similarly, an integrated eligibility system will advance us in pursuit of Strategy #5, which calls for assembling a “comprehensive view of clients.” Finally, the STP calls for enabling connectivity “anytime, anywhere,” encouraging the development of on-line self-service capabilities for clients and mobile virtual workplaces for agency staff. An integrated eligibility determination system will do just that. The table below summarizes the various components of the STP that an integrated eligibility system will satisfy.

Comprehensive View of Clients	o Supports use of a master client record o Single location for verified client data (e.g. financial, eligibility, benefit etc.) o Facilitate future view of an integrated case and payments through integration with legacy case management and payment systems
Trusted Sources for Health & Human Service Data	o Reduce data duplication and entry into multiple systems through single application for various programs. o Reduce data inconsistencies and inaccuracies through workflow automation o Trusted source for verified client data (e.g. financial, eligibility, benefit etc.) o Improve data access and data share across programs through integration with other DHS systems. o Role based data access and security improves data protection and compliance.

	o Consistent and accurate data reporting and analysis o Field-level audit and reporting capabilities
Business Automation	o Automated workflows using task queues inside the Worker Portal o Automated decision making and business rules using the business rules engine o Reduced manual and paper based processes o Real time determination of eligibility and benefit amount o Automated verification of client information o Interface with legacy systems
Connectivity Anytime, Anywhere, in Multiple Ways	o Applicant and worker portal allows real-time, 24/7 access to application, eligibility, and benefit information. o Clients can apply, update information, report change in circumstances, and communicate with their assigned case workers through multiple channels. o Multiple device and browser agnostic capability supports connectivity from anywhere
Dynamic Needs Supported by Seamless Services	o Industry best practices and standards based modular architecture and design (e.g., Service Oriented Architecture (SOA), Enterprise Service Bus (ESB) etc.) enables to leverage existing functionality and also expose functionality through web services

3.5 Project Objectives

DHS believes pursuing an Integrated Eligibility Determination Project makes sense. The high-level business objectives driving this effort are:

- Allowing applicants to apply for benefits on-line, reducing the need to travel to local offices and reducing the need to provide duplicate information when applying for benefits from more than one program
- Automating manual processes in order to:
    - Reduce the amount of time that elapses between completing an application and making an eligibility determination
    - Reduce the amount of time that staff must spend creating, reviewing, and acting on each application
    - Reduce the rates of errors in making eligibility determinations
- Allowing for seamless sharing of information and transfer of cases among program staff
- Compliance with federal funding program requirements to support programmatic operations.

3.6 Success Criteria

Project success will be measured both in terms of the improvements it provides to Oregonians, to DHS, and to eligibility workers, and in terms of the degree to which the project establishes scope, quality, budget, and schedule expectations and then delivers on those expectations.

3.6.1 Integrated ONE Benefits & System Functionality

Key benefits of the Integrated ONE System include:

- Oregonians can set-up an account, apply for and receive real-time eligibility determinations for Medicaid (both MAGI and Non-MAGI), SNAP, TANF, and ERDC using a single application via the user-friendly Applicant Portal
- Coordination of eligibility determination work between OHA and DHS for mixed households
- Electronic verification information sources minimize documentation that the client will be required to provide
- Operational reports that will allow for workload management across eligibility determination caseloads
- Single system for eligibility determination data for accurate reporting to federal partners
- Centralized and verified enrollment data available for Coordinated Care Organizations for MAGI & Non-MAGI clients
- Consistent high quality data source for reporting CMS-mandated operational statistics

Integrated ONE System Functionality includes:

- Workflow automation inside the Worker Portal
- Automated business rules using Corticon Rules Engine – including real time eligibility determination to support the Applicant Portal
- Automated notice generation using HP ExStream
- Address validation service using Melissa Data
- Automated verification interfaces with the Federal Data Services Hub, the state Medicaid Enrollment System (MMIS), and the Oregon Employment Department
- Automated Bi-Directional Account Transfer with the FFM & Minimum Essential Coverage check for Medicaid benefits
- Integration with the existing document management service provided by DHS Imaging and Records Management System
- Integration of Computer Associates Identity & Access Management Solution to provide single sign-on integration with OHA's Active Directory

3.6.2 Key Performance Indicators: Measures of Business Success

The following Key Performance Measures are routinely collected by DHS's Performance Excellence Office. Implementation of a new Integrated Eligibility system is expected to "move the needle" on these indicators in the desirable direction:

- Customer Satisfaction: % of DHS Customers that rank the quality of DHS Service as good or excellent
- Employee Engagement: % of DHS staff that report medium-high or high level of engagement
- Accuracy:
    - % of SNAP PER QC reviews for SSP branch offices where accuracy measures 95% or better
    - % of TANF QC reviews for SSP branch offices where accuracy measures 95% or better
    - % of ERDC QC reviews for SSP branch offices where accuracy measures 95% or better
    - % of APD QC and QA reviews for APD branch offices where accuracy measures 95% or better
- Timeliness:

- % of new SNAP Expedited and Non-Expedited applications meeting processing timelines
- % of new SNAP Benefits issued within 0-1 days
- % of APD cases with a redetermination date that is current or less than 1 month overdue compared to the total cases with a review date

3.6.3 Measures of Project Success and Completion

Project Success Measures

- Project is completed on time in comparison to the latest approved baseline schedule.
- The last approved baseline schedule does not deviate by more than 10% from the schedule projected at Stage Gate 3.
- Project is completed within budget in comparison to the latest approved baseline budget.
- The latest approved baseline budget does not deviate by more than 10% from the budget projected at Stage Gate 3.
- The system satisfies all of the requirements in the Requirements Traceability Matrix at Stage Gate 3 as subsequently modified through the project's change management criteria.
- At the close of the warranty period, there are no Critical or Major defects remaining and the ratio of Minor defects remaining to the size of the system is below industry averages.

Project Completion Criteria
The project will be complete when all of the following are true:

- System has been in production through a six-month warranty period
- All contracted work has been completed and accepted, and final payments have been made to all vendors
- The Office of the State Chief Information Officer and the Legislative Fiscal Office have approved the project's Stage Gate 4 submission
- A steward for Operations and Maintenance is identified and has formally accepted handoff of the system
- The position responsible for post-project monitoring and reporting on measures of success has been identified and its occupant has formally accepted the handoff
- Final reports required by funders of the system, if any, have been delivered and accepted
- Project documentation has been assembled and archived consistent with agency and state records retention policies

4 Alternatives Analysis

In the Stage Gate 2 version of this business case, DHS identified and evaluated four alternatives approaches to the project. They were:

- Implement Non-MAGI Medicaid Eligibility Determination into the ONE system
- Implement Integrated Eligibility Determination into the ONE system
- Acquire External Eligibility Services from Another State
- Do Nothing

A full analysis of the costs, benefits, and risks of those alternative approaches is contained in that older version of the business case. Based on that analysis, DHS's executives selected the second alternative, Implement Integrated Eligibility Determination in the ONE system.

This newer business case contains updated information about the costs, benefits, and risks of the selected alternative focusing specifically on developing a more complete and accurate estimate of the costs of designing, developing, implementing, maintaining, and operating the proposed system and the business processes that will depend on it. The purpose is to determine whether new information discovered or developed during the project planning phase should be cause for reconsidering the decision to pursue the selected alternative.

4.1 Assumptions and Constraints

The project is subject to these constraints:

- CMS will not support enhanced funding for a Non-MAGI Medicaid solution that is separate from ONE.
- The exception to the OMB Circular A-87 cost allocation requirements to support integration of other human service programs into the ONE system will expire at the end of calendar 2018.
- Total spending in federal fiscal year 2016 has approval by the Centers for Medicare and Medicaid Services and by the Food and Nutrition Service. It is limited to $11,406,585, of which $1,673,188 is state funds.
- Total spending in the 2015-2017 biennium has legislative approval and is limited to $55,962,563, of which $8,340,000 is state funds.
- Of the approved state funding, $7,500,000 in bonding is approved by the legislature. Funds from bonds will likely not be available until March 2017.
- 35 limited duration positions are authorized for the project during the 2015-2017 biennium.

These assumptions are factors in the Alternatives Analysis below:

- CMS and FNS, which have already approved FFY 2016 funds for the project will approve DHS's plans for Integrated Eligibility system development during FFYs 2017, 2018, and 2019.
- The legislature—which has already approved funding for the project in the current biennium—will approve the state's share of development and operations costs for the 2017-2019 biennium during its 2017 session, releasing funding at appropriate points in the implementation process
- OHA's new MAGI eligibility system, ONE, will become fully operational 2016 and OHA's use of the system will stabilize by the end of 2017.
- Maintenance & operations of the ONE System will be performed by Deloitte Consulting continuously through December 2018.
- MAGI Medicaid-related enhancements to the ONE System will be performed by Deloitte Consulting and no other vendors will perform work directly on the ONE system before December 2018.
- Project oversight, operations oversight, and contract management efforts will sufficiently orchestrate OHA's ONE operations and maintenance work, OHA's ONE MAGI enhancement efforts, and this project so that none prevents the others from being successful.

- DHS will plan and execute in coordination with this project, a separate project that plans and carries out the decommissioning, partial decommissioning, or other modification of DHS legacy systems where Integrated Eligibility work is not strictly dependent on that legacy system work. (Legacy system-related tasks on which Integrated Eligibility tasks depend directly are considered in the scope of this project.)
- DHS leaders, acting in a fashion similar to OHA's leaders on the ONE project, will support a strategy of minimizing the amount of customization required when transferring Kentucky's solution to Oregon (This requires a willingness to change policies, procedures and administrative rules, rather than changing the system when the system doesn't support some current Oregon practices.)
- Business staff (business leaders, program and policy experts, field/operations representatives, and other stakeholders) will be made available in sufficient numbers to the project when they are needed
- Technical staff will be made available to the project when they are needed

4.2 Solution Requirements

4.2.1 High Level Requirements

A high-level description of the system's requirements follows. A more thorough, but still layperson-accessible description of the requirements is found in the Fit-Gap Specification document, one of the key deliverables of the Fit-Gap phase of the project.

On day one of implementation, the system will determine financial eligibility for the following DHS and OHA in scope programs:

In Scope DHS Self Sufficiency Programs		
Program	**Type of Assistance (TOA)**	**Description**
Supplemental Nutrition Assistance Program (SNAP)	CTCE	Categorical Eligibility
	EXCE	Expanded Categorical Eligibility
	BBCE	Broad Based Categorical Eligibility
	SNAP	SNAP
	ESNP	Expedited SNAP
	DSNP	Disaster SNAP
	ABAWD	Able Bodied Adults without Dependents Requirements
	OFSET	Oregon Food Stamp Employment Transition Program
Temporary Assistance for Needy Families (TANF)	TANF	TANF
	EPPT	Employment Payments
	TDVS	TANF Domestic Violence
	TJPI	Jobs Participation Incentive
	PSSI	State Family Pre-SSI
	JOBS	Jobs Opportunities and Basic Skills

		Note - Only determination of JOBS mandatory individuals and assessment status, not ongoing case management
Child Care Program (CCPG)	ERDC	Employment-Related Day Care

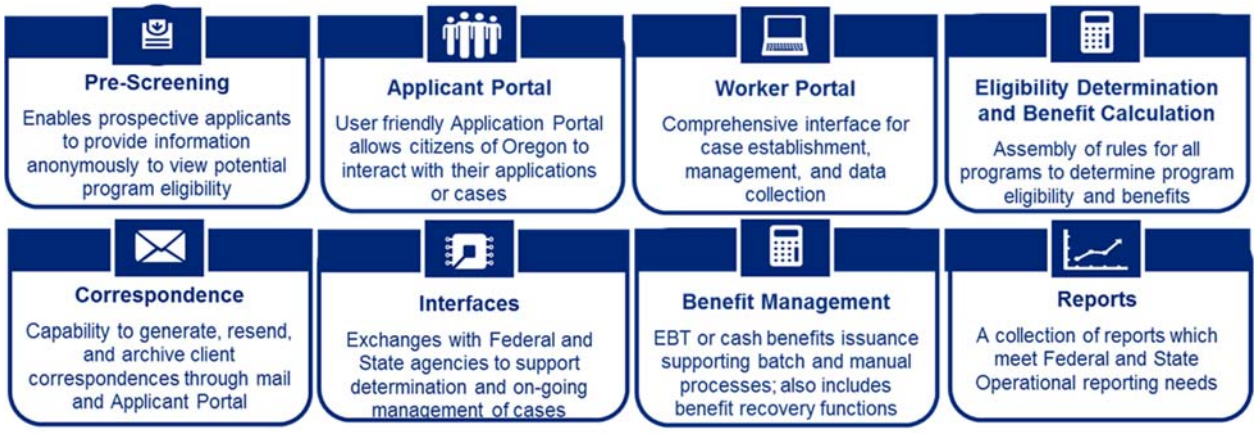
In Scope DHS Aging and People with Disabilities (APD) Programs		
Program	**Type of Assistance (TOA)**	**Program Description**
Non-Modified Adjusted Gross Income (Non-MAGI) Medicaid	QMB-BAS	Qualified Medicare Beneficiaries – Basic
	QMB-SMB	Qualified Medicare Beneficiaries - Special Limited Medicare Beneficiaries
	OSIPM-SSI	Oregon Supplemental Income Program Medical - Supplemental Security Income
	OSIPM-1619B	Oregon Supplemental Income Program Medical - 1619B
	OSIPM-Survivor Widows	Oregon Supplemental Income Program Medical - Survivor Widows
	DAC	Disabled Adult Children
	Pickle	Pickle Amendment Clients
	OSIPM-AB	Oregon Supplemental Income Program Medical - Aid to the Blind
	OSIPM-OAA	Oregon Supplemental Income Program Medical - Old Age Assistance
	OSIPM-AD	Oregon Supplemental Income Program Medical - Aid to the Disabled
	OSIPM-Acute Care	Oregon Supplemental Income Program Medical - Acute Care
	OSIPM-EPD without Services	Oregon Supplemental Income Program Medical - Employed Persons with Disabilities not receiving services
	OSIPM-EPD with Services	Oregon Supplemental Income Program Medical - Employed Persons with Disabilities receiving services
	QMB-DW	Qualified Medicare Beneficiaries - Disabled Worker
	Special Needs	Special Needs
	QMB-SMF	Qualified Medicare Beneficiaries - Qualified Individuals
	Services - LTC/Waiver	Services – Long Term Care or Waiver
	OSIPM-IC	Oregon Supplemental Income Program Medical - Independent Choices program

In Scope Oregon Health Authority (OHA) Programs		
Program	**Type of Assistance (TOA)**	**Program Description**
Modified Adjusted Gross Income (Non-MAGI) Medicaid	ADLT	OHP Plus Adult
	CHIP	OHP Plus CHIP
	CHL1	OHP Plus Child under age 1, under 185%
	CHL4	OHP Plus Child, age 1 through 18, under 133%
	EMAD	CAWEM Adult
	EMC1	CAWEM Child under age 1, under 185%
	EMC4	CAWEM Child age 1 through 18
	EMPC	CAWEM Parent or Other Caretaker Relative
	EMPP	CAWEM Plus Pregnant Parent or Other Caretaker Relative
	EMPR	CAWEM Plus Pregnant Woman
	EMPW	CAWEM Pregnant Woman
	FFCC	OHP Plus Former Foster Care Youth
	HIA1	Hospitalized Adult inmate
	HIA2	Hospitalized Pregnant Woman inmate
	PACA	OHP Plus Parent or Other Caretaker Relative
	PCPR	OHP Plus Pregnant Parent or Other Caretaker Relative
	PREG	OHP Plus Pregnant Woman
	TP45	OHP Plus Assumed Eligible Newborn

The following programs are out of scope:

Out of Scope Programs and Sub-Programs		
Program	**Type of Assistance (TOA)**	**Description**
CCPG	CCJB	Child Care for JOBS Participants
	CCTN	Child Care Supportive Service for TANF recipients.
TANF	PSTF	Post TANF
	PRTF	Pre-TANF
	N/A	TANF related Case Management Functions
REF	REFG	Refugee program for individuals seeking assistance and otherwise ineligible
MAGI-Medicaid	BCCP	Breast and Cervical Cancer
Non-MAGI Medicaid	N/A	All Service Eligibility Functions
Summer Meals	SEBTC	Summer Electronic Benefit Transfer for Children

These are the planned system's high-level functions.



Pre-screening – Pre-screening module in Applicant Portal enables prospective applicants to provide a minimal set of information to the system anonymously to see the programs for which they may qualify. The module will include assessment capabilities for all programs offered by Integrated ONE, including MAGI (Medicaid & Non-MAGI), SNAP, TANF, and ERDC. It is important to note that the pre-screening process is not an official eligibility determination and individuals must formally submit an application in Applicant Portal or by contacting a DHS or an OHA office. The data collected during Pre-screening will be saved.

Applicant Portal (AP) – The Applicant Portal enables the registered users' access to the system to apply for benefits as well as enable them to take action on their ongoing benefits. The applicant portal allows users to apply for Medicaid (MAGI & Non-MAGI), SNAP, TANF, and ERDC as a part of an Integrated ONE application. The citizens will be able to take actions on

their ongoing applications or cases including to report a change, recertification of an ongoing program, withdrawal of ongoing application or request to discontinue an ongoing program, upload documents, view Request for Information (RFI) notices, and start a new application. It will also include additional functionalities such as the ability to request an appeal/ hearing/, request an EBT/ Medicaid Card, view claims/ disqualification / TANF summary and submit a SNAP short application. The applicant portal will have role based dashboards. The applicant portal will incorporate the user account creation process that is currently established in the MAGI Medicaid ONE system Applicant Portal.

Worker Portal (WP) – Worker Portal allows case workers to manage the lifecycle of an application/case by providing functionality to perform intake on new applications, determine eligibility and benefit amounts based on the data provided during intake, disburse benefits and process case changes. It also contains modules for support-functions like appointment, task management, hearing and appeal, and complaints to help the users perform daily activities.

Eligibility Determination and Benefit Calculation (EDBC) – As the central repository for business rules defined by policy and administrative procedure, EDBC is the module where the Integrated ONE system determines each person's eligibility and benefit level based on the information collected through the worker or applicant portal and verification status of key data elements that affect eligibility (income, resources, citizenship, etc.) For Medicaid programs, eligibility determination is limited to financial eligibility for Medicaid. Service eligibility determination and authorization for Medicaid and other SSP case management services is not in scope for the initial implementation. For the purposes of determining financial eligibility, the eligibility rules engine will evaluate individuals and households through multiple modules to confirm their compliance with both state and federal program rules. All eligible individuals will be included in the benefit group which will be used to determine the benefit amount or ERDC days of care the individual may receive.

Correspondence – The correspondence module generates the notices required to support a case life cycle. Integrated ONE system generates the notices automatically and notices are automatically forwarded to State's centralized print center for printing and mailing. Case Workers will have the ability to review the notices and determine the accuracy before the notices are mailed out daily during the nightly batch cycle.

Interfaces – Interfaces are a critical component for the implementation of Integrated ONE system and it will interface with federal agencies, State agencies, and other Trusted Data Sources (TDS) to support critical business processes such as verification, fraud detection, federal reporting, benefit issuance, and recovery. Interfaces are also required to share data with other state systems to support their business processes such as provider payments and referrals. The system will use both batch and real-time interfaces to meet the business needs.

Benefit Management – The Benefit Management module supports two key functions – benefit issuance and benefit recovery. The benefit issuance function allows for automatic benefit issuance through Electronic Benefit Transfer (EBT) card, Checks and Direct Deposit through Electronic Fund Transfer (EFT). The function also allows authorized users the ability to issue benefits manually outside the constraints of eligibility, if necessary.

The Benefit Recovery function determines overpayments against issued benefits because of case changes. Overpayments are referred to ICM (Claims management) System for

establishing and maintaining claims. Certain portion of benefit amount is recouped from future benefits based on the outstanding claims amount received from ICM

Reports – This module focuses on generating Operational, federal and State reports necessary for the administration of the APD and SSP programs. The operational reports span across reports generated from key business processes that include:

- New Applications
- Report-A-Change and
- Redeterminations
- Task Management
- Reports required for audits, quality assurance
- Interface activity reports

Federal reports span across mandated reports required by federal and State government for DHS and OHA programs. These include reports specifically for SNAP, TANF and ERDC programs as well as reports for Medicaid (MAGI and Non-MAGI) program.

4.2.2 Detailed Requirements

Detailed requirements for the system are found in the Requirements Traceability Matrix, one of the key deliverables of the Fit-Gap phase of the project.

Those requirements were developed by comparing the functionality of the Transfer Solution to DHS's business needs, determining where there were gaps, and determining whether to close those gaps with policy, process, or procedure changes, with changes to the Transfer Solution, or with a combination. The Fit-Gap phase of the project include thorough requirements vetting with a cross-section of DHS subject matter experts.

The requirements list also includes OHA's requirements that were developed for the MAGI Medicaid project in order to ensure the eventual implementation of the Integrated Eligibility systems satisfies the needs of both OHA and DHS.

4.3 Alternatives Identification

In 2014, DHS, in consultation with the Office of the State CIO and the Legislative Fiscal Office, concluded that from-scratch, custom development of a Non-MAGI Medicaid eligibility system was too costly and too risky compared to an approach that relied on transferring a system already in successful operation in another state. The CMS policy to fund only a single financial eligibility system per state and the fact that Medicaid Title XIX will provide 90 percent of the funds needed for the system further constrains the alternatives available to DHS.

Consequently, Oregon's only viable alternative to the status quo must include enhancement of the ONE system to support Non-MAGI Medicaid eligibility determinations. In its Stage Gate 2 business case, DHS explored four possible courses of action, including continuing in the current state. These were the alternatives:

Alternative #1: Implement Non-MAGI Medicaid Eligibility Determination into the ONE System
Under this alternative, the ONE system would have been extended to support Non-MAGI Medicaid eligibility determinations and service authorization to community-based care programs only. This approach limits the scope of DHS programs that would be affected. It requires transfer of the Kentucky system, removal or disabling of the functionality in that system supporting programs like SNAP and TANF, and customization for Oregon's Non-MAGI Medicaid program. Use opportunity for 90/10/federal funding to improve IT system.

Alternative #2: Implement Integrated Eligibility Determination into the ONE System
Under this alternative, the ONE system would have been extended to support Non-MAGI Medicaid eligibility determinations and SNAP, TANF, and ERDC determinations, as well as service authorizations for community-based care programs. This approach involves a wider range of DHS programs. It avoids the risk and expense of removing functionality for these programs from the Kentucky system. It requires potential customization for a larger number of Oregon programs. This alternative could be rolled out all at once or it could be phased-in program-by-program. Use Medicaid 90/10 federal funding to the benefit of other programs.

Alternative #3: Acquire External Eligibility Determination Services from another State
Just like Alternative #1, this alternative would have extended ONE to support Non-MAGI Medicaid eligibility determinations only. Like Alternative #2, it would have supported eligibility determinations for the SNAP, TANF, and ERDC programs. However unlike Alternative #2, that support would have been outside of ONE. In this alternative, DHS would have contracted with another state to support SNAP, TANF, and ERDC eligibility decisions. At a minimum, that would have involveed modifying the partner state's system for those programs to accept applications from Oregonians and make eligibility determinations based on Oregon's rules. Limiting factors included lack of integration of Non-MAGI Medicaid program eligibility with MAGI program eligibility and recording of Oregon-specific MAGI, CHIP, and CAWEM rules. The project team was unable to identify a state where this approach is being used. Therefore, cost estimates for this alternative were unattainable.

Alternative #4: Do Nothing
Under this alternative, there would be no additional investment in the ONE system and no acquisition of eligibility services from another state. Improvements to current processes would be limited to those that arise naturally through the DHS's continuous improvement program. This alternative means losing the opportunity for enhanced federal funding to improve IT systems and thus results in greater cost in state funding for future enhancements.

4.4 Alternatives Analysis—Integrated Eligibility Determination vs. Do Nothing

Because "Implement Integrated Eligibility Determination into the ONE System" was the alternative selected at Stage Gate 2, this version of the business case, which was developed for consideration at Stage Gate 3, explores only that alternative and the Do Nothing option. See the earlier business case for a more complete description of the costs, benefits, and risks of the rejected alternatives.

4.4.1 Alternative #2 – Implement Integrated Eligibility Determination

Cost

We estimate the total four-year cost of implementing this alternative and operating it through the end of June 2019 at $177.1 million. (See Appendix A.) This alternative incurs the full cost of Fit-Gap analysis, design, configuration, customization, testing, and training for the SNAP, TANF, and ERDC programs in addition to Non-MAGI Medicaid. It includes costs for OHA to upgrade to the Integrated ONE sytem. It also includes operating the system during the phased roll out starting in May 2018, through the end of the warranty period in March 2019, and through the end of state fiscal year June 30, 2019.

Between the time the phased roll out begins in May 2018 and the warranty ends in March of 2019, there will be systems operations work and systems development work happening simultaneously. Our federal partners allow states to classify maintenance and operations costs incurred while a system is under development as part of the cost of the project, making them eligibile for a more attractive federal/state funding ratio. Consequently, DHS will define all system development costs incurred through March 2019 and all system maintenance and operations costs incurred through December 2018 as part of the project's total cost and define maintenance and operations costs incurred after December 2018 as standard maintenance and operations. That allows the state to take advantage of the OMB circular A-87 exception until its expiration December 31, 2018.

Consequently, the $177.1 million total cost consists of $163.0 million in project costs and $14.1 million in operations costs. The project cost estimate in the Stage Gate 2 business case estimated the project at $126.1 million. The new estimate, $163.0 million, is 29% higher than the old one, with nearly 40% of that difference due to the decision to characterize certain operations costs as project costs and the rest due to discoveries during the Fit/Gap analysis and project planning.

Benefits

This approach was selected at Stage Gate 2, and it will achieve all of the high-level requirements. Benefits of this approach include:

- Clients seeking Medicaid eligibility (either MAGI or Non-MAGI) and clients seeking SNAP, TANF, and ERDC eligibility will be able to apply on-line and they will receive faster eligibility determinations.
- Clients applying for medical assistance and for one or more of SNAP, TANF, and ERDC will make a single application regardless of programs they are applying for.
- Eligibility workers in APD and AAA offices will be more productive and make fewer eligibility determination errors in both the Medicaid and SNAP programs.
- Workers in SSP offices may be more productive and will make fewer eligibility determination errors in the SNAP, TANF, and ERDC programs.
- Problems associated with the handoff of cases between OHA and DHS will be reduced, as will problems associated with handoffs among APD/AAA offices and SSP offices. This alternative avoids the $2 million annual cost of maintaining 25 additional Non-MAGI Medicaid eligibility workers who will be required because of a growing caseload.
- More importantly, this alternative is expected to result in eliminating more than $25 million per year in errors in the SNAP, TANF, and ERDC programs. Consolidating financial eligibility information for all programs in a single system will better support

cross-program case coordination and service eligibility determinations. Consequently, subsequent needs assessments, service authorizations, and provider payments will be facilitated in a more timely fashion.
- This approach allows for the full or partial retirement of several existing systems including Client Maintenance, Client Index, CAPI, and FSMIS. Estimates of savings from no longer having to support those systems are not available and are not included in the cost analysis.

Risk

This project has the risks associated with large information technology projects involving complex requirements and a lengthy schedule. It involves a large number of stakeholders. It will impose substantial policy and procedure changes on Non-MAGI Medicaid eligibility workers in APD/AAA offices and on SNAP, TANF, and ERDC eligibility workers in SSP offices. By eliminating some old information systems and reducing the scope of others, this approach reduces long-term risks that system failures will interrupt the delivery of DHS programs, but it puts additional short-run demands on the staff who support those systems.

During the planning phase, the project implemented a management process for identifying and evaluating risks and for developing and carrying out risk response plans. At this writing, project leadership is tracking nine risks, five of which have been judged to both have a high probability of occurring and to threaten a high impact to the project. They are summarized here:

- Our focus on preferring policy and process change before technology change reduces technical risk but substantially increases the amount of process change that must be undertaken.
- The Fit/Gap analysis has given us a clear understanding of the scope of the Integrated Eligibility project, but we don't yet have a full understanding of the scope of the project's effects on legacy information systems and a related project that will be required to address those effects.
- The Office of Information Services, which supports many affected legacy information systems, may not have capacity to simultaneously participate in this project, participate in the related legacy system change project, and support on-going operations, maintenance, and enhancement of legacy systems that will remain after the Integrated Eligibility project.
- OHA was not fully engaged during the Fit/Gap Analysis, increasing the risk of delays and unexpected costs ensuring that new system will satisfy DHS's requirements and continue to satisfy OHA's requirements already supported by the ONE system.
- The project's Technology Management Plan would impose security requirements on DHS|OHA's directory services that it might not be prepared to support.

Four additional risks whose probability of occurrence or impact to the project are thought to be lower are under active management by project leadership. They are:

- Limited time capacity of business leaders to accommodate the volume of decisions required during Fit/Gap analysis.
- Delays in filling key leadership positions might cause project delays or reduce the quality of project decisions and deliverables.
- The review cycle for oversight bodies might delay the start of DDI work.

- Data quality in legacy systems might make it difficult to cleanse and populate data from legacy systems into the new system threatening to interrupt service to Oregonians.

Response plans are in place for all nine risks and each seems to be controlled.

During the planning phase, the project's independent quality assurance vendor drafted an initial independent assessment of risks facing the project. That assessment is under review and has not been finalized. Two of the four risks it highlighted are similar to risks already receiving attention from project leadership. The remaining ones are concerns about ensuring sufficient DHS and OHA staffing during the execution phase of the project and improving planning for state tasks and resources during execution.

4.4.2 Alternative #4 – Do Nothing

Cost

The Do Nothing alternative requires the addition of state staff to process the increasing eligibility caseloads without automation. A rough estimate of additional APD/AAA eligibility staff needs over the next four years, based upon projected caseload increases, is 25, costing the state approximately $2.0 million annually by the end of four years.

There are potential CMS sanctions for not providing on-line capability for Non-MAGI Medicaid applicants, as there is an expectation that states provide this functionality for all Medicaid applicants, not just MAGI applicants. In addition, the state could face sanctions or penalties from the federal Food and Nutrition Services agency (FNS) if SNAP error rates continue to grow beyond the national average. Since the majority of states now have automated eligibility systems, their error rates are dropping where Oregon's error rate is staying the same, or in some areas, growing.

Benefits

Business process and policy changes for staff are limited to new or emerging policy changes.

Risk

This alternative is not sustainable in the long run in the face of increasing case loads and technological risks.

Automating eligibility determinations and providing an applicant portal for Non-MAGI Medicaid clients are expectations set by CMS and failure to provide those things will jeopardize the relationship DHS has with CMS.

DHS systems would continue to operate under an antiquated, siloed business model, lacking the agility and infrastructure to support the current DHS growth trajectory. Two primary legacy systems Family Service Management Information System (FSMIS) and Client Maintenance System (CMS) and over 35 additional subsystems are used to provide, track and maintain client/caseworker interaction information for SNAP, TANF, ERDC and Non-MAGI Medicaid benefits. These systems have over 100 interfaces to other systems within DHS and OHA and with other external entities. Current ACA regulations and federal IT funding policies require a

level of interoperability and integration across medical benefits and human services programs that the existing DHS legacy systems simply cannot support.

4.5 Alternatives Analysis – Maintenance and Operations Support Strategy

An information system of this scope and complexity will require substantial resources to maintain and operate. Those costs must be estimated and considered in determining the advisibility of investing in the system. Leaders of DHS|OHA's Office of Information Services and project leaders considered maintenance and operations support strategies across the spectrum ranging from permanent reliance on the system's developer for all maintenance and operations activities all the way to bringing every aspect of maintenance and operations in house immediately upon completion of the warranty period.

Maintenance and operations activities generally cover a broad range of activities and can require resources with a broad range of operational and technical knowledge, skills and abilities. On one end of that range are basic operations monitoring functions. On the other end are highly-specialized and deeply technical functions that integrate and configure COTS components of the system such as its business rules engine. In between are functions such as triggering and monitoring batch processes, installing new versions of component software, tuning database performance, deploying new builds of custom components, and writing, testing, and debugging application code.

A strategy that would bring all maintenance and operations in house was rejected, even as a vision for the long term, as fiscally infeasible. Support for some of the COTS components (e.g., the Corticon rules engine and the CA identity and access management suite) requires knowledge and skills that are so specialized and high-priced that it is unrealistic to imagine the state ever able to hire and retain employees able to do this work.

On the other hand, DHS and OHA do not want to find themselves in a situation where they are too reliant on a sole source for all maintenance and operations support forever. However, at the conclusion of the development and warranty period, DHS and OHA expect to have accumulated a substantial collection of system enhancement requests and only the development contractor will be well-positioned to provide those services.

The strategy proposed is this:

- Negotiate two post-development statements of work with the systems integrator. One will cover basic maintenance and operations services and the other will cover system enhancements. Each will have a term of at least 12 and no more than 36 months.
- The basic maintenance and operations agreement will include provisions for knowledge transfer that will enable the state to begin to perform those operations tasks that are consistent with its IT staffing model, both in terms of the skills the state can hire and retain and in terms of the degree to which the state chooses to staff for nighttime and weekend operations.
- At the conclusion of those agreements, new ones will be required and will be developed through an open, competitive procurement process in which the systems integrator will be permitted to compete.

5 Conclusions and Recommendations

5.1 Conclusions

Development of an Integrated Eligibility Determination system continues to appear to be a desirable investment for Oregonians, for DHS and OHA, and for eligibility workers, particularly in light of the looming expiration of the OMB Circular A-87 cost allocation exception and the active support of our CMS and FNS partners.

Between December 2015 and July 2016, project planning activities and the Fit/Gap Analysis work has:

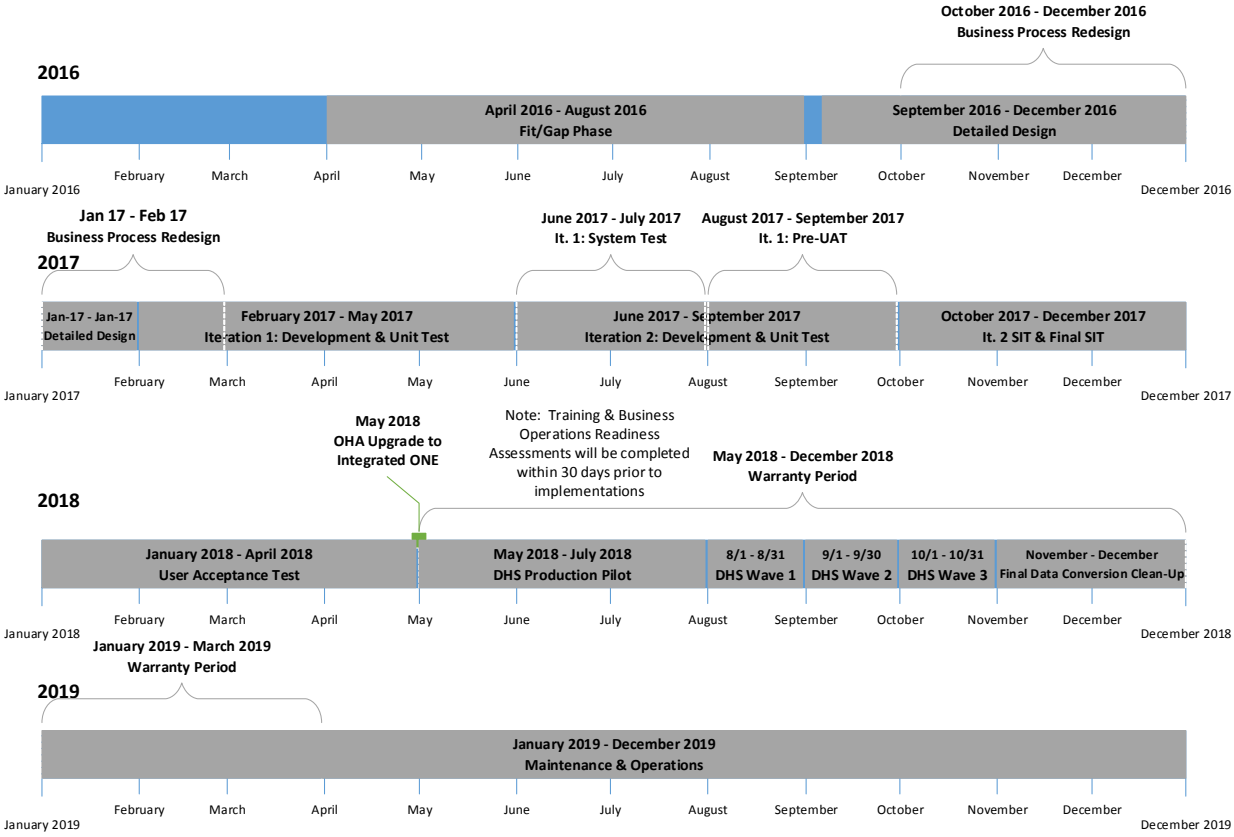
- Completed the identification and documentation of a complete set of system requirements to support the work of DHS's administration of Non-MAGI Medicaid, SNAP, TANF, and ERDC eligibility and OHA's administration of MAGI Medicaid eligibility.
- Documented the architecture, infrastructure, and security changes that will be required to extend ONE to support eligibility determination for Non-MAGI Medicaid, SNAP, TANF, and ERDC
- Developed a Business Transition Plan that establishes a roadmap for the policy, process, procedure, and organizational change that will be required to implementent and opereate the new system.
- Negotiated a tentative statement of work with the system integrator for design, development, and implementation services at a fixed price.
- Identified a post-project maintenance and operations strategy and developed cost estimates for that work.
- Developed a tentative work plan and schedule integrating both vendor and state tasks.

With those things in place, DHS has a more fully developed understanding of the scope, costs, benefits, and risks of undertaking the project. The project team continues to support extending ONE to support eligibility determinations made by DHS for its major programs. And it supports the model for Maintenance and Operations proposed in Section 4. The DHS leadership team concurs.

The sections that follow offer a high-level schedule for action and a description of the potential consequences of not acting.

5.2 Schedule

The following chart lays out a high-level schedule for the project.



DRAFT

A more detailed project schedule, fully elaborated for the first months of design work, is part of the Preliminary Work Plan and Schedule for DDI, a separate Stage Gate #3 submission. A high-level chart describing the schedule is in Appendix B.

5.3 Consequences of Failure to Act

Given the current degree of manual processing and the projected growth in caseload, failure to act will result in delays in eligibility determinations, delays in access and payment for services, continuing and growing customer and provider discontent, and potential lawsuits. An increase in the number of workers throughout the state will be required to complete the manual eligibility assessment and determination procedures and make the system coding entries that are needed to support service authorizations and payments.

CMS expects Oregon to implement a Non-MAGI Medicaid eligibility system and has extended 90/10 funding for eligibility system development for a limited time, through December 2018. Failure to act now could result in a funding match decrease to a 50/50 rate for the eventual

implementation of a Non-MAGI Medicaid solution, costing the State of Oregon considerably more in general funds.

The approach recommended has the additional benefit of supporting the eligibility determination needs of the SNAP, TANF, and ERDC programs with a system paid for primarily with federal Medicaid funds under the A-87 exemption that also runs through 2018 only.

Failure to act on this opportunity means that the eventual satisfaction of the needs of those programs will come at higher state expense and, for the TANF program, the use of federal funds for an eligibility system will come directly out funds that would otherwise be available for benefits to clients. The Stage Gate 2 version of this business case estimated that added state cost in the neighborhood of $40 million.

6 Complete Case Checklist

6.1 Checklist for the Completed Case

- ☒ Has the case clearly defined what the case is about, the purpose for the proposed solution, what business problems the proposed solution attempts to solve, and the scope of the proposal?
- ☒ Has the cash flow, the flow expenditures, and the intake of financial benefits been presented over a common time period for the case, for each alternative action considered (including the “status quo”/current state alternative).
- ☒ Are the assumptions and methods for assessing the proposal’s impacts clearly defined, understandable, and acceptable? Do not forget risk impacts!
- ☒ Does the business case include the non-financial costs and benefits?
- ☒ Are the factors critical to the success of the proposal clearly defined?
- ☒ Are there critical success factors that can be managed? Is there a risk analysis that identifies and measures the relevant risks to the proposal?
- ☒ Are recommendations and conclusions based on a clear comparison of alternatives in terms of contributions to business objectives, problems solved, financial outcomes, and risks?
- ☒ Does the case clearly identify the estimated timeframes, costs, and implementation strategy required to successfully deliver the recommended solution?
- ☒ Does the case clearly express to consequences of failure to act on the recommended alternative?

7 Appendixes and References

Two appendixes follow.

Appendix A contains the cost detail for implementing Integrated Eligibility Determination into the ONE System. document, and relies on the Maintenance and Operations strategy recommended in Section 4.

Appendix B contains a full page version of the schedule found in Section 5.2.

Appendix A – Cost Worksheet

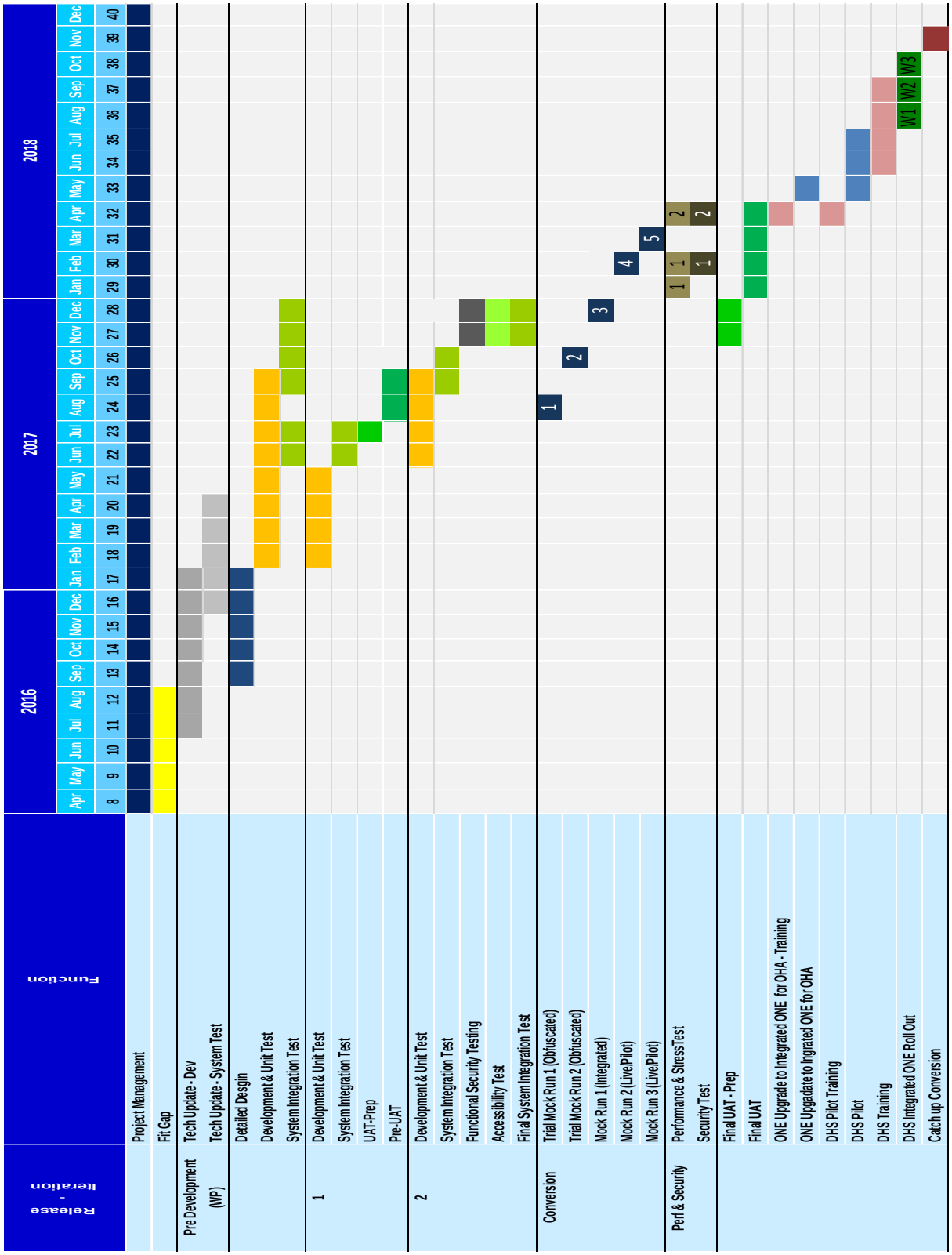
PROPOSAL CASH FLOW

$ in 1000s

Discount rate 0.0%

$ in 1000s	*Year ending…* Jun 30 2016	Jun 30 2017	Jun 30 2018	Jun 30 2019	TOTAL
BENEFITS / GAINS					
Avoid staff growth				2000.0	2000.0
SNAP payment accuracy				7785.0	7785.0
TANF payment accuracy				3360.0	3360.0
Benefit item 4				1590.0	1590.0
Total Benefits/Gains	0.0	0.0	0.0	14735.0	14735.0
COST ITEMS inflows (outflows)					
Personal Services Costs (Salaries & Benefits)					
State Perm Staff	(593.3)	(2778.6)	(6804.3)	(5023.5)	(15199.7)
State Temp Staff	(547.7)	(2564.9)	(6280.9)	(4637.1)	(14030.5)
State LD Staff					0.0
Services & Supplies/Capital Outlay Costs					
State Data Center Costs					
Consulting Services					0.0
Hosting		(4128.0)	(3440.0)		(7568.0)
Storage					0.0
Network					0.0
Software Costs					
SW Purchase/Upgrade		(3000.0)	(1500.0)		(4500.0)
SW License Maintenance					0.0
Hardware Costs					
Hardware Purchase/Upgrade					0.0
Hardware Ongoing Maint					0.0
IT Professional Services					
System Integrator	(1957.5)	(30631.7)	(47105.8)	(18597.7)	(98292.7)
QA Vendor	(5.8)	(1633.9)	(1648.7)	(711.6)	(4000.0)
Staff Augmentation					0.0
Operational Staff					0.0
Operational Augmentation					0.0
Contingency		(2162.5)	(2956.3)	(1131.3)	(6250.0)
Other	(10.0)	(60.0)	(4358.7)	(22825.2)	(27253.8)
Total Costs	(3114.2)	(46959.6)	(74094.5)	(52926.3)	(177094.7)
CASH FLOW SUMMARY inflows (outflows)					
Cash inflows (outflows)					
Benefits and Gains	0.0	0.0	0.0	14735.0	14735.0
Costs	(3114.2)	(46959.6)	(74094.5)	(52926.3)	(177094.7)
NET CASH FLOW	**(3114.2)**	**(46959.6)**	**(74094.5)**	**(38191.3)**	**(162359.7)**
Cumulative Net CF	(3114.2)	(50073.8)	(124168.4)	(162359.7)	(162359.7)
Discounted Cash Flow					**NPV**
At 0.0%	(3114.2)	(46959.6)	(74094.5)	(38191.3)	(162359.7)

7.1 Appendix B – Tentative Project Schedule



Department of Human Services
AUDIT RESPONSE REPORT

1. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2013, audit # 2014-09, (dated April 2014)

- We recommend department management improve controls in the Receipting Unit to ensure all checks are safeguarded, properly tracked and accounted for in the financial records.

  The agency appropriately segregates the duties of handling checks in its Salem facility. Under the current system, checks received by mail are sorted by category, recorded by count and delivered to the staff member who is responsible for that category. The item count can be reconciled from the online deposit system reports to an excel spreadsheet created by the unit.

  The count and amount of checks received through this process is a small portion of the total revenue recorded by the Receipting unit.

  We have strengthened internal controls on the handoff of checks by including, in addition to a count of checks, the dollar amount, reconciliation, and a check redistribution log.

  As of June 2015, the OFS Receipting unit has overhauled the check scanning process and now images checks into OED (On-Line Electronic Deposit) immediately. There is no longer a reconciliation of a manual process. This finding is complete.

- We recommend department management align policies and procedures with governmental accounting standards to record expenditures in the proper period and we recommend management provide training to staff to ensure that prior period adjustments are utilized when appropriate.

  We disagree with the materiality of the finding, although we agree that the operational controls can be improved. Each year the agency records regular, routine transactions to refinance revenue and expenditures related to lagged receipt of various revenue sources. As mentioned in the audit finding, these are normal transactions that occur as part of our regular business process.

  In 2009, due to the large dollar amount of these transactions, the agency asked for advice from the Department of Administrative Services, Statewide Accounting and Reporting Services (SARS) on the proper use of prior period adjustments for these transactions. In response, SARS stated, "it's not appropriate to incorporate a prior period adjustment into a routine practice. Prior period adjustments should be reserved for (those infrequent) corrections of errors." This advice was consistent with both the Oregon Accounting Manual (OAM) 15.85.00.PO and related governmental accounting standards outlined in Governmental Accounting Standards Board (GASB) circulars.

  During the 2013 statewide financial audit, auditors again recommended prior period adjustments for routine transactions. On December 3, 2013, the agency, Secretary of State Auditors and SARS met again to discuss the issue. At the meeting, SARS leadership agreed with the auditors that these transactions could, most likely, require prior period adjustments. The agency stated their belief that use of prior period adjustments for routine transactions was contrary to the OAM and GASB.

  To ensure that the agency was not in violation of OAM, the agency stated that it would change the practice of recording prior period adjustments (to include material routine transactions) if the OAM was updated to reflect the change. On December 5, 2013, SARS updated OAM 15.85.00.PO to include new language on when to record a prior period adjustment for these types of transactions.

Since the change in language in the OAM, the unit has started reviewing all adjustments that occurred during fiscal year 2014 to see if prior period adjustments needed to be done. Clarification to staff of the change in the OAM occurred through the use of Office of Financial Services newsletter, training information shared with the Grant Accounting unit, and a process update to improve ability to capture data that would need prior period adjustments.

- We recommend department management review and revise accrual methodologies for revenues and expenditures, as necessary, and perform periodic retrospective comparisons of accruals to actual amounts to ensure the accrual methodologies are reasonable.

  Due to an error during year-end reporting, the healthcare provider tax (HPT) revenue, drug rebate revenue and Medicaid Management Information Systems, expenditure accrual estimates were based on a 60-day rather than a 90-day availability period. This accounted for three of the four audit comments in this finding.

  As a corrective action, beginning in fiscal year 2014, the Statewide Financial Reporting unit modified its processes to ensure all governmental fund accrual calculations were based on the 90-day availability period. If actual HPT revenues were not known during month 13 financial adjustment periods, the agency used estimates such as trends and projections based on Generally Accepted Accounting Principles (GAAP). The estimates are compared to actuals for reasonableness.

  Statewide financial reporting timelines require agencies to record accrual estimates within approximately 30 days after the end of the fiscal year even though the accrual period doesn't end until 90 days after the end of the fiscal year. This timeframe produces variances between the estimates and actuals. The fiscal year 2013 variances were partially due to the inherent nature of using estimates. The $17.4 million and the $7.5 million variances seem high, but only make up 6.4% and 2.8% of the total accrual of $270 million.

  Although variances of actuals and estimates are expected, the agency agrees that accrual amounts should be compared to actuals, and future accrual modifications should be implemented as needed. Therefore, as a

corrective action, beginning in 2014 the Statewide Financial Reporting unit implemented a yearly review of its operating statements to document variances and adjust accruals if needed.

Clarification to staff of the change in the OAM occurred through the use of OFS newsletter, training information shared with Grant Accounting unit, and a process update to improve ability to capture data that would need prior period adjustments. The Statewide Financial Reporting unit has reviewed and updated accrual methodologies as appropriate.

- We recommend department management timely estimate and properly record liabilities in the department's financial records. We also recommend department management implement adequate internal controls to ensure all liabilities are appropriately reported in the financial statements.

  We agree that the existing year-end review process for liabilities can be improved.

  The estimate cited in the finding from August 2013 was from a rough range estimate by an IT project staff person and was not based on a clear, appropriate methodology and was not detailed enough to estimate the impact by fund. The complexity of the analysis resulted in an actual estimate that was provided to leadership and validated by financial staff in January 2014, after the close of the financial reporting period. It is not the normal practice of the agency to place estimates of liability on the financial statements that do not meet GAAP standards.

  When the agency had an adequate remediation estimate, it followed the appropriate process and provided the Department of Administrative Services, Statewide Accounting and Reporting Services the following subsequent event disclosure:

  The Department of Human Services has initiated a data remediation project to correct data conversion issues in OR-KIDS related to eligibility and payment records. Subsequent to completion of the financial statements, the agency developed a methodology to estimate the potential financial impact of the

remediation. A rough estimate of the magnitude is $20 million refinancing from state general fund to various federal grants. The remediation methodology was approved on January 15, 2014.

Statewide Financial Reporting Unit follows a year-end checklist for liability review as part of the year-end process.

- We recommend department management review user access to OR-Kids, ensure services are coded correctly in OR-Kids, review Adoption Assistance and Foster Care cases to verify eligibility is correct in OR-Kids, and ensure overpayment adjustments process correctly. We also recommend department management reimburse the federal agency for unallowable costs.

  The Child Welfare Systems Innovations Manager managed an effort to review and improve the partner access agreements, determine appropriate level of access, specific user roles and procedures to ensure compliance. The Federal Compliance Unit worked with Office of Business Intelligence (OBI), Office of Financial Services (OFS), Office of Information Services (OIS) and OR-Kids System Analysts to mitigate eligibility conversion issues whether through Data Remediation or manual clean-up. The Post Adoption Services Manager worked with OFS, OIS and OR-Kids System Analysts to correct the technical issues causing incorrect closure of Title IV-E eligibility on the Adoption Assistance cases, to identify all cases affected, and to correct the eligibility on the affected cases. The non-recurring services will be corrected and any inappropriate claims will be resubmitted to correct the claim on the CB-496 report.

  The service coding corrections and reimbursement adjustments were to be completed by June 1, 2014. A change request was submitted to address the incorrect processing of overpayments that involved an Enhanced Supervision rate. The completion date of this request was based on availability of programmers and the prioritization of work to be completed by OIS.

  The Federal Compliance Unit (now called Federal Policy, Planning and Resources) worked with the Office of Business Intelligence to create Eligibility Status Reports. These reports have been used by the field

Eligibility Specialist to complete the manual clean-up of any outstanding converted eligibility data issues. The final clean-up was completed in June 2015.

- We recommend department management identify and correct data conversion issues and repay the federal government for the duplicate claims.

  On January 30, 2014, the Office of Financial Services posted a remediation estimate in the accounting system in the amount of $23.3 million, thereby refunding payment amounts due to the federal government. The Office of Financial Services, Office of Information Systems, OR-Kids System Unit and the Federal Compliance Unit analyzed the conversion issues and determined the most appropriate action to take to remediate the financial conversion issues.

  The department has applied the data fix necessary to address the data conversion issues that caused the duplicate claims. In addition, the department has made accounting adjustments related to the refinancing issues. These final adjustments were completed during the first part of January, 2015 with an effective date of December 31, 2014.

- We recommend department management make appropriate corrections and adjustments to the accounting records to prevent the department from requesting federal reimbursement for expenditures incurred outside the period of availability.

  The federal draws were reconciled at the end of each quarter to the total federal expenditures reported to Administration for Children and Families (ACF). The IVE reports have been revised dating back to the September 30th, 2011 report and all adjustments were included in the June 30th, 2015 report. All SFMA entries were completed by September 30th, 2015.

  Change requests have been written to correct the OR-Kids system issues identified in this finding. These changes will prevent the application of trust money to payments with service dates prior to January 1,2008,

prevent workers from being able to end a placement as "opened in error" when that placement has dates prior to January 1, 2008 and not allow reimbursement greater than two years in the past.

- We recommend department management ensure CB-496 reports are complete, accurate, and adequately supported.

  The Office of Financial Services (OFS) has modified its query process to ensure that all costs for the entire grant are reported on the correct line in the 496 report. OFS will also ensure all documentation used to support the federal report will be kept with the report.

  Corrective action was taken so that all documentation is retained with the report. The IVE reports have been revised dating back to the September 30th, 2011 report and all adjustments were included in the June 30th, 2015 report. All SFMA entries were completed by September 30th, 2015.

- We recommend department management ensure all required documentation is completed, reviewed and maintained, and that certification dates in OR-Kids are supported by corroborating documentation. We also recommend department management reimburse the federal agency for costs paid to providers who were not certified at the time of payment.

  The department issued an Informational Memorandum on April 1, 2014 providing clarification on the documentation of the certification dates to record for a Certificate of Approval issued. The Informational Memorandum covers the initial and any subsequent Certificate of Approval. The department has also updated the OR-Kids Business Process Guides to clarify the documentation of certification dates in OR-Kids and filing of the Certificate of Approval in the OR-Kids online file cabinet.

  The department corrected the eligibility in June 2015 and the inappropriate claims were adjusted on the CB-496 Quarter Ending June 30, 2015. The corrective action required a service desk ticket and a rebuild of the child's eligibility and caused a delay in the completion date. The department submitted the Program

Improvement Plan to the Administration for Children and Families and it was approved on June 24, 2015. The department must submit quarterly updates, and the final report was submitted July 22, 2016.

An Action Transmittal was sent out to the field on June 15, 2016 with detailed processes the field and other agencies must follow until the OR-Kids modifications are implemented. The Title IV-E specialists received a training (via a conference call) in which the Action Transmittal was reviewed on June 16, 2016.

- We recommend department management ensure CB-496 reports are complete, accurate, and adequately supported. We also recommend management implement processes to ensure the numbers reported for the average number of children assisted are accurate.

  For line items on the report which have no expenditures, OFS confirmed with program this information is correct. Adjustments are completed as necessary to ensure all expenditures are reported on the correct line.

  The counts of children with non-recurring Adoption Assistance administrative expenses are calculated using OR-Kids expenditure data for those Adoption Assistance services with "non-recurring" in their title. An error was made when the service types were set up in OR-Kids, such that one service that should have been designated as "non-recurring" was not. On March 12, 2014, that service type title was corrected in OR-Kids. Counts for children receiving this service will be included in the Title IV-E Non-Recurring Administrative Cost Expenses line in future CB-496 reports.

  The IVE reports have been revised dating back to the September 30th, 2011 report and all adjustments were included in the June 30th, 2015 report. All SFMA entries were completed by September 30th, 2015.

- We recommend department management ensure verification of income with IEVS screens is clearly documented in client case files when determining client eligibility.

  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.

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 and specifically documented for every client. In fact, some partners such as the Social Security Administration that provide information used in screening applications require in our state agreement with them that we do not document that we obtained specific information from their screens.

However, the department agrees with the need to reinforce the importance of narrating that relevant information on income was verified using the IEVS screens. The department will continue to reinforce the importance of narrating when issues with narrating this factor are identified through the current Quality Assurance and Quality Control reviews.

On February 20, 2015, a TRACS change release was implemented to include the "IEVS checked" checkbox. This change eliminates the need for workers to narrate "all IEVS screens checked" when determining eligibility for SNAP, ERDC and TANF.

- We recommend department management strengthen controls to ensure projected hours of participation appropriately reflect the client's employment status, reported activity participation reflects actual hours, and data entered into the automated data processing system is accurate and complete.

  The department identified that one of the reasons for the work hour inaccuracies is due to how the weeks are programmed in the TRACS system. The department has already begun to make programming changes to correct the automated week calendar so that it aligns with the federal report.

  With respect to the errors in projected hours and client employment status, the department plans to strengthen controls and build upon current efforts to maximize accuracy in the reporting of data. Work Verification Plan reviews are currently conducted annually. This internal control process reviews for

compliance with the federal participation requirements for the TANF and SSP-MOE data reports, validating accuracy of data and documentation. In addition to statewide communication on best practices as well as error trends, the department has identified point persons in each district who will help communicate to staff the correct coding of participation related information.

Quality Assurance reviews have recently begun on TANF cases across the state as a means to strengthen controls for TANF case management accuracy in the Self Sufficiency programs. These reviews will continue as resources allow, providing a review of participation practices. The elements of acting on reported changes to update projected hours accurately, as well as ensuring documented hours are input into TRACS accurately, will be specifically called out and added to the review tool. In addition, case management training materials will be reviewed to provide clear expectations for coding the employment status, projecting hours and accurately reporting the participation hours related to employment on Self Sufficiency TANF cases.

In April 2014, the department made programming changes to correct the automated week calendar so that it aligns with the federal report. This change affected federal data transmissions from May 2014 forward.

In the spring of 2013, the TANF program identified point persons in each district who help communicate to staff the correct coding of participation related information.

Work verification JOBS audits are conducted every year. In January 2014, a summary of audit results was shared statewide. The results included acting on reported changes to update projected hours accurately, and ensuring documented hours are input into TRACS accurately. In the spring of 2014, some areas of the state with lower accuracy received an additional review, training and coaching. Lead staff from many field branches were included so that they could help disseminate the information associated with best practices and error trends.

In February 2014, case management training materials and staff tools were reviewed and revised. Other online guides were revised in June 2014 and posted in the "staff tools" website. These tools provide

expectations for coding the employment status, projecting hours, and accurately reporting the participation hours related to unsubsidized work on Self Sufficiency TANF cases.

In the summer of 2014, the TANF program created a TANF Federal Participation Toolkit and made it available to all staff. The toolkit was shared at statewide program manager and line manager meetings. It includes several guides to help improve upon the accuracy of work participation data and to maximize federal participation hours for the state. Several districts began conducting case reviews for the purpose of engaging families in JOBS or other activities and to check to ensure that those families are still eligible for TANF. These reviews include ensuring the case plan activities are accurately coded in the TRACS system. In addition, TANF program staff visited a few areas of the state in the fall of 2014 to provide training and consultation on the JOBS Activity Guidelines.

Work Verification Plan reviews (also known as the JOBS Audits) are currently conducted annually. A summary of audit results is shared statewide. The department plans on continuing these audits and building in more opportunities for coaching and mentoring for branch leadership, staff and partners. This will allow for further guidance on the correct use of JOBS activity codes, correct use of attendance tracking documents (including treatment, education and job readiness hours), and accurate counting toward participation hours. The JOBS Activity Guidelines (JAG) will be used as the curriculum of this targeted effort. The JAG will be adjusted and updated to ensure compliance with the Work Verification Plan as needed. Field audits were conducted during the fall and winter of 2015, the review summaries are available.

The TANF policy unit will gathered an internal Federal Data group to research the errors and identify root cause(s), with the intent to establish corrective actions to focus on either preventing or detecting and correcting processing errors. This team drafted a plan in November 2016.

Our cross-functional TANF program integrity group will continue to identify ways to train, coach, and review field staff work related to the calculation of work hours. Special attention will be focused on conversion of hours based on pay schedules, which resulted in two of the six errors cited.

Work Verification Plan training is updated in the training that is provided to staff and includes information on JOBS hours and how to calculate and enter information on TRACS. Monthly emails are being developed to share with field staff through local meetings and staff huddles, however this information has not yet been distributed.

The department's usage of the Electronic Document Management System along with the standardized filing method, implemented in phases beginning October 2015, has reduced the potential for lost documentation.

The department submitted a revised Work Verification Plan with an effective date of July 1, 2016. During the month of July 2016, a workgroup consisting of policy and program staff from around the state met to discuss a complete overhaul of the Work Verification Plan to be effective October 1, 2016. The new format will include more details around matters of benefit conversion and ongoing eligibility documentation. In addition to increased documents and published tools for staff, the policy unit staff now send regular emails several times each month focusing on participation issues that has been identified as needing further explanation These emails are distributed to the front-line staff and leadership as a means to help guide conversations in the field in regards to participation and program accuracy. The topics for the emails are identified through case reviews, questions submitted to the policy unit, and questions frequently asked during training.

- We recommend department management prioritize the correction of OR-Kids coding errors and completion of monitoring reports to ensure the benefit threshold of $25,350 is not exceeded and re-determinations are completed timely.

  The corrections to the seven clients who exceeded the $25,350 limit were corrected and adjustments completed to TANF in February 2014. A total of $470,530.40 was refinanced to another funding source from TANF.

  Analysis determined the five clients where re-determinations were not completed timely had the re-determinations completed prior to when the sample was pulled. For these clients, their TANF eligibility

ended because their re-determinations were not completed. However, the last of these client re-determinations was completed July 9, 2013. This resulted in the need to make funding adjustments in the quarters in which re-determinations were made. The current report workarounds are helping identify TANF clients that need a re-determination and they are being completed. The Federal Compliance Unit has been completing internal audits and providing findings to the Federal Revenue Specialist and Supervisor for corrective action. Information from audit findings and daily technical assistance is used to develop topics for bi-weekly conference calls between the Federal Compliance Unit and Federal Revenue Specialists. The Federal Compliance Unit also provides quarterly one-day trainings to the Federal Revenue Specialists and Supervisors to review policy and procedure.

The Federal Compliance Unit worked with the Office of Business Intelligence, Office of Information Services and OR-Kids to prioritize critical reports to ensure Federal Revenue Specialists have the tools they need to manage their workload and complete TANF re-determinations timely and accurately. The report to notify staff of instances where the $25,350 TANF reimbursement limit has been met, has been completed. This report was available in a User Acceptance Testing environment for several months and was moved to production in November 2014. This report is the EL-3008-S TANF $20K Summary Report. This report lists any client whose reimbursement of services paid for by TANF funds is greater than or equal to $20,000 over the past 365 days. In addition, a detail report was added so that a user can get all the transaction records that make up the noted amount for the client.

- We recommend department management ensure complete and accurate client information is used to compile the quarterly data reports.

  The department agrees that the data populating the ACF-199 and ACF-209 reports need to be as accurate and complete as possible. Currently, a team of Office of Information Services (OIS), Office of Business Intelligence (OBI), Self-Sufficiency Business Analysts, and Self-Sufficiency Program (SSP) staff meets weekly to address known or presenting data quality issues for these federal reports. Significant progress has been achieved over the past year to increase the data accuracy and completeness of these reports. This

includes resolving several of the items listed in this audit findings report. DHS recognizes that a continued effort is still necessary in order to resolve known data quality and data completeness issues.

The inaccurate reporting of Maintenance of Effort (MOE) clients in the ACF-199 TANF Data Report was corrected in May 2013 with a change to the selection criteria for each federal report. In addition, an alert report process was implanted to notify financial staff of clients needing to have their funding source changed. Unfortunately, the updated data was not incorporated in time for the Federal Fiscal Year (FFY) 2012 file resubmissions. This data was correctly reported for the FFY 2013 quarters.

The department started correctly reporting cases exempted from the federal time limit due to living in "Indian Country" to the Administration for Children and Families (ACF) federal reports in FFY 2013. The department implemented these changes in April 2013. Unfortunately, the updated data was not incorporated in time for the FFY 2012 file resubmissions. For FFY 2013 and forward this data will be correctly reported.

The specifics for the reported hour inaccuracies issue was investigated in early 2014. The error that was identified was that the TRACS application had a week that started counting hours from Saturday through Friday, while the data extraction coding had an alternate start day, resulting in a mismatch of hours reported for a week. This system issue was corrected April 2014.

TANF-funded child welfare cases continue to be excluded from the ACF-199 report due to the child welfare system coding issues. A corrective action to this known issue is being actively worked. There is a team consisting of a Child Welfare Business Analyst, Office of Business Intelligence (OBI), and Self-Sufficiency Business Analyst staff who are working to refine the requirements and data extraction coding for the data needed from the Child Welfare case management system. Progress has been made to correctly identify the population needed in the federal reports from the child welfare system, though complete data accuracy has not yet been achieved.

The TANF Policy Unit and other team members continue to work with the OBI, OIS, the Self-Sufficiency Business Analyst Team to prioritize critical data and coding changes needed to ensure accurate and complete reporting in the ACF-199 and ACF-209 federal reports.

Child Welfare cases are now being included in TANF federal reports. Corrective action has been taken on all categories identified in this finding including the duplicate case issue identified in the data submitted on the ACF-209 and the inclusion of TANF-funded child welfare cases in the ACF-199. Programming changes to address the problem with reporting duplicate cases were made and the changes were incorporated with the data submitted for FY 2014 forward. Also, as of June 2015, Child Welfare cases are now being included in the TANF federal reports.

- We recommend department management coordinate resources to better maintain and more readily provide sufficient application documentation.

  The department has developed a business case for an electronic case document storage system. We believe that a coordinated and consistent process for electronic case document storage will provide more readily accessible application documentation. This effort involved training, archiving and transfer agreements, business process development, communication plans, and technology installs.

- We recommend the department seek additional guidance from the federal government to ensure five-year time limit monthly exemptions are being appropriately applied in accordance with federal regulations.

  The department was interpreting the "Indian Country" provisions of time limits according to the Bureau of Indian Affairs (BIA) designation of "service area". The TANF program, in coordination with the department's Tribal Affairs Director, sent an inquiry on June 2, 2014 to the U.S. Department of the Interior requesting which areas in Oregon constitute "Indian Country." The Department of the Interior sent a response to DHS on August 1, 2014 which included that the Department of Interior is unable to honor the request of DHS for three main reasons: (1) an undertaking analyzing all lands in Oregon that meet the

definition of Indian Country provided in 18 U.S.C. § 1151 would be quite large; (2) the Bureau of Indian Affairs has previously responded indicating they do not use the section 1151 in their administration of social programs , rather, the term Service Area is used; and (3) the Department of Interior's provision of legal advice is limited to the interests that affect one of their client agencies followed by a request from the agency. The Department of the Interior recommended DHS consult with the Tribes affected by the program.

DHS consulted with Oregon Tribes. There was formal opposition from the Confederated Tribes of Siletz Indians, the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians, as well as the Klamath Tribes.

On March 31, 2015 ACF issued a decision on this finding which directed the department to provide a methodology and timeline for utilizing the definition of "Indian Country" consistent with federal regulation. The department again consulted with Oregon Tribes through the Department of Justice on a way to address their concerns.

On August 28, 2015 the department sent ACF a question and proposed a clarification on a way to achieve compliance with TANF regulations while also recognizing the Tribes' restoration acts. The plan also incorporated Oregon's proposed clarification. The extension to the plan of correction was subsequently obtained on October 1, 2015.

The department has now completed the consultation process with Oregon's recognized tribes and ACF. The planned implementation date for all changes is January 1, 2017. Tribes were notified October 7, 2016 about the changes that will be implemented the last week of November. Staff will received training in November and December of 2016 and the full implementation of all changes will be January 1, 2017.

- We recommend department management strengthen controls to ensure all documentation supporting a provider's eligibility determination is retained. For current providers with missing documentation, we recommend the department verify they are eligible to provide services.

Through the avenue of agenda items at Aging and People with Disabilities (APD) Supervisors Quarterly Meetings, APD Program Managers meeting, articles in the newsletter "In the Loop", and a training module at the 2013 Regional meetings, APD has worked to remind managers and staff of the policies and documentation required to support a provider's eligibility and forms that must be retained within the provider files. Provider Relations Unit will also provide resources and education for the Developmental Disability program providers. The APD offices have obtained the missing documentation for most of the providers listed.

Of the 17 providers who needed data base checks, we were able to satisfactorily complete all of the checks.

For three of the providers, the department could not locate the enrollment agreements, two providers were terminated, and we were able to locate the enrollment for the third application.

For the provider that did not have a criminal background check, we were able to verify that the check was completed.

For the six providers where we were unable to locate provider files, we have since documented the criminal background check and provider enrollment documents.

The department's Aging and People with Disabilities (APD) and Office of Developmental Disability Services (ODDS) Provider Relations Unit has taken steps to require the submission of provider enrollment agreements and other items necessary to ensure provider eligibility determination when processing new, reenrolling, and revalidating providers. There are exceptions for some specific providers where the provider eligibility documentation is maintained in the field and only a portion of the provider validation is completed by the Provider Relations Unit. For those specific providers with documentation maintained in the field, APD and ODDS management continue to work with local office managers to communicate the necessity to retain the provider eligibility documentation within their provider files. The record retention requirements

have been communicated to the management of the field offices responsible for retaining provider eligibility documentation not otherwise submitted to the Provider Relations Unit.

APD continues to remind field staff of the importance of gathering and maintaining all required documentation for provider eligibility, including the completion of all relevant database checks. This topic is covered at District/Program Manager meetings, supervisor meetings, and through articles in the APD newsletter. Gathering of specific documentation related to the findings was completed in August 2016.

- We recommend department management document procedures for completing annual reviews and strengthen the process for conducting desk reviews to include reviewing and making adjustments that could affect the annual payment rate. We also recommend department management ensure full reviews are completed and adequately documented and evidence of supervisory review and approval is retained.

  Documentation was provided on which facilities were audited and how those facilities were selected for this audit cycle. APD shared the number of facilities reviewed and draft procedures that APD will use for performing future reviews.

  Department management has made significant changes to the Nursing Facility Cost Review process. The department hired a Program Analyst 4 (PA4) to assist on these reviews. The PA4 and an Operations and Policy Analyst 3 are working on the process. In addition, the department has implemented and documented management review of this process. Draft procedures were completed in early 2014 to document the process and finalized in June 2014. These procedures are reviewed periodically to make necessary revisions.

- We recommend department management strengthen controls to ensure sufficient documentation is maintained to demonstrate compliance with federal requirements, and ensure the client liability is calculated accurately.

  Through the avenue of agenda items at Aging and People with Disabilities (APD) Supervisors Quarterly Meetings, APD Program Managers meeting, articles in the newsletter, "In the Loop," APD has worked to

remind managers and staff of the policies and documentation required to support a client's eligibility and forms that must be retained within the client files. APD is also working to implement scanned client files for field offices so that all documentation will be readily available. For the two clients where errors occurred in determining the client's liability, one of the clients is in a nursing facility and another is deceased. Information was sent to the Estate Recovery Unit to determine if these questioned costs were eligible for estate recovery. The department will continue working within our programs to ensure these requirements are shared with staff and continue to be followed appropriately.

- We recommend department management correct the transactions processed with this incorrect coding. We also recommend department management ensure system coding is appropriately updated to allow only current FMAP rates to be used.

  The department has implemented a process change related to Program Cost Account (PCA) structure. The Office of Financial Services (OFS) now enters an 'effective end date' on PCA's to prevent a PCA from being used on a transaction after the grant period has closed.

  The four identified transactions have been corrected in the accounting system with balance transfers. Additional research is being done to ensure there are no additional documents that need adjustment. The change in process was implemented March, 2014.

- We recommend management develop a plan based on current resources to ensure the timely completion of provider health and safety standard surveys for nursing facilities.

  Oregon has a long history of meeting the Centers for Medicare and Medicaid Services (CMS) performance standards related to surveying facilities in fewer than 15.9 months. The Nursing Facility Licensing Unit is dedicated to bringing our CMS performance standard back into compliance. Over the past four years various staffing resource issues, such as the position freeze and mandatory furloughs, have significantly affected our ability to complete our work timely. In fact, our vacancy rate for surveyors reached 34% by the

end of the freeze. Implementation of the Quality Indicator Survey (QIS) also contributed to our failure to meet the CMS performance standards. In addition to the general difficulties inherent of a new process and system, this new federally mandated survey process has increased our required survey team size (particularly for small facilities), increased training requirements, and lengthened total survey time.

Over the past few years we have implemented several continuous improvement activities that have resulted in efficiency gains to the survey process, in turn reducing the amount of time it takes to survey a provider. Those efficiencies have resulted in a significant reduction in new surveyor training time. We have made efforts to minimize survey related travel and made reductions in report writing time. We have implemented an Electronic document workflow process, streamlined our report review process to facilitate a faster turnaround time between surveys, and provided provider training on how they can prepare for the new QIS process. Additionally, since July 2013 we have hired a significant number of new surveyors. This has been offset by a number of retirements and staff resignations.

During the last few years, we also assessed the survey and training teams to optimize production, optimized survey and surveyor turnaround time, evaluated utilization of CMS approved survey contractor to help us complete surveys and evaluated our surveyor recruitment process to enable us to reach better and more qualified applicants. We have also brought retired and resigned surveyors back on a temporary basis to perform surveys.

All surveys conducted were less than 15.9 months since August 15, 2015, in compliance with the federal requirement.

- We recommend authority management develop a security plan that addresses all federally required components, develop and implement a formalized risk analysis program, and ensure system security reviews are conducted timely for all applicable systems involved in the administration of the Medicaid program.

We agree the Department of Human Services and Oregon Health Authority have not completed all the elements of a formal ADP risk analysis and security review of the Medicaid systems. However, as we have previously communicated, the agencies have traditionally relied on third-party assessments such as SOC 1, Type 2 reports, audits from Office of Inspector General, Secretary of State, and the Enterprise Security Office's Annual Information Systems Business Risk Assessment report to provide this information. Security control assessment is included in these assessments. Vulnerability assessment scans of the MMIS system software are periodically performed at least every three years or whenever major changes are made to the system. The last vulnerability assessment took place in September 2016.

We use these audits and reports, as well as leveraging reports from the Privacy and Incident Response section, to assist in that determination. While not strictly a formal risk assessment per se, it does provide an analysis of controls from both a system as well as program perspective. In addition, Information Security and Privacy Office (ISPO) staff have conducted physical security walk-throughs of the State Data Center where the MMIS production servers are located.

An information security risk assessment was conducted by the Information Security and Privacy Office (ISPO) on the Provider Services and Provider Enrollment units of Division of Medical Assistance programs (DMAP), which administers the Medicaid program for the State of Oregon. The risk assessment was completed in March 2015. In January 2015, the Oregon Health Authority began an agency-wide restructure. As a result of this major restructure and transitional projects, further ISPO-conducted risk assessments were postponed. We also agree that we need to develop a formal risk assessment and security review program based in industry standards and best practices that assesses risks for programs as a whole and not on a system-by-system basis.

- We recommend department management ensure branch offices are aware of and follow the established procedures for securing EBT cards.

DHS developed a Financial Desk Training for Aging and People with Disabilities (APD) and Self Sufficiency Program (SSP) staff, whose duties involve financial business process, and field managers. The

Financial Desk Training includes a section on the established procedures for Electronic Benefit Transfer (EBT) card security. The Field Business Procedures Manual and the Business Review Tools are used as a basis for the training curriculum. SSP Office and Business Managers received the financial desk Electronic Benefit Transfer (EBT) Card Security section of the training prior to June 2014, along with expectations for complying with EBT card security and inventory procedures. In addition, a communication was sent to office leadership in June 2014, regarding the importance of securing EBT cards and following the policy outlined in the Field Business Procedures Manual for monthly inventory.

Financial Manager Training webinars, including a section on established procedures for EBT card security, were held on December 23, 2014; February 11, 2015; and February 12, 2015 and has been converted to a webinar and posted in the Learning Center on May 19, 2015.

There were 19 sessions of the Financial Desk Training that took place in various locations across the state between September 23, 2015 and November 9, 2015. This training will be offered as needed for new staff in the future.

As with other findings, APD has also addressed this topic through agenda items at APD Supervisors Quarterly Meetings, APD Program Managers meeting, and articles in the newsletter, "In the Loop". Through these efforts APD has worked to remind managers and staff of the policies and documentation needed in effective management of the EBT card security.

APD has monitored the Financial Desk Training course and determined that all APD and AAA branches have completed the training. Self Sufficiency has taken corrective action and completed branch office monitoring at the end of July 2016.

2. Temporary Assistance for Needy Families: High Expectations, Stronger Partnerships, and Better Data Could Help More Parents Find Work, audit #2014-08 (dated April 2014)

- We recommend the Department of Human Services:

  Improve case management
  - Use additional case managers to increase the amount of client contact and set an expectation that each client will progress toward self-sufficiency;
  - Prioritize additional work supports as funds become available, particularly subsidized child care that allows more parents to participate in work activities;
  - Develop procedures for self-sufficiency offices to better assess new and returning clients and connect clients to needed medical care;
  - Create detailed case plans that include strengths and interests, progress milestones, and meaningful activities;
  - Track progress, build time limits into case planning, and conduct intensive reviews at key intervals, such as 24 and 48 months;
  - Work with case managers and supervisors to address their concerns about the sanctions process and ensure they consistently hold clients accountable;
  - Increase discussion of client progress during re-certifications and routine client contacts;
  - Improve services to clients with barriers by including work-related activities in case plans when appropriate, monitoring progress made in treatment, and following through on disability analyst recommendations;
  - Require some level of participation before fully sanctioned clients are allowed to reinstate their TANF benefits;
  - Develop a process to identify top performing TANF workers and share best practices among case managers and regional offices.

Expand partnerships

- Build connections with Coordinated Care Organizations so clients can receive thorough assessments, referrals, and appropriate medical treatment;
- Increase collaboration with other organizations that provide crucial services to TANF clients, including GED instruction, rehabilitation, apprenticeships, community support and employment services;
- Work with university researchers to help assess program effectiveness, as other states have done.

Use data to drive improvements

- Assess which client interventions work best and direct limited resources to proven programs;
- Continue developing data capabilities to track client progress, assist case management and improve agency wide operations.

Ensure compliance with federal requirements

- Work with the federal government to determine if time-limit extensions for economic hardship were appropriate and if the Indian Country exemption is too broad.

We recommend that DHS management work with the Legislature and Governor to:

- Consider revisiting budget and program decisions made during the recession that decreased client services and increased the number of TANF clients, using improved data on program performance and client needs;
- Study the costs and benefits of raising the income limit for TANF clients who find work;
- Consider allowing case managers more flexibility when re-engaging clients and administering sanctions;
- Consider authorizing extended benefit holds as an initial step when clients fail to participate, reducing the use of the cumbersome and punitive disqualification process;
- Explore alternatives to Oregon's state clock policy that could be less administratively burdensome.
- Consider adding small-scale participation incentives.

We recommend that Congress and the Department of Health and Human Services consider modifying federal regulations to:

- Allow clients more time and credit for pursuing GED certificates and higher education while working or looking for work;
- Allow clients with barriers to employment to receive more participation credit for documented progress in activities, such as health care, addiction treatment and vocational rehabilitation, that help them address their barriers;
- Give credit for partial participation in work-related activities, such as unpaid work experience and community service, particularly for clients with documented barriers.

- We recommend that federal auditors further review federal TANF regulations that limit participation credit for clients who pursue education, health care, addiction treatment and other activities that help them address their barriers to work.

The Secretary of State's Temporary Assistance for Needy Families (TANF) audit largely confirms weakness in program structure that the Department has been actively discussing with policy makers and stakeholders since the recession began in 2008. Third party validation by qualified auditors is always welcome and valuable.

We appreciate the accurate portrayal of the challenging economic circumstances in Oregon and the many consequences for the state TANF program as described in the audit report. Additionally, the agency agrees with the findings that improvements can and should be made in terms of employment outcomes and client engagement in the TANF program.

While the audit points out that Oregon's TANF program does not lack for vision or ambition, it is regrettable that it largely ignores the dual purpose of the program: Safe and stable families, as well as employed parents.

In 2007, through House Bill 2469, the Oregon Legislature codified and funded a comprehensive TANF program designed to achieve the dual purposes of the TANF program. Data shows that in the first year of implementing the HB 2469 model, the program was starting to achieve the expected results. Unfortunately, the recession forced even more families out of work and into the TANF program. It also forced difficult decisions about resources for the TANF program. Because jobs were in short supply for even the most qualified job-seekers, the Legislature chose to prioritize TANF's family stability side. It left the cash assistance side of the program in place as part of a safety net for children and drastically reduced employment supports and services for adults in the program.

The report recognizes that the TANF program during the audit period was not structured to prepare people for jobs that did not exist during the recession. Still, the audit spends considerable time on the issue of accountability, both with respect to DHS staff holding individuals accountable, and individuals on TANF taking responsibility to get back to work. That discussion perpetuates the traditional conversation about this program and the people it serves, rather than recognizing the structural challenge of the disincentives for work that are part of Oregon's safety-net.

Compounding those structural issues -- specific to poverty and the TANF program itself during the audit period -- were the overarching challenges for all job seekers during the recession. Those challenges are underscored by the fact that the Unemployment Insurance program (which, like TANF is also intended to be temporary) has been extended multiple times since the recession began (and, at the time of this audit report release, six years later, the U.S. Congress is considering another extension).

That being understood, the agency agrees that best practice involves engaging clients fully in case planning, supporting those plans with the appropriate services, and holding clients accountable for full participation in plans and services. The TANF program already has begun seeing improvements in these areas as the result of the Legislature supporting the redeployment of staff and a small expansion of the JOBS program budget for employment services in the 2013-15 Legislatively Adopted Budget (LAB).

Next Steps:

The Department takes the results of the TANF audit seriously, particularly in the spirit of improving outcomes for Oregon's children and families. Following is a summary of the audit recommendations DHS has implemented:

Additional Case Management

The department hired additional case managers in January 2014. There were a total of 167 Human Services Specialists 3's converted to 162 Case Managers. The first phase released 128 positions to fill in October 2013 and the second phase released 34 positions in December 2013.

Self-Sufficiency Expectation

The JOBS Participation Project outlined the following strategies on December 18, 2014:

- *Establish clear statewide requirements through protocols for administering JOBS program.*
- *Establish clear understanding of current and ongoing performance per district.*
- *Recommend ongoing management of participation through use of performance reports developed at the state level e.g. Snapshot, TRACs, attendance tracking tools etc.*
- *Assist each district in identifying successes and barriers to success in order to develop implementation and sustainability plans for JOBS participation.*

Implementation began in January 2015 by teams from the Office of Continuous Improvement supporting each district with development of localized implementation of the participation protocols targeting consistent process to engage participants of all employment readiness levels. Sustainability of the work in each district was completed by June 2015. An expectation that each client will progress toward self-sufficiency by engaging in a plan to move forward will result in increased work participation rates.

Prioritize Work Supports as Funds Become Available

The JOBS program budget for 2013-15 included a small expansion. There was $1.4M set aside to cover increased child care rates and up to $1.8M additional for support services that could include child care expenditures for participating clients.

Rule 461-190-0211 was amended on July 1, 2013 to increase flexibility with contracted and support services. The changes include:

- *Additional JOBS services such as life skills, family stability services, GED supports for adults, up to 12 months in vocational training, and other activities that support family stability and employment efforts; and*
- *Support services changes that allow child care for two-parent families as determined on a case by case basis, and support services for more activities such as life skills, on the job training, and SS application appointments.*

Policy Transmittal SS-PT-13-026 was issued on June 26, 2013. It included a Jobs Activities and Support Services quick reference guide which provides a list of available activity codes and guidance for JOBS support services. The guide was made available in the TANF Employment Staff Tools intranet page.

The Policy Transmittal, SS-PT-14-032 issued in December 2014, amended rule 461-190-0211 on January 1, 2015 increasing flexibility with contracted and support services to allow a JOBS exempt individual to volunteer for the JOBS program if the reason for their exemption is due to having a dependent child under the age of six months. Since making these changes, more parents have had access to contracted activities and support services that include child care.

Procedures to Assess New and Returning Clients

A workgroup was convened to modify the up-front assessment during the spring and summer of 2014. In August 2014, the My Self-Assessment Tool was created. During the pilot testing, it was determined that additional changes needed to be made.

The department consulted with the Center on Budget and Policy Priorities (CBPP) while they visited Oregon in October 2014. They shared some assessment tools currently in use by other states. These tools were shared during the October 15, 2014 Program Manager meeting.

In light of the CBPP visit, and the need to get an online version of capturing the elements within the work readiness, guidance, checklists, and tools are being developed for staff to help participants access needed medical/mental evaluations and services. This group has identified the following next steps:

- *TANF policy is identifying needed categories and the potential design of an online tool. A draft example is being developed for further conversations between the BA's and the TRACS design team to determine the feasibility and possible timeline associated with this project.*
- *Identify field representation to join the planning: to provide the field perspective on where and how this would fit into the process of working with a client and to minimize the time needed to input the data in the system.*

In order to better assess the needs of and provide resource referrals and accommodations to those with disabilities, training has been provided to staff throughout 2014 and 2015. In addition to this training, a document defining the steps for referral for a psychological evaluation was drafted on December 30, 2014, as well as a Psychological Evaluation Checklist on January 26, 2015. These documents provide guidance for usage of the DHS forms 729 series, which are used for requesting evaluations and services.

A project plan was developed to coordinate the many facets of this body of work and to ensure forward motion on implementation of a measureable employment ready assessment tool.

Procedures Connecting Clients to Medical Care

DHS worked with OHA to ensure TANF recipients had medical eligibility determinations fast-tracked to allow access to medical care. This was outlined in Policy Transmittal SS-AR-14-004 which was issued on

January 31, 2014. To provide clarification of this process to the branch offices, an FAQ document was issued on April 28, 2014. The Policy Transmittal was updated and reissued in July 2015 SS-AR-15-011.

Detailed Case Plans

With the hiring of additional case managers along with declining caseload, more time has been devoted to case planning. The JOBS Participation Project as well as the TANF pilot initiatives focused on family stability and employment in a variety of ways across the state from October 2013 through December 2014. The JOBS Participation Project has identified successful approaches, which have been shared with staff as the project rolls out.

An investment was made in training specific to focusing on strengths based practices. PSU provided Enhanced Case Management in three distinct modules.

- *Module 101 is a 1-day training to outline foundational elements and core concepts including motivational interviewing, assertive engagement, stages of change, culture of poverty and trauma informed practice. As an initial phase, sessions delivered around the state have a priority focus on newly hired case managers. Leadership and/or administrative staff are also encouraged to participate.*

- *Module 201 is a 3-day training with a much deeper focus on practice and application. Session attendees would include those that are connected to and or support the specific family work including eligibility workers, case managers, lead workers, supervisors, administrators and other staff deemed appropriate. Content and format was designed to specifically support the unique role the individual plays within the SSP system. Ongoing coaching and support will be offered as a follow up to ensure sustainability and capacity building. All districts are included in a phased rollout of 201 Modules.*

- *Module 301 is a 2-day training focused on core skills, qualities and abilities to coach others in the field with attendees including ICCs, lead workers, supervisors, management and other deemed appropriate. Though training sessions are a great way to share concepts and key ideas, true*

transformative work occurs at the coaching level. Not only does this approach reinforce concepts from earlier sessions, it also builds capacity at the local level to continue the practice. To foster consistency and sustainability, deliberate strategies have been taken to link and/or align with current leadership training efforts within DHS (Supervisory Quarterly, ICC Meetings, Supervisory Conferences, etc.).

This training began October 2013 and has been held in various locations across the state.

To date portions of each Module (101, 201, and 301) have been incorporated into the training curriculum redesign. Training redesign will offer an ongoing opportunity to incorporate portions into position specific training. Topics such as Trauma informed Care, Understanding Poverty, Empathy, Strengths Based Practice are now part of the Fundamentals training received by all SSP staff. Module 201 is a deeper dive into skills necessary for case managers to connect with families in a meaningful way that facilitates progress towards self-sufficiency and continues to be offered across the state. Module 301 was required for leadership statewide and parts of the curriculum have been imbedded in both Fundamentals and Case Management training courses. These modules have led to changes in engaging families by teaching techniques of assessing written communication to ensure they reflect the philosophical intent, by practicing consulting and coaching approaches, and more welcoming engagement practices that focus on participant strengths, setting goals, and gauging their interest.

Key Interval Reviews

Automatic notifications were implemented to inform individuals when they have reached 48 out of 60 months of TANF receipt. Policy Transmittal SSPT-14-013 was issued on May 15, 2014 providing guidance and awareness of automated 48 month notice and to describe expectations to engage client.

Multiple TANF time limit tools have been provided and made available on the staff tools website (http://www.dhs.state.or.us/caf/ss/tanf/tanf-time-limits.html). The 48-month checklist was posted to the site in

May 2014. This checklist is used to assess clients status, includes referral resources, long term financial planning, and prioritization of JOBS services.

Statewide reports were modified in January 2015 to assist field managers and staff in identifying families who are close to meeting the 60-month time limit. Policy Transmittal SS-AR-15-001 was issued on January 15, 2015 to provide guidance on working the monthly time limit reports.

The department will continue to improve this process under HB 3535 that was signed into law in July 2015. There currently is a workgroup made up of DHS staff and stakeholders who are making recommendations for implementing the HB 3535 provision, including recommendations on extension criteria and case management at critical points in the 60-month continuum. The workgroup is also reviewing notices and the process flow for time limit extensions. The implementation date for the new policies was spring 2016.

Sanction Process and Accountability

Training on the re-engagement requirements began in 2014. This training was intended to help staff feel more confident in working through the re-engagement process and to build consistency statewide in holding clients accountable.

Disqualification case reviews are conducted every six months and provide an opportunity to coach staff.

A work team explored client accountability recommendations, which resulted in a series of recommended statute changes. HB 3535 was signed into law in July 2015. There currently is a workgroup made up of DHS and stakeholders who will be making recommendations for implementing the new provisions, which include restructuring the sanction amounts. The implementation date for the new policies was in July 2016 which includes a process improvement implementation rollout.

Based on the workgroups recommendations the TANF policy was updated to revise the following rules: OAR 461-190-0231, 461-130-0330, 461-130-0335 and 461-135-0089. A policy transmittal (SS-PT-16-013) was

also distributed to staff explaining the new rules and the progressive grant reductions that apply to the whole family grant. Training was also provided statewide on June 28th and July 7th. The Office of Continuous Improvement developed a Re-Engagement protocol which has now been rolled out to all districts to improve the consistency of the process.

Client Progress Discussions

Improvements have been made in this area with the hiring of case managers. As the caseload has been declining, there is more time for case management and for more regular client contact. The number of families who are participating in activities has increased. Discussions about progress result in case plan development. The total number of cases not meeting participation rate requirements due to having no plan dropped from 30.8% in January 2014 to 15.5% in January 2015.

Improving Services to Clients with Barriers

Some improvements have been made in this area with hiring case managers and the declining caseload as it has resulted in additional time for case management.

After consulting with the Center on Budget and Policy Priorities (CBPP) to learn about three examples from other states, the Department has made an effort to improve the assessment tools and data tracking so that gaps in services can be identified.

The State Family Pre-SSI/SSDI (SFP) managers attended a meeting with Self-Sufficiency program managers and a process is being developed to coordinate better with disability analysts to maximize resources. A meeting with Vocational Rehabilitation and TANF program field managers was conducted April 8, 2015 to improve understanding of the different programs and to improve coordination at the local level.

A workgroup composed of disability analysts, field staff, and TANF staff has been meeting to improve current coordination efforts. Recommendations will be made to leadership for implementation;

recommendations will include consistent referral processes, identification of external resources, identified training needs, and possible contracted services.

Required Participation before Sanctioning

This option was discussed in a workgroup and recommended to move forward. The department worked on OAR changes that included cooperation periods before TANF benefits are reinstated to an individual after serving a sanction. In July 2016, OAR 461-130-0335 was updated to reflect the changes in cooperation periods.

Sharing Best Practices from Top Performing Workers

Although we will not create a process of identifying top performing TANF workers, we have identified best practices that increase engagement of participants. The development of protocols began in May 2014 in District 11. Statewide protocols are being implemented in each district with the involvement of the DHS Office of Continuous Improvement. The Participation Tool Kit was developed and is maintained on the TANF Staff Tools website, http://www.dhs.state.or.us/caf/ss/tanf/tanf-time-limits.html.

Build Connections with Coordinated Care Organizations

The Department started discussions from fall 2013 with CCO's to build a connection with members so field staff can play a role in their medical treatment as part of case management. In order to assist clients with accessing benefits, a process to prioritize medical eligibility for TANF clients was developed in April 2014.

Once priority medical determinations have been made, OHA medical coverage recipients have access to medical, mental health, and alcohol and drug treatment services. The department works with the participant to identify and access necessary services as part of their case plan.

Increase Collaboration with Other Organizations Providing Crucial Services
The passage of the Workforce Innovation and Opportunity Act (WIOA) and the inclusion of TANF as a mandatory partner in the workforce system presented an opportunity to improve the employment prospects of people in TANF. A formalized WIOA implementation workgroup was formed which includes the TANF program as a full participant along with other workforce agency representatives, including Vocational Rehabilitation.

The TANF program is also represented in the State's Workforce Policy Implementation group. The TANF program collaborated with BOLI on an application for a Dept. of Labor Apprenticeship grant. In October 2015, the DOL awarded Oregon a $3 million grant. TANF participants are among the target populations to be served by this grant. The TANF program is represented in a soon to convene implementation committee.

Work with University Researchers
While the TANF Reinvestment package funded data analytics, the 2015-17 department budget did not specifically include funding for contracts with universities. The TANF program has been in discussions with advocate stakeholders on how to partner with universities to help assess program effectiveness.

Direct Limited Resources to Proven Programs
The TANF Reinvestment package included a pot of money for expanding partnerships to help participants maintain employment, prevent re-entry into TANF, and address family stability. The department plans to direct these limited resources to fund innovative project proposals that improve outcomes for TANF participants in the areas mentioned above. Requests for proposals are planned for release by January 2016.

DHS has approved 17 district support service projects (13 of these have fully executed contracts in place for this work) and 5 Community Collaborative Impact grants (4 executed contracts and the final one is awaiting DOJ approval).

Continue Developing Data Capabilities

A "family case progression report" showing the percent of families with monthly progress towards family stability, work readiness, or employment was developed in spring/summer of 2014 and has been made available to field leadership and staff.

Improvements have also been made with respect to other reports containing family case detail (such as the "snapshot report" to be able to do additional follow-up with families. Reports shared with field in fall 2014 accompanied with presentations at Program Managers in September 2014 and line managers in January 2015. TANF Policy and Office of Business

Determine if Economic Hardship Time-Limit Extensions are Appropriate and if the Indian Country Exemption is Too Broad.

The DHS has consulted with the Department of Interior and with Oregon Tribes. On March 31, 2015 ACF issued a decision on this finding, which directs DHS to provide a methodology and timeline for utilizing the definition of "Indian Country" consistent with federal regulation. On August 28, 2015 DHS sent ACF a question and proposed a clarification on a way to achieve compliance with TANF regulations while also recognizing the Tribes' restoration acts. While still awaiting a response from ACF, DHS requested an extension to the plan submission date. DHS submitted a plan of correction on September 25, 2015 that includes timeframes for achieving basic compliance beginning January 2016 and incorporates Oregon's proposed clarification. The extension to the plan of correction was subsequently obtained on October 1, 2015.

Tribes were notified October 7, 2016 about the changes that will be implemented the last week of November. Staff received training in November and December 2016 and the full implementation of all changes will be January 1, 2017.

Revisit Prior Decisions Made During the Recession
This audit recommendation was directed at the Legislature and the Governor. The 2015 Legislative Assembly and Governor responded to this audit recommendation by passing HB 3535 and the DHS TANF budget, which together included close to $30 million in investments on behalf of TANF participants.

Study the Cost and Benefit of Raising Income Limits
During the 2015-17 budget development process the department studied the costs and benefits of raising the income limit for TANF participants who find work. HB 3535 along with the DHS TANF budget, both approved in July 2015, funded an increase in the TANF income limit at exit due to employment along with other supports for newly employed families. These policy changes were implemented in April 2016.

Consider More Flexibility when Re-Engaging Clients and Administering Sanctions
DHS worked with CBPP, FSRC, and DOJ to provide recommended statute amendment allowing more flexibility in the engagement and disqualification processes. The TANF Statute Change Briefing Sheet for HB 3535 included an amendment to address this concern. Section 2, Amendment 6 Request states the following:

> *"Adults in the TANF program will benefit from these statute modifications because the changes coupled with additional training for DHS staff will clarify that the re-engagement process is an opportunity to review whether the participant's case plan is adequate. This change will also allow DHS to determine sanction levels in rule and provide for adjustments to changing circumstances. This change adds flexibility without losing the protections for clients that are already included in law. Administrative rules, policy, notices, and training will be modified to align with the statute change and the overall intent."*

Consider Authorizing Extended Benefit Holds and Reducing the Use of the Disqualification Process
A benefit hold pilot was conducted in 2013 within branches of D3. The pilot identified JOBS mandatory participants that either did not show to appointments to develop plans to move forward or who did not show to the activities themselves. Timely notices were required to advise participant of change in benefit delivery

method, home visits were attempted, and if contact was made or no contact but ten days into the benefit period then benefits were released since a legal reduction/closure notice had not yet been sent. The pilot resulted in increasing the workload for staff and adding complexity to the process with the increased potential for error. It did not show increases in participation nor did it decrease re-engagement efforts. The Department decided to not explore this option further.

Explore Alternatives to Oregon's State Clock Policy

The Department has worked with staff from Center on Budget and Policy Priorities (CBPP) and Department of Justice to include proposed language to the HB 3535 currently in front of the 2015 Legislative Assembly. In preparation for the HB 3535, many presentations were held with advocates and legislators to ensure full understanding of the policy and intentions being put forth.

The TANF Statute Change Briefing Sheet for HB 3535 included an amendment to address this concern. Section 2, Amendment 7 Request states the following:

> *"This change will provide more clarity for TANF participants about the number of months they have available in their time limit. This change also aligns with federal law regarding extensions beyond the time limit based on hardship. The extensions occur after 60 months of cash assistance have been provided. This change does not create one federal and state clock for past TANF receipt but provides better consistency of both clocks for new families in the program. In other words - assuming the change happens - there is a greater likelihood from the implementation date forward, of a new family having one single clock for time limit purposes."*

Rules are currently being implemented for April 1, 2016 to carry out the decisions made in HB 3535.

Consider Adding a Small-Scale Participation Incentive

In the summer and fall of 2014 a number of districts provided short-term incentives to help clients increase their engagement in the TANF program activities. Guidance for purchase and use of incentives was written

and shared with staff in September 2014. It included items such as: gas vouchers and cards; retail store cards; donated gift certificates; donated detergent or other household needs; donated coffeehouse cards; and teen parent engagement baskets with donated items such as diapers and children's books. While districts reported these incentives showed improved engagement outcomes, this was discontinued due to budget constraints.

3. Child Care in Oregon: Difficult to Afford; New Regulations May Improve Safety but Further Raise Costs, audit #2014-25 (dated December 2014)

- Determine if an administrative rule or statutory change is required to allow ODE licensing staff to monitor unlicensed providers who serve children receiving subsidy and initiate the change process.

  The Early Learning Division (ELD) and DHS pursued both statutory and administrative rule changes to allow for onsite monitoring of license-exempt providers who care for children on the subsidy program. Federal law requires that enforcement for monitoring begin no later than December 2016. Statutory authority in the form of a legislative concept was submitted by ELD to the Oregon State Legislature in the 2016 session.

  Section 2 of HB 2015 amended ORS 417.728 to allow the Early Learning Division, Office of Child Care (OCC) to conduct on-site inspections for license exempt child care providers. H B2015 enrolled and OR Laws 2015 chapter 698 shows the amendment to ORS 417.728. The bill was signed July 20, 2015.

  ORS 329A.505 provides authority for ODE Office of Child Care to conduct on-site inspections of license exempt child care providers required under federal law.

- Monitor and inform the HB 3330 committee of changes in the demand for fingerprinting services among providers to determine whether enough Fieldprint sites are available to meet the demand.

Both ELD and DHS will continue working with the Department of Administrative Services and the fingerprinting contractor to minimize the impact of the new statewide requirement for electronic fingerprints and the related federal rules taking effect in the next two to three years. DHS has representation on the HB 3330 committee and continues to work with the Department of Administrative Services and the fingerprinting contractor regarding availability of electronic fingerprint sites and changes in demand related to federal rules.

- Determine costs associated with the comprehensive background checks, inspections, and posting inspection reports online and develop strategies to minimize the burden on providers and families.

  ELD and DHS will continue leading a Child Care Policy Reform Implementation Planning team to comprehensively evaluate and plan for the new rules. This will include determining costs as well as leveraging current efforts underway, such as the overhaul of the child care regulatory information system. This system will include license-exempt providers and the public will be able to access monitoring and compliance history and consumer education. Changes that create a fiscal impact are subject to collective bargaining through the two child care provider unions.

  Planning is underway for implementation of background check changes as required by federal regulations beginning January 2017 by both agencies. The Background Check Unit – which is a DHS/OHA shared service – will have a Policy Option Package (POP) to help address processing costs for license exempt providers and reduce out of pocket costs for license exempt providers. ELD will have a POP to help address additional out of pocket costs for licensed providers.

- Consider tracking parents who stop receiving assistance and providers who stop providing care and the movement of providers between different types of regulated care, including those who migrate between licensed and unlicensed care, including those who migrate between licensed and unlicensed care settings.

DHS will consider implementation of a survey system to ascertain whether families stop receiving assistance due to the new regulations. Baseline information is under development. The survey is planned to begin after implementation of monitoring visits and increased health and safety training.

4. Department of Human Services: OR-Kids Financial System Problems, audit #2014-28 (dated December 2014)

This audit focused on one part of the OR-Kids computer system, the financial module, and we wanted to provide some additional context prior to discussing specific issues identified in the audit report.

The OR-Kids project converted data from paper files and seven disconnected systems used by the DHS Child Welfare program into a single Statewide Access Child Welfare Information System (SACWIS). OR-Kids provides important case management and data collection tools to meet Federal reporting requirements, as well as information to inform decision making and support for caseworkers' interaction with children, youth, and families through the life of a Child Welfare case.

This audit report confirmed many of the very issues the agency had been monitoring. In fact, the Oregon legislature, Governor's office and our federal partners were kept fully apprised of status and issues throughout OR-Kids development and rollout.

All complex technology systems have challenges – with data conversion, accuracy, interruptions in service, and other issues (small and large). However, the OR-Kids system itself, especially the child safety and foster care management modules, has allowed caseworkers consistent access to the system since go-live in 2011, with very little downtime – which was not true of the legacy systems it replaced.

Even before the system was launched, the agency was working to identify and prepare for technical and training issues, including those identified in this audit report. As the project rolled out, DHS leadership and project staff continued to closely monitor and adjust to address problems for providers and staff. The agency

reallocated resources to address technical and process issues and ensure that corrective action and improvements were put in place.

Today, the OR-Kids system continues to work and provide the important support for child safety and business processes we expected when we launched more than three years ago.
A few of the benefits OR-Kids has delivered are listed below:

- *All Child Welfare information is contained in a single state system;*
- *Workers can better screen reports of child abuse and neglect because more information is linked and can be quickly searched across files;*
- *OR-Kids has created efficiencies, through automated processes, that allow casework to take less time than in the old systems. Our most recent Workload Survey shows that workers are now spending more time with children and families than doing paperwork and multiple data entry;*
- *System is generating accurate information for federal and state reporting purposes, as well as for our new public foster care information site;*
- *More than 43,000 cases are managed each month by 3,200 users; and*
- *A total of $561 million has been processed and paid to 30,462 providers through the financial module of the OR-Kids system (about 1.5 million payment records).*

We accept the recommendations in the audit report, and we have taken (and continue to take) steps to address the issues identified in the recommendations (as discussed below).

- We recommend the Department of Human Services closely review OR-Kids transactions and financial reports to ensure accuracy and appropriateness, and return any amounts owed for federal overcharges.

  It should be noted that most of the funding errors occurred during a single data conversion event in which millions of payment records were converted to incorrect accounting codes.

Once the agency received its first comprehensive grant level remediation document (for transactions from August 2011 through December 2012), we put an estimate on the state accounting system to reimburse the federal government $23.3 million. The following two quarters' remediation estimate resulted in an additional $3.4 million adjustment. The final data conversation reconciliation was completed in December 2014, resulting in an approximate $500,000 final adjustment.

In June 2014, the agency also implemented a final permanent data fix on the remaining "untouched" converted cases thereby permanently fixing this data conversion issue. All adjustments related to this issue have now been made.

- We recommend the Department of Human Services make changes to the financial module to prevent it from claiming federal funding outside the two year period.

  The OR-Kids system was not designed to disallow federal claiming outside the federal two-year limit. Therefore, the agency has been manually reducing these costs to ensure we do not charge the federal government for claims outside the allowable period.

  The agency has a documented system change to resolve this issue and this change is in the queue for action. For now, we will continue to manually remove old transactions so that the federal government does not pay costs outside the two-year limit.

  Planned changes will prevent the application of trust money to payments with service dates prior to January 1,2008, prevent workers from being able to end a placement as "opened in error" when that placement has dates prior to January 1, 2008 and not allow reimbursement greater than two years in the past. A subsequent requirements gathering session occurred in October 2016. Due to the complicated financial information that must be considered, such as each grant requiring different rules and functionality, implementation of this change to production could take over a year. A business process and work around

were created regarding placement corrections prior to January 1, 2008, to ensure these types of errors do not occur in the system.

- We recommend the Department of Human Services take steps to ensure a more robust supervisory review of transactions takes place.

  The agency expects that the supervisory review of OR-Kids transactions will be a check and balance on potential human errors in working with the system, and we have taken several steps to increase the effectiveness of those reviews.

  The Child Welfare program has done communications to case workers, as well as to supervisors and managers, about the importance of accuracy in the system. Those communications were followed up by approval and oversight trainings at the agency's Supervisor Quarterly meetings. As a further safeguard, technical staff placed a monetary cap on approved expenditures by service category to ensure that no large errors could be processed. The Office of Financial Services has also implemented a review of large transactions to ensure they are correct. The Office of Financial Services' process for review was completed July 2014.

  Spending Limits were added to the OR-Kids services, causing medium edits to trigger and require manager override, when a payment record exceeds the spending limit for that specified service.

  Since these controls were put in place, transaction errors have been better identified and corrected prior to payments being issued.

- We recommend the Department of Human Services address the security recommendations included in the confidential management letter.

  The agency agrees with the recommendations in the Confidential Management Letter, and we are taking actions as addressed in our confidential response.

  The access control issues were addressed in early 2015. Additional work has now been completed to monitor OR-Kids access.

5. DHS and OHA Statewide Single Audit Including Selected Financial Accounts for the Year Ended June 30, 2014, audit #2015-05 (dated April 2015)

- We recommend department management ensure its internal controls over its check receipting process are sufficient to ensure all checks are safeguarded, properly tracked and accounted for in the financial records.

  The agency has implemented a new check receipting and reconciliation process. The OFS Receipting unit has overhauled the check scanning process and now images checks into On-Line Electronic Deposit (OED) immediately.

- We recommend department management implement system changes to OR-Kids to prevent transactions from reimbursing outside the period of availability. We also recommend management make appropriate corrections and adjustments to the accounting records to prevent the department from requesting federal reimbursement for expenditures incurred outside the period of availability.

  The federal draws are reconciled at the end of each quarter to the total federal expenditures reported to Administration for Children and Families (ACF). Remediation adjustments were completed in December 2014. Revisions to all federal reports dating back to September 30, 2011 have been included as prior period adjustments on the June 30, 2015 report. Adjustments to the state accounting system were completed by September 30, 2015. We hope to have the OR-Kids system adjustment issue resolved by December 31, 2016.

Planned changes will prevent the application of trust money to payments with service dates prior to January 1,2008, prevent workers from being able to end a placement as "opened in error" when that placement has dates prior to January 1, 2008 and not allow reimbursement greater than two years in the past. A subsequent requirements gathering session occurred in October 2016. Due to the complicated financial information that must be considered, such as each grant requiring different rules and functionality, implementation of this change to production could take over a year.

- We recommend department management implement and document processes to ensure quarterly CB-496 reports are complete, accurate, and adequately supported by the accounting records.

  All documentation is currently being filed with the report, as well as saved electronically. A new reconciliation process is currently in place to ensure quarterly reports reconcile to the state accounting system.

  The federal draws are reconciled at the end of each quarter to the total federal expenditures reported to Administration for Children and Families (ACF). Remediation adjustments were completed in December 2014. Revisions to all federal reports dating back to September 30, 2011 have been included as prior period adjustments on the June 30, 2015 report. Adjustments to the state accounting system were completed by September 30, 2015.

- We recommend department management ensure all required documentation is completed, reviewed, and maintained. We also recommend department management reimburse the federal agency for costs paid to the provider who was not certified at the time of payment.

  The department participated in a Federal Title IV-E Foster Care review in July 2014. During that review, similar compliance issues were identified. The review required a submission of a Program improvement Plan (PIP). The PIP included changes to OR-Kids to ensure the Title IV-E specialist is able to accurately ascertain all required elements of the certification procedures are completed prior to determining a child is Title IV-E eligible and reimbursable. Federal Policy, Planning and Resources Unit will developed

procedures for the Title IV-E Specialists to view criminal background check documentation, certificates and home studies to ensure the Title IV-E eligibility does not begin prior to the first of the month in which all the required certification procedures are completed.

The department submitted the Program Improvement Plan to the Administration for Children and Families and it was approved on June 24, 2015. The department must submit quarterly updates and the final report was submitted July 22, 2016.

The department completed training of the Title IV-E specialists on the proper procedures to view criminal background check documentation, certificates and home studies to ensure the Title IV-E eligibility is determined accurately. This training occurred at the Title IV-E Specialist Quarterly in February 2015. The department corrected the eligibility on the error case, and made subsequent adjustments for other children in the home.

An Action Transmittal was sent out to the field on June 15, 2016 with detailed processes the field and other agencies must follow until the OR-Kids modifications are implemented. The Title IV-E specialists received a training (via a conference call) in which the Action Transmittal was reviewed on June 16, 2016.

- We recommend department management ensure its methodology for allocating administrative costs to the Title IV-E Foster Care program is documented and adequately supported.

  The Federal Policy, Planning and Resources (FPPR) manager worked with the Permanency Manager to review develop and document a method for allocating the administrative cost for contracts. The Federal Policy, Planning and Resources (FPPR) manager has identified all the contracts with unique methodology for allocating administrative costs. The FPPR manager completed an analysis to determine the appropriate funding methodology and make the necessary changes through the Office of Contracts and Procurement and the Office of Financial Services. The correct PCA and Index were provided to the support person for all contracts that continue to use an old funding methodology. All adoption contract invoices received after June 2016 should be processed with the correct PCA/Index.

- We recommend department management identify all causes of closed federal eligibility and improve its case management processes to ensure federal reimbursements are received for eligible cases. We also recommend department management re-open federal eligibility for all eligible cases that were incorrectly closed.

  The department identified human error as the cause of most of the closed Title IV-E eligibility, and efforts began immediately to correct the eligibility on these cases. The Post Adoptions manager and the Title IV-E coordinator have a monthly report to monitor any new cases where Title IV-E eligibility closes in order to ensure proper federal reimbursement and to continue the analysis on why Title IV-E eligibility is closed. The Post Adoptions manager and Title IV-E coordinator work with OR-Kids business analysts if an OR-Kids deficiency is discovered. If an OR-Kids deficiency is discovered, appropriate actions are taken to fix the system.

  The department completed the corrections in April 2015 and the total amount of federal reimbursement retroactively claimed in the 3rd quarter of Federal Fiscal Year 2015 was $4.3 million. The Post Adoptions manager monitors the monthly report for any cases where Title IV-E adoptions assistance eligibility is closed when there is an active adoption assistance payment and ensures her staff corrects the eligibility to ensure appropriate and timely reimbursement of federal funds.

  The department monitors OR-Kids Eligibility Status reports quarterly to ensure the "no eligibility" records remains low. The "no eligibility" records are errors and need to be corrected.

- We recommend department management continue to correct known applicable child eligibility data issues and develop a consistent process to identify and document applicable child eligibility to ensure data used to estimate the savings in state expenditures is accurate. Also, once clarification is received from the federal agency, department management should ensure applicable child eligibility is applied appropriately to prior cases and make any necessary corrections.

The department worked on cleaning up Adoptions Assistance Applicable Child eligibility based on our interpretation of the federal regulation specific to applicable child; however, based on the questions brought forward during last year's audit, we determined we needed clarification. The department requested assistance from Region X and we were told a program instruction was coming. The department waited to clean up the applicable child eligibility and finalize our methodology for calculating the applicable child savings until after we received this clarification

In May 2015 the department received the Children's Bureau policy instruction (ACFY-CB-PI-15-06), which outlined the requirements for calculating adoption savings related to applicable child eligibility. The PI confirmed that the changes in program eligibility criteria impacts only the number of children who, absent the applicable child criteria, would not be determined as title IV-E eligible for adoption assistance.

The department has opted to use "actual amounts" to track and calculate applicable child adoption savings. Requirements have been finalized for an updated OR-Kids determination that will allow us to track children who are eligible as applicable child only and children who are eligible based on their foster care episode and applicable child criteria. Completion of the new determination was estimated for March 2016. In the interim, we are utilizing the existing adoption assistance determination in the OR-Kids system to track those children who are title IV-E eligible as applicable child only. In June 2015 the department completed redetermination of approximately 1,000 adoption assistance determinations to clean-up data conversion errors impacting applicable child data.

The department has completed a significant manual cleanup of the Adoption Assistance eligibility determinations to accurately capture the children who are eligible for Adoption Assistance due to the "applicable child" criteria only. The FPPR unit is working with OR-Kids business analyst and the Office of Business Intelligence to identify any remaining children whose Adoption Assistance IV-E eligibility does not accurately reflect why the child is eligible for Title IV-E adoption assistance. Based on the data provided by

OR-Kids business analyst, the IV-E specialists and IV-E Program Coordinator completed the clean-up in September 2016.

OR-Kids Business Analysts and FPPR Policy Analysts have designed the necessary changes in order to document that a child is eligible for Title IV-E adoption assistance when they are eligible for by meeting both eligibility criteria (traditional adoption assistance eligibility rules and applicable child rules). Currently the system allows us to document one or the other, therefore we can accurately track and calculate our Adoptions Applicable Child Savings. Due to other competing priorities implementing these changes into the system will be delayed until 2017.

- We recommend department and authority management strengthen controls to ensure sufficient documentation is maintained to demonstrate compliance with federal requirements, support for payment amounts and income is retained, and the client liability is calculated accurately.

  The department continues working within our programs to ensure these requirements are shared with staff and continued to be followed appropriately. Since the period of time covered by the audit, DHS Self-Sufficiency field offices have been in the process of moving toward electronic case files as part of our EDMS Expansion project.

  As part of this effort, in November 2014 an all-staff transmittal was issued identifying the standardized data capture elements for offices that have moved to electronic case files. This standardization assists in locating documentation in EDMS. Additionally, DHS Self-Sufficiency field offices were also provided with refresher tools on archiving to help in documenting which case files and time frames are shipped to Archives to be scanned.

  APD has completed the roll out of the EDMS Expansion and all files are in the process of being converted to electronic format. Training was completed in every field office and AAA throughout the state. It is believed that having files in electronic format will ensure that eligibility documentation is not lost and will be easier to locate when needed.

APD offices have completed training and roll out of the EDMS system for client eligibility documentation. The program continues to remind staff and managers of the importance of maintaining client documentation through staff meetings and "In the Loop" newsletter articles.

- We recommend department management strengthen controls to ensure documentation supporting a provider's eligibility determination is retained. For current providers with missing documentation, we recommend the department verify they are eligible to provide services.

  The department's Aging and People with Disabilities (APD) and Office of Developmental Disability Services (ODDS) Provider Relations Unit has taken steps to require the submission of provider enrollment agreements and other items necessary to ensure provider eligibility determination when processing new, reenrolling, and revalidating providers. There are exceptions for some specific providers where the provider eligibility documentation is maintained in the field and only a portion of the provider validation is completed by the Provider Relations Unit. For those specific providers with documentation maintained in the field, APD and ODDS management reminded local office managers of the necessity to retain the provider eligibility documentation within their provider files.

  The department has completed the database checks on the eleven providers mentioned in the finding. The department also verified the eligibility of the five providers identified with missing provider enrollment agreements. The department has taken the necessary steps to revalidate or close the associated provider numbers. Three of these providers have current provider agreements and are eligible to provide services. Two other providers are no longer providing services. We have made adjustments in our accounting system to return the federal funding for these two providers for the enrollment period.

The Provider Relations Unit has participated in multiple education and outreach sessions addressing the provider enrollment validation process including program manager meetings, licenser trainings, and ODDS plan of care conference calls reminding local staff and managers of the need to retain the provider eligibility documentation within their provider files.

The department's Aging and People with Disabilities (APD) and Office of Developmental Disability Services (ODDS) continues to work within our programs to ensure the provider eligibility documentation held by our field offices is retained. The record retention requirements have been communicated to the management of the field offices responsible for retaining provider eligibility documentation not otherwise submitted to the Provider Relations Unit.

APD continues to remind field staff of the importance of gathering and maintaining all required documentation for provider eligibility, including the completion of all relevant database checks. This topic is covered at District Program Manager meetings, supervisor meetings, and through articles in the APD newsletter. Gathering of specific documentation related to the findings was completed in October 2016.

- We recommend management develop a plan based on current resources to ensure the timely completion of provider health and safety standard surveys for nursing facilities.

  Oregon has a long history of meeting the Centers for Medicare and Medicaid Services (CMS) performance standards related to surveying facilities in fewer than 15.9 months. The Nursing Facility Licensing Unit is dedicated to bringing our CMS performance standard back into compliance and we anticipate reaching compliance in early 2016.

  Over the past four years various staffing resource issues, such as the position freeze and mandatory furloughs, have significantly affected our ability to complete our work timely. In fact, our vacancy rate for surveyors reached 34% by the end of the freeze.

Implementation of the CMS Quality Indicator Survey (QIS) process also contributed to our failure to meet the CMS performance standards. In addition to the general difficulties inherent in a new process and system, it increased our required survey team size (particularly for small facilities) for a period of time, increased training requirements, and lengthened total survey time during the implementation period.

Over the past few years we have implemented several continuous improvement activities that have resulted in efficiency gains to the survey process, in turn reducing the amount of time it takes to survey facilities. Those efficiencies have resulted in a significant reduction in new surveyor training time.

We have made efforts to minimize survey-related travel and made reductions in report writing time. We have implemented an electronic document workflow process, streamlined our report review process to facilitate a faster turnaround time between surveys, and provided provider training on how they can prepare for and assist with the survey process. Since January 2013 we have hired 19 new surveyors. However, we have had 16 surveyors leave in the same time period due to retirements, promotional opportunities, competition with private industry related to salary, and surveyors not demonstrating skills needed to make it through trial service.

During the last few years, we also assessed the survey and training teams to optimize production, optimized survey and surveyor turnaround time, evaluated utilization of CMS approved survey contractor to help us complete surveys and evaluated our surveyor recruitment process to enable us to reach better and more qualified applicants. We have also begun brought retired and resigned surveyors back on a temporary basis to perform surveys.

All surveys conducted were less than 15.9 months since August 15, 2015, in compliance with federal requirements.

- We recommend department management strengthen controls to ensure adherence to department policy and procedure regarding documentation of participation, projection of hours of participation, and to ensure data entered into the automated data processing system is accurate and complete.

  Work Verification Plan reviews (also known as the JOBS Audits) are currently conducted annually. A summary of audit results is shared statewide.

  Our internal Federal Data group identified two systems issues that contributed to the conflicting data in the findings. Both are being addressed by programmers and business analysts in conjunction with TANF Program. These fixes will be programmed and reflected for FY 2015 data.

  The department's usage of the Electronic Document Management System along with the standardized filing method, implemented in phases beginning October 2015, has reduced the potential for lost documentation.

  The department submitted a revised Work Verification Plan with an effective date of July 1, 2016. During the month of July 2016, a workgroup consisting of policy and program staff from around the state met to discuss a complete overhaul of the Work Verification Plan to be effective with the October 1, 2016 effective date. The new format will include more details around matters of benefit conversion and ongoing eligibility documentation. In addition to increased documents and published tools for staff, the policy unit staff now send regular emails several times each month focusing on participation issues that has been identified as needing further explanation. These emails are distributed to the front-line staff and leadership as a means to help guide conversations in the field in regards to participation and program accuracy. The topics for the emails are identified through case reviews, questions submitted to the policy unit, and questions frequently asked during training.

- We recommend department management ensure verification of income with IEVS screens is clearly documented in client case files when determining client eligibility.

  The department has made great strides to improve the awareness and knowledge of this requirement to field staff.

  The department held statewide accuracy and case management summits, at which time this topic was discussed to build awareness. An Action Request Transmittal was sent in October 2014 to clarify expectations and provide guidelines and examples of necessary narrations to support that IEVS screens were indeed checked. The summits were followed up by a policy transmittal in November 2014 of all the Questions and Answers which allowed an additional reminder to be visible statewide. December 2014 allowed the "On Target" to put an article on the front page to keep the importance on the radar.

  TANF Quality Assurance reviews revised their criteria in January 2015 to add IEVS as a specific element for review. This raises awareness in a way that requires follow up and corrections to be made.

  In February, the department implemented a systems support in the form of an "IEVS checked" box on the TRACS narrative systems and sent a Policy Transmittal in on February 27, 2015.

  These cited efforts at education, awareness, and systems support constitute the corrective action plan for this finding.

- We recommend department management ensure complete and accurate client information is used to compile the quarterly data reports.

  The department agrees that the data populating the ACF-199 and ACF-209 reports need to be as accurate and complete as possible. A team of Office of Information Services (OIS), Office of Business Intelligence (OBI), Self-Sufficiency Business Analysts, and Self-Sufficiency Program (SSP) staff meets weekly to address known or presenting data quality issues for these federal reports. Significant progress has been achieved to

increase the data accuracy and completeness of these reports. This includes resolving several of the items listed in this audit findings report. DHS recognizes that a continued effort is still necessary in order to resolve known data quality and data completeness issues.

It was identified that the programming that applies the data set to the month of assistance was not aligned and caused future codings to reflect as sanctions or programs before their actual effective date. Specifically related to the sanctions, a data collection fix was implemented and will be reflected in data transmitted from March 1, 2015 forward.

Additional errors related to complete hours (including excused and holiday) not transmitting as recorded in TRACS has been identified and should be fixed for FY 2015 data.

A team consisting of Child Welfare Business Analyst, OBI, Self-Sufficiency Business Analysts, Programmers, and Program have been working to refine the requirements and data extraction coding for the data needed from the Child Welfare case management system. Progress was made to correctly identify the population needed in the federal reports.

As of June 2015, Child Welfare cases are included in the TANF federal reports. Action was taken on all categories identified in this finding including the duplicate case issue identified in the data submitted on the ACF-209 and the inclusion of TANF funded child welfare cases in the ACF-199. Programming changes to address the problem with reporting duplicate cases were made and the changes were incorporated with the data submitted for FY 2014 forward.

- We recommend the department seek a conclusion from the federal government to ensure five-year time limit monthly exemptions are being appropriately applied in accordance with federal regulations.

  The department agrees that a conclusion should be sought on the time limit exemption associated to Indian Country. The department has followed the advice from the Administration for Children and Families (ACF) by consulting with the local Bureau of Indian Affairs, as well as the Department of Interior, Office of the

Solicitor. The department also consulted with Oregon Tribes, three of which submitted letters affirming the State's current interpretation of Indian Country.

The department sought validation from ACF that the current interpretation of Indian Country used by the department for the purposes of time limits falls within the realm permissible by federal law.

On March 31, 2015 ACF issued a decision on this finding which directs the department to provide a methodology and timeline for utilizing the definition of "Indian Country" consistent with federal regulation. The department has been consulting with Oregon Tribes through the Department of Justice on a way to address their concerns.

On August 28, 2015 the department sent ACF a question and proposed a clarification on a way to achieve compliance with TANF regulations while also recognizing the Tribes' restoration acts. While still awaiting a response from ACF, the department submitted a plan of correction on September 25, 2015 that included timeframes for achieving basic compliance beginning January 2015. The plan also incorporated Oregon's proposed clarification.

The extension to the plan of correction was subsequently obtained on October 1, 2015. The department has now completed the consultation process with Oregon's recognized tribes and ACF. The planned implementation date for all changes is January 1, 2017. Tribes were notified October 7, 2016 about the changes that will be implemented the last week of November. Staff received training in November and December of 2016 and the full implementation of all changes will be January 1, 2017.

- We recommend management determine the amount of interest owed to the federal government for Medicaid and CHIP and ensure clearance patterns in the draw calculation spreadsheet are updated annually to reflect any changes in the CMIA agreement.

  We determined the amount of interest owed and included it with our interest spreadsheet which was sent to the Oregon Department of Administrative Services on December 1, 2015. The accountant has put on the

calendar a reminder to update the check clearance pattern percent and has also put a note in the spreadsheet to update.

- We recommend the department update the cost allocation plans to reflect current practices and ensure future changes are communicated timely.

  Historically, the agency submitted biennial updates to the cost allocation plan and submitted changes to the plan annually when significant changes were made. There were no significant modifications to the plan during the last year so an update was not submitted to the Division of Cost Allocation.

  The agency agrees that updates to the plan should be submitted annually, even if no changes are made. Further, the agency is currently communicating with the Division of Cost Allocation for guidance on their process for the submission of amendments to the public assistance cost allocation plans regarding mid-year modifications.

  Due to changes in the organizational structure of OHA, our update of the OHA PACAP was delayed until July 2016. The current biennium cost allocation plan was submitted for review in July 2016 and is awaiting a response from DCA.

- We recommend department management ensure client's monthly copay is correctly calculated and client's income documentation is maintained.

  Four cases were identified for incorrect copay calculation. Two of the cases cited were due to using medical income instead of the calculated child care income (audit sample months were August and October of 2013). During these sample months, workers were calculating income for medical and child care at the same time. We anticipate this will not be an ongoing issue because Self Sufficiency workers stopped determining medical eligibility in December 2013. The remaining two cases cited were due to conversions between TANF and ERDC.

Self Sufficiency field offices are in the process of moving toward electronic case files as part of our EDMS Expansion project. In November 2014, a transmittal was issued identifying the standardized data capture elements for offices that have moved to electronic case files to assist in locating documentation in EDMS.

Program provided a copy of On-Target Newsletter, Policy Transmittal, April Self Sufficiency Supervisor Agenda and May 2015 SSP Field Leadership Update, which addressed the need to correctly determine copays when transitioning from TANF to ERDC.

Additional communications will be sent to department field staff and trainers for the Employment Related Day Care (ERDC) program identifying methods to prevent copay calculation errors. Child care policy staff will work with the Direct Pay Unit staff to develop a process to address situations when a copay is not being met and there are multiple providers involved.

The Self-Sufficiency Program (SSP) field offices were still in the process of moving toward electronic case files as part of our Electronic Document Management System (EDMS) expansion project. This should assist the department in locating documentation in EDMS in the future. A gradual statewide rollout of the new procedures related to electronic document management of customer documents and standardized data capture began in October 2015. By January 2016, all SSP offices completed training and started using the new procedures.

A transmittal was issued June 15, 2016 to inform field staff of the error reasons resulting in incorrect copay calculations and policy reminders/tips to prevent these errors. The transmittal also included additional tips to increase accuracy in the ERDC program.

Child care policy staff continue to work with the Direct Pay Unit staff to develop a process to address situations when a copay is not being met and there are multiple providers involved.

A focused internal review of ERDC cases is planned to improve the accuracy rate. The review team will include ERDC policy analysts, local branch staff, and reviewers from Quality Assurance (QA) and Quality

Control (QC). This will help to review a higher number of cases and make corrective actions on any cases found in error.

- We recommend department management ensure branch offices are aware of and follow the established procedures for securing EBT cards.

  Self Sufficiency Program Office Managers and Business Experts received the Financial Training for Managers, focusing on Electronic Benefit Transfer (EBT) card security and managing RACF access, in May 2014. In addition, a communication was sent to office leadership in June 2014, regarding the importance of securing EBT cards and following the policy outlined in the Field Business Procedures Manual for monthly inventory.

  The Financial Training for Managers was converted to a webinar format and was delivered live to Self-Sufficiency, Child Welfare and Aging and People with Disabilities management on December 23, 2014, February 11, 2015 and February 12, 2015. A webinar, The Financial Training for Manager, was recorded and posted to the Learning Center on May 19, 2015.

  There were 19 sessions of the Financial Desk Training that took place in various locations across the state between September 23, 2015 and November 9, 2015. This training will be offered as needed for new staff in the future.

  In order to ensure that this training has been implemented throughout all Self Sufficiency, Aging and People with Disability and Area Agency on Aging (AAA) branch offices across the state, Central Office will provide monitoring between April 1, 2016 and July 31, 2016.

  APD has monitored the Financial Desk Training course and determined that all APD and AAA branches have completed the training. Self Sufficiency has taken corrective action and completed branch office monitoring at the end of July 2016.

- We recommend department management ensure its review process identifies transactions charged to a grant award outside the period of availability.

  The agency has previously reviewed all documents at a detail level except for entries being processed through our cost allocation system. Now, all transactions, regardless of source, are reviewed to ensure expenditures were incurred during the period of availability.

  OFS provided evidence to show that adjustments were made to take cost allocation expenditures out of FY 2014 and charge them to the appropriate period.

- We recommend department management improve its review process by considering implementing a more in depth review, ensuring critical formulas cannot be modified and providing training to staff.

  The additional check digits were added and training done prior to the original response date. A review of the process found that the review was generally effective. However, protecting critical formulas was problematic. Periodic management or peer reviews to ensure the critical formulas remain in place has been added to the review process.

6. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2015, audit #2016-09 (dated April 2016)

- Recommend department management ensure that adequate documentation is retained to demonstrate controls are operating as intended to ensure that expenditures are paid at proper rates.

  The Office of Financial Services has developed a "System Update Tracking Sheet" as documentation when federal funding split codes rate changes are updated or modified in systems. The tracking sheet was implemented with the federal rate changes effective October 1, 2015.

- Recommend department management consider the financial statement impact resulting from adjustments or entries made in underlying coding to ensure amounts are properly reported.

  To ensure the agency receives the accrual transaction information timely; the Statewide Financial Reporting unit has updated its accrual procedure to include instructions to request the accrual information before July 1 with the year-end task list, and then to check back for this information no later than August 1. To ensure the accrual review will include an analysis of the financial impact, a section has been added to accrual procedures to include review at the comptroller and rollup GAAP object level.

- Recommend department management review OR-Kids transaction processing and make system modifications as appropriate to ensure proper financial reporting of program expenditures. We also recommend department management review prior year and current year transactions and reimburse the federal agency for grant expenditures claimed inappropriately.

  Change requests have been written to correct the OR-Kids system issues identified. These changes will ensure the correct split group is selected when refinancing historic transactions, allow placement corrections in a different age group for a child when they've aged into the next age group, change the eligibility batch to consider eligibility dates that occur after the TPR date, and ensure correct PCAs are charged by grant phase so accurate reporting to SFMA of the expenditure of federal funds will occur.

- Recommend department management implement system changes to OR-Kids to prevent transactions from reimbursing outside the period of performance. Recommend management make appropriate corrections and adjustments to the accounting records to prevent the department from requesting federal reimbursement for expenditures incurred outside the period of performance.

  Planned changes will prevent the application of trust money to payments with service dates prior to January 1,2008, prevent workers from being able to end a placement as "opened in error" when that placement has dates prior to January 1, 2008 and not allow reimbursement greater than two years in the past. A subsequent requirements gathering session occurred in October 2016. Due to the complicated financial

information that must be considered, such as each grant requiring different rules and functionality, implementation of this change to production could take over a year.

- Recommend department management ensure all required documentation is completed, reviewed, and maintained and ensure client eligibility is terminated timely, as well as clarify and document whether the home study must be signed by the supervisor for a provider to be certified. Also recommend that department management reimburse the federal agency for costs paid related to the ineligible child and provider.

  The Federal Policy, Planning and Resources unit provided a refresher training for Title IV-E eligibility specialists on February 25, 2016. This training included an overview of OR-Kids eligibility reports and recommended strategies for utilizing them to manage workload and support timely redeterminations.

  The department was required to complete our Program Improvement Plan (PIP). The final PIP report was submitted July 22, 2016. The PIP is the result of a Federal Title IV-E Foster Care review in July 2014, in which Oregon was found not to be in substantial compliance with Title IV-E Foster Care regulations. The majority of the PIP is regarding how to improve the documentation of background check information and implementing a quality assurance process for monitoring certification.

  The department submitted a significant design change to the OR-Kids provider module that will require that the home study and all background checks have an approval date prior to the foster care home becoming fully certified. This will be supported by an enhancement to the Foster Care Certification check list in which the OR-Kids functionality on this page will enforce compliance with rule and policy through system edits preventing system approval of a certificate unless required pieces of work have been entered. This will help drive appropriate certification practice. Included as part of the PIP, the department is developing a training plan to ensure successful implementation of the changes in OR-Kids and the certification rules.

The OR-Kids changes are scheduled to be deployed in the end of 2016. In order to be in compliance with the Title IV-E and close Child Welfare's Title IV-E Program Improvement Plan DHS Child Welfare implemented an interim plan to ensure background checks are completed an approved prior to claiming Title IV-E foster care maintenance. Effective June 15, 2016 the background check approvals must be scanned and uploaded to OR-Kids. The Title IV-E eligibility specialist will review the background check approval documentation and will not determine a child eligible for Title IV-E prior to the approval dates. An Action Transmittal was sent out to the field on June 15, 2016 with detailed processes the field and other agencies must follow until the OR-Kids modifications are implemented. The Title IV-E specialists received a training (via a conference call) in which the Action Transmittal was reviewed on June 16, 2016.

Prior year eligibility corrections were completed for the child associated with the payment sample, however the department did not correct the eligibility for other children placed in the provider home during the ineligible period. The department has now corrected eligibility for those additional children.

- Recommend department management ensure its methodology for allocating administrative costs to the Title IV-E Foster Care program is documented and adequately supported, and also ensure that coding is correct and up-to-date in the accounting system. We also recommend department management reimburse the federal agency for unallowable costs.

  The department has identified all the contracts with unique funding methodologies for allocating administrative costs and determined the appropriate funding methodology. The Federal Policy, Planning and Resources manager worked with Office of Financial Services to change the funding on the contracts and make the appropriate adjustments. In June 2016, the department changed the funding structure for all Adoptions Unit contracts to be consistent. All of the contracts now report to the Child Welfare design cost allocation funding structure.

- Recommend department management ensure payments are reviewed and approved properly to ensure appropriate payments to providers. Also recommend department management reimburse the federal agency for unallowable costs.

  The OR-Kids team will review the transactions in the finding. Once the issue is identified, we will either initiate a change request to resolve the identified issues in the system, or if unrelated to the system, refer the issue to others within the department based on the suspected cause. The agency will review and correct any unallowable costs as necessary.

- Recommend department management document the methodology used to review maintenance payment rates for continuing appropriateness, including a specific, time-limited schedule for review.

  The department will institute this requirement into the Oregon Administrative Rules set 413-090-0005 thru 0050. Foster Care Payments for a Child or Young Adult Living with a Certified Family or Living Independently. The intention is to review these rates every two years (odd years) though the department budget preparation processes for Governor's Recommended Budgets, which are due in the fall of the odd number years.

- Recommend department management ensure all required documentation is completed, reviewed, and maintained. Also recommended is that department management reimburse the federal agency for costs paid to the ineligible provider.

  The department was required to complete our Program Improvement Plan (PIP). The final report was submitted July 22, 2016. The PIP is the result of a Federal Title IV-E Foster Care review in July 2014, in which Oregon was found not to be in substantial compliance with Title IV-E Foster Care regulations. The majority of the PIP is regarding how to improve the documentation of background check information and implementing a quality assurance process for monitoring certification.

The department submitted a significant design change to the OR-Kids provider module that will require all background checks have an approval date prior to the foster care home becoming fully certified. Another part of the design is an enhancement to the Foster Care Certification check list in which the OR-Kids functionality on this page will support rule and policy, which will help drive appropriate certification practice. As part of the PIP, the department is developing a training plan to ensure successful implementation of the changes in OR-Kids and the certification rules.

The OR-Kids changes are scheduled to be deployed in the end of 2016. In order to be in compliance with the Title IV-E and close Child Welfare's Title IV-E Program Improvement Plan DHS Child Welfare implemented an interim plan to ensure background checks are completed an approved prior to claiming Title IV-E foster care maintenance. Effective June 15, 2016 the background check approvals must be scanned and uploaded to OR-Kids. The Title IV-E eligibility specialist will review the background check approval documentation and will not determine a child eligible for Title IV-E prior to the approval dates. An Action Transmittal was sent out to the field on June 15, 2016 with detailed processes the field and other agencies must follow until the OR-Kids modifications are implemented. The Title IV-E specialists received a training (via a conference call) in which the Action Transmittal was reviewed on June 16, 2016.

- Recommend department management continue to correct known "applicable child" eligibility data issues in OR-Kids to ensure data used to estimate the savings in state expenditures is complete and accurate.

  The department had completed a significant manual cleanup of the Adoption Assistance eligibility determinations to accurately capture the children who are eligible for Adoption Assistance due to the "applicable child" criteria only. Prior to the audit sample being pulled, the Federal Policy, Planning and Resources (FPPR) unit was working the eligibility specialists to continue the cleanup of the eligibility data, including the "applicable child" cleanup. The FPPR unit is working with OR-Kids business analyst and the Office of Business Intelligence to identify any remaining children whose Adoption Assistance IV-E eligibility does not accurately reflect why the child is eligible for Title IV-E adoption assistance. Based on the data

provided by OR-Kids business analyst, the IV-E specialists and IV-E Program Coordinator completed the clean-up in September 2016.

OR-Kids Business Analysts and FPPR Policy Analysts have designed the necessary changes in order to document that a child is eligible for Title IV-E adoption assistance when they are eligible for by meeting both eligibility criteria (traditional adoption assistance eligibility rules and applicable child rules). Currently the system allows us to document one or the other, therefore we can accurately track and calculate our Adoptions Applicable Child Savings. Due to other competing priorities implementing these changes into the system will be delayed until 2017.

- Recommend department management strengthen controls to ensure documentation supporting a provider's eligibility determination is retained. For current providers with missing documentation, recommend the department verify they are eligible to provide services.

  The department's Aging and People with Disabilities (APD) and Office of Developmental Disability Services (ODDS) continues to work within our programs to ensure the provider eligibility documentation held by our field offices is retained. The record retention requirements will be communicated to the management of the field offices responsible for retaining provider eligibility documentation not otherwise submitted to the Provider Relations Unit.

  The department verified the eligibility by obtaining a new provider enrollment agreement and I-9 form for the one provider missing both documents. For the three providers only missing their I-9s, the department verified their eligibility by obtaining the I-9 forms. For the one provider missing their background check and the two providers missing evidence of two of the required federal database checks, corrective actions from prior audit responses have been implemented that require verification of criminal history checks and maintenance of the required database checks completed at the time of enrollment, reenrollment and revalidation. All three of these providers were confirmed eligible to provide services.

- Recommend department and authority management strengthen controls to ensure sufficient documentation is maintained to demonstrate compliance with federal requirements and the client liability is calculated accurately.

  The department's Aging and People with Disabilities office will remind their managers and staff of the policies, appropriate documentation and retention of applications needed to determine eligibility for our program. These reminders will be agenda items for the APD Program Managers meeting, the APD Supervisors meeting and will be included in an "In the Loop" newsletter article.

  The department researched and has taken action on the nine cases with missing applications. For these cases, either an application has been obtained by the office, a current application was found on file, or the client is now deceased. We will also explore best practices to help better document evidence of redeterminations being completed in a timely manner.

  In relation to the eligibility coding error identified in the finding, the authority was actively working to renew the individual's benefits. The renewal was completed and benefits closed August 31, 2015. The authority will return the identified questioned costs to the federal government.

  The department has returned the federal funds for the one client identified in the finding where the client liability was calculated using an incorrect income.

- Recommend management strengthen controls to ensure only allowable costs are paid for at appropriate federal funding participation rates.

  The Office of Financial Services has a process to cross check the documentation provided by program staff to ensure the appropriate transfer has been completed. The agency is also working on a process to automate this transfer within the MMIS system.

A coding matrix was developed to allow users to select the correct coding for the allowable expenditures.

For noted transaction errors corrective action was developed and is in operation at this time. A new agreement is being negotiated. Adjustments were made to ensure correct federal funding.

- We recommend management develop a security plan that addresses all federally required components, develop and implement a formalized risk analysis program, and ensure system security reviews are conducted timely for all applicable systems involved in the administration of the Medicaid program.

  We agree the Department of Human Services and Oregon Health Authority have not completed all the elements of a formal ADP risk analysis and security review of the Medicaid systems. However, as we have previously communicated, the agencies have traditionally relied on third-party assessments such as SOC 1, Type 2 reports, audits from Office of Inspector General, Secretary of State, and the Enterprise Security Office's Annual Information Systems Business Risk Assessment report to provide this information. Security control assessment is included in these assessments. Vulnerability assessment scans of the MMIS system software are periodically performed at least every three years or whenever major changes are made to the system. The last vulnerability assessment took place in September 2016.

  We use these audits and reports, as well as leveraging reports from the Privacy and Incident Response section, to assist in that determination. While not strictly a formal risk assessment per se, it does provide an analysis of controls from both a system as well as program perspective. In addition, Information Security and Privacy Office (ISPO) staff have conducted physical security walk-throughs of the State Data Center where the MMIS production servers are located.

  An information security risk assessment was conducted by the Information Security and Privacy Office (ISPO) on the Provider Services and Provider Enrollment units of Division of Medical Assistance programs (DMAP), which administers the Medicaid program for the State of Oregon. The risk assessment was completed in March 2015. In January 2015, the Oregon Health Authority began an agency-wide restructure. As a result of this major restructure and transitional projects, further ISPO-conducted risk assessments were

postponed. We also agree that we need to develop a formal risk assessment and security review program based in industry standards and best practices that assesses risks for programs as a whole and not on a system-by-system basis.

- Recommend management develop a plan based on current resources to ensure the timely completion of provider health and safety standard surveys for nursing facilities.

  Oregon has a long history of meeting the Centers for Medicare and Medicaid Services (CMS) performance standards related to surveying facilities in fewer than 15.9 months. The Nursing Facility Licensing Unit is dedicated to bringing our CMS performance standard back into compliance and we anticipate reaching compliance in early 2016.

  Oregon has a long history of meeting the Centers for Medicare and Medicaid Services (CMS) performance standards related to surveying facilities in fewer than 15.9 months. The Nursing Facility Licensing Unit is dedicated to bringing our CMS performance standard back into compliance.

  Over the past few years various staffing resource issues, such as the position freeze and mandatory furloughs, have significantly affected our ability to complete our work timely. In fact, our vacancy rate for surveyors reached 34% by the end of the freeze.

  Implementation of the CMS Quality Indicator Survey (QIS) process also contributed to our failure to meet the CMS performance standards. In addition to the general difficulties inherent in a new process and system, it increased our required survey team size (particularly for small facilities) for a period of time, increased training requirements, and lengthened total survey time during the implementation period.

  Over the past few years we have implemented several continuous improvement activities that have resulted in efficiency gains to the survey process, in turn reducing the amount of time it takes to survey facilities. Those efficiencies have resulted in a significant reduction in new surveyor training time. We have made efforts to minimize survey-related travel and made reductions in report writing time. We have implemented

an electronic document workflow process, streamlined our report review process to facilitate a faster turnaround time between surveys, and provided provider training on how they can prepare for and assist with the survey process. Since January 2013 we have hired 19 new surveyors. However, we have had 16 surveyors leave in the same time period due to retirements, promotional opportunities, competition with private industry related to salary, and surveyors not demonstrating skills needed to make it through trial service.

As of August 15, 2015, all surveys conducted were less than 15.9 months and will continue to be less than 15.9 months going forward.

- Recommend department management ensure a client's monthly copay is correctly calculated and a client's application, income and special needs rate documentation is maintained. Additionally, department management should develop a process to identify when the copay is not being met when multiple providers are used.

  Communications will be sent to department field staff and trainers for the Employment Related Day Care (ERDC) program identifying methods to prevent copay calculation errors. Child care policy staff will work with the Direct Pay Unit staff to develop a process to address situations when a copay is not being met and there are multiple providers involved.

  During this audit period, the Self-Sufficiency Program (SSP) field offices were still in the process of moving toward electronic case files as part of our Electronic Document Management System (EDMS) expansion project. In November 2014 a transmittal was issued identifying the standardized data capture elements for offices that have moved to electronic case files. This should assist the department in locating documentation in EDMS in the future. A gradual statewide rollout of the new procedures related to electronic document management of customer documents and standardized data capture began in October 2015. By January 2016, all SSP offices completed training and started using the new procedures.

A transmittal was issued June 15, 2016 to inform field staff of the error reasons resulting in incorrect copay calculations and policy reminders/tips to prevent these errors. The transmittal also included additional tips to increase accuracy in the ERDC program.

A focused internal review of ERDC cases is planned to improve the accuracy rate. The review team will include ERDC policy analysts, local branch staff, and reviewers from Quality Assurance (QA) and Quality Control (QC). This will help to review a higher number of cases and make corrective actions on any cases found in error.

Child care policy staff continue to work with the Direct Pay Unit staff to develop a process to address situations when a copay is not being met and there are multiple providers involved.

- Recommend department management strengthen controls to ensure adherence to department policy and procedure regarding documentation of participation and projection of hours of participation, and to ensure data entered into the automated data processing system is accurate and complete.

  In reviewing the six cited exceptions from this year's audit findings the department will need to focus on systems fixes, increased guidance on calculating verified work hours, and improving our processes for receiving and retaining documentation.

  The TANF policy unit will gather an internal Federal Data group to research the errors and identify root cause(s), with the intent to establish corrective actions to focus on either preventing or detecting and correcting processing errors. This team drafted a plan in November 2016. Our cross-functional TANF program integrity group will continue to identify ways to train, coach, and review field staff work related to the calculation of work hours. Special attention will be focused on conversion of hours based on pay schedules, which resulted in two of the six errors cited.

  Work Verification Plan training is updated in the training that is provided to staff and includes information on JOBS hours and how to calculate and enter information on TRACS. Monthly emails are being developed

to share with field staff through local meetings and staff huddles, however this information has not yet been distributed.

The errors associated with inadequate documentation were due to a lost pay stub from a file transfer between branches and the use of annualizing income based on income tax documentation. The department's usage of the Electronic Document Management System along with the standardized filing method, implemented in phases beginning October 2015, has reduced the potential for lost documentation.

The department submitted a revised Work Verification Plan with an effective date of July 1, 2016. During the month of July 2016, a workgroup consisting of policy and program staff from around the state met to discuss a complete overhaul of the Work Verification Plan to be effective October 1, 2016. The new format will include more details around matters of benefit conversion and ongoing eligibility documentation. In addition to increased documents and published tools for staff, the policy unit staff now send regular emails several times each month focusing on participation issues that has been identified as needing further explanation. These emails are distributed to the front-line staff and leadership as a means to help guide conversations in the field in regards to participation and program accuracy. The topics for the emails are identified through case reviews, questions submitted to the policy unit, and questions frequently asked during training.

- Recommend department management ensure the report accurately reflects the activity of the reporting period.

  The department agrees that the data populating the ACF-199 and ACF-209 reports need to be as accurate and complete as possible. Currently, the Federal Data Group meets as needed to review summary reports and any quality issues that have been identified. This group already has programming underway to address all sanction types and to ensure this alignment with sanction and effective date is rectified.

  The data used for the transmission of ACF-199 and ACF-209 uses the months on TANF as indicated on an end of month file. Using this data causes the reports to be inaccurate by underreporting time on TANF by

one month. The Federal Data group is working on how to capture and align the full months on TANF prior to transmitting the data for the reports.

An identified error in the ACF-209 related to the "type of family for work participation" has been researched by programmers and the available data within CMS and TDRS have been used to their fullest. The need to inform and train staff in regard to coding parent fields is necessary to identify two-parent cases. Trainings and policy have been updated to include the importance of parental coding.

The Federal Data group is still researching ways to ensure duplicate individuals are not included in the reports. This group will develop a corrective action plan with the goal of transmitting the FFY 2016 data without this duplication.

- Recommend the department comply with the directive from DHHS and work with DHHS to resolve the different interpretations of the federal requirements for the TANF program.

  The department agrees that working with DHHS to resolve the different interpretations of the federal requirements for the TANF program regarding the interpretation of Indian Country is of most importance.

  The department engaged in formal tribal consultations with the individual tribes in order to adhere to tribal consultation policies. The department submitted a request for clarification to ACF in regards to the Indian Country definition as it relates to the Restoration Acts of Oregon tribes.

  The department has now completed the consultation process with Oregon's recognized tribes and ACF. The planned implementation date for all changes is January 1, 2017. Tribes were notified October 7, 2016 about the changes that will be implemented the last week of November. Staff received training in November and December of 2016 and the full implementation of all changes will be January 1, 2017.

- Recommend management ensure staff receive training regarding the proper coding for expenditures and allow ability of expenditures. Additionally, management should ensure documentation is maintained to support expenditures paid. Further, for the specific items identified, management should correct the coding errors and ensure the expenditures are billed to the appropriate program and/or source of funds.

  Agency management understands the importance of ensuring staff are trained on proper account coding, documentation, and allowable cost principles. Management will work with the Office of Financial Services to develop tools to assist staff in choosing the proper codes and develop additional quality assurance processes to review for unallowable costs. The identified transactions have been corrected.

- Recommend management update the cost allocation plans for the department and authority to reflect current practices and ensure future changes are communicated timely.

  The agency will continue to submit annual cost allocation plan updates and interim updates when there are major changes to allocation methodologies. Due to changes in the organizational structure of OHA, our update of the OHA PACAP was delayed until July 2016. The current biennium cost allocation plan was submitted for review in July 2016 and is awaiting a response from DCA.

- Recommend department management implement a process to verify that branch offices implement the training and follow the established procedures for securing EBT cards.

  DHS developed a Financial Desk Training for Aging and People with Disabilities (APD) and Self Sufficiency Program (SSP) staff, whose duties involve financial business process, and field managers. The Financial Desk Training includes a section on the established procedures for Electronic Benefit Transfer (EBT) card security. The Field Business Procedures Manual and the Business Review Tools are used as a basis for the training curriculum. Office leadership communicated the importance of securing EBT cards and following the policy outlined in the Field Business Procedures Manual for monthly inventory.

The Financial Manager Webinar was offered live on February 11, 2015 and February 12, 2015, towards the end of the audit period. There were 96 attendees who completed this first offering. This training was added to the DHS Learning Center on May 19, 2015 as a continual offering.

There were 19 sessions of the Financial Desk Training that took place in various locations across the state between September 23, 2015 and November 9, 2015. This training will be offered as needed for new staff in the future.

In order to ensure that this training has been implemented throughout all Self Sufficiency, Aging and People with Disability and Area Agency on Aging (AAA) branch offices across the state, Central Office will provide monitoring between April 1, 2016 and July 31, 2016. APD has monitored the Financial Desk Training course and determined that all APD and AAA branches have completed the training. Self Sufficiency has taken corrective action and completed branch office monitoring at the end of July 2016.

7. DHS: To Better Achieve its Mission, Vision and Goals, DHS Must Increase Efforts to Address Employees' Concerns, audit # 2016-24 (dated October 2016)

- We recommend DHS management develop and implement a plan to address the seven areas needing improvement: tools and resources, compensation, hiring practices, recognition, professional development, stress and workload, and communication. We recommend DHS management administer a work environment survey at least annually that includes the factors we identified that influence engagement. We recommend management use the future survey results to revise the plan, as needed.

  DHS will prioritize recommended actions based on those which are most "in our control" and those which will achieve the greatest positive impact on DHS culture. DHS plans to continue to utilize the workforce related measures in the DHS management system that overlap with the Work Environment Survey (Employee Engagement, Performance Feedback, and Diversity) and determine in what ways the "unique elements" of the Work Environment Survey may augment our established processes.

DHS Audits in 2015-2017

2015 – 2017 Internal and External Audits and Reviews for DHS

Internal Audits and Consults

Name of Audit:	Internal Fraud Detection
DHS Programs:	Agency Wide
Status:	Completed
Name of Audit:	SPOTS Audit (2014)
DHS Programs:	Agency Wide
Status:	Completed
Name of Audit:	Child-Caring Agency Licensing Agency – GUTD
DHS Programs:	Child Welfare, Program Design Services, Shared Services
Status:	Completed
Name of Audit:	Child-Caring Agency Screenings and Investigations – GUTD
DHS Programs:	Child Welfare, Shared Services
Status:	Completed
Name of Audit:	Contract Development and Administration – Child Welfare
DHS Programs:	Child Welfare, Shared Services
Status:	In Progress
Name of Audit:	Staff Safety II
DHS Programs:	Agency Wide
Status:	In Progress
Name of Audit:	Contract Delegation (2016)
DHS Programs:	Shared Services
Status:	In Progress
Name of Audit:	Program Delivery Use of Investigation Reports
DHS Programs:	Child Welfare, Shared Services
Status:	In Progress

Name of Audit:	Oregon Home Care Commission SPOTS Audit
DHS Programs:	Aging and People with Disabilities
Status:	In Progress

Name of Audit:	DOJ Attorney Billing Analysis (Consult)
DHS Programs:	Child Welfare
Status:	Completed

Name of Audit:	Ethics Structural Review (Consult)
DHS Programs:	Agency Wide
Status:	Completed

Name of Audit:	Opinion on Imaging Documents (Consult)
DHS Programs:	Agency Wide
Status:	Completed

Name of Audit:	Chehalem Consultation (Consult)
DHS Programs:	Child Welfare, Program Design Services
Status:	Completed

Name of Audit:	Payroll Time Code Reviews – Military Leave (Consult)
DHS Programs:	Central Services
Status:	Completed

Name of Audit:	OHA Provider Audit Unit Review of Medicaid Medically Fragile Children's Waiver, Medically Involved Children's Waiver, Behavioral Model Waiver, Support Services Waiver, and the Comprehensive Waiver
DHS Programs:	Aging and People with Disabilities, Developmental Disabilities
Status:	In Progress

Secretary of State Audits

Name of Audit:	State Agencies Respond Well to Routine Public Records Requests, But Struggle with Complex Requests and Emerging Technologies
DHS Programs:	Agency Wide
Status:	Completed

Name of Audit:	Senate Bill 616: Community Housing Trust Account Investigation
DHS Programs:	Developmental Disabilities, Shared Services
Status:	Completed
Name of Audit:	Statewide Single Audit For Year Ending 6-30-2015
DHS Programs:	Agency Wide
Status:	Completed
Name of Audit:	Oregon Needs Stronger Leadership, Sustained Focus to Improve Delinquent Debt Collection
DHS Programs:	Shared Services
Status:	Completed
Name of Audit:	To Better Achieve its Mission, Vision and Goals, DHS Must Increase Efforts to Address Employees' Concerns
DHS Programs:	Agency Wide
Status:	Completed
Name of Audit:	Improving State Computer System Security Will Take Time, Resources and Cooperation
DHS Programs:	Information Services
Status:	Completed
Name of Audit:	Wage Data Use Review
DHS Programs:	Agency Wide
Status:	Completed
Name of Audit:	Oregon Eligibility (ONE) and Medicaid Management Information System (MMIS) System Review
DHS Programs:	Information Services
Status:	In Progress
Name of Audit:	Statewide Single Audit For Year Ending 6-30-2016
DHS Programs:	Agency Wide
Status:	In Progress

Name of Audit:	DHS Aging Programs – In Home Care
DHS Programs:	Aging and People with Disabilities
Status:	In Progress

Name of Audit:	Medicaid Performance Review
DHS Programs:	Aging and People with Disabilities, Developmental Disabilities, Information Services, Shared Services
Status:	In Progress

Name of Audit:	Succession Planning
DHS Programs:	Central Services
Status:	In Progress

Name of Audit:	Child Welfare Performance Review
DHS Programs:	Child Welfare
Status:	In Progress

Federal Audits and Reviews

Name of Audit:	Food and Nutrition Service (FNS) Oregon Treasury Offset Program Review and Training
DHS Programs:	Shared Services
Status:	Completed

Name of Audit:	Social Security Administration (SSA) Representative Payee Review (Salem and Eugene)
DHS Programs:	Aging and People with Disabilities, Child Welfare
Status:	Completed

Name of Audit:	SSA Representative Payee Review (Stabilization and Crisis Unit)
DHS Programs:	Developmental Disabilities
Status:	Completed

Name of Audit:	Supplemental Nutrition Assistance Program (SNAP) Federal Fiscal Year (FFY) 2015 State Agency Management Evaluation
DHS Programs:	Aging and People with Disabilities, Self Sufficiency
Status:	Completed

Name of Audit:	Payment Error Rate Measurement (PERM) FFY 2014
DHS Programs:	Aging and People with Disabilities, Developmental Disabilities, Shared Services
Status:	Completed
Name of Audit:	Office of Inspector General (OIG) Audit of Office of Licensing and Regulatory Oversight (OLRO) Nursing Facility Survey Unit
DHS Programs:	Aging and People with Disabilities, Program Design Services
Status:	Completed
Name of Audit:	Health and Human Services (HHS) OIG Survey of Medicaid Claims Adjustments
DHS Programs:	Shared Services
Status:	Completed
Name of Audit:	Centers for Medicare and Medicaid (CMS) Home and Community Based Services (HCBS) Aged and Physically Disabled Waiver Review
DHS Programs:	Aging and People with Disabilities, Developmental Disabilities
Status:	Completed
Name of Audit:	Government Accountability Office (GAO) Study of Medicaid Personal Care Services
DHS Programs:	Aging and People with Disabilities, Developmental Disabilities
Status:	Completed
Name of Audit:	Federal Bureau of Investigation (FBI) Non-Criminal Justice Information Technology Security Review
DHS Programs:	Information Services, Shared Services
Status:	Completed
Name of Audit:	United States Department of Agriculture (USDA) FNS SNAP Education Management Evaluation FFY 2015
DHS Programs:	Aging and People with Disabilities, Self Sufficiency
Status:	Completed

Name of Audit:	USDA Financial Management Review of SNAP FFY 9-30-2015
DHS Programs:	Aging and People with Disabilities, Self Sufficiency, Shared Services
Status:	Completed

Name of Audit:	SNAP Program Access Review
DHS Programs:	Aging and People with Disabilities, Self Sufficiency
Status:	Completed

Name of Audit:	PERM FFY 2017
DHS Programs:	Aging and People with Disabilities, Developmental Disabilities, Shared Services
Status:	In Progress

Name of Audit:	CMS Home and Community Based Services Office of Developmental Disabilities Services Comprehensive Waiver Review
DHS Programs:	Developmental Disabilities
Status:	In Progress

Name of Audit:	Administration for Children and Families (ACF) Child and Family Services Review
DHS Programs:	Child Welfare
Status:	In Progress

Name of Audit:	HHS OIG Review of Medicaid Community First Choice Option (K-Plan)
DHS Programs:	Aging and People with Disabilities, Developmental Disabilities
Status:	In Progress

Other Agency Audits and Reviews

Name of Audit:	LEDS/NCIC Triennial System Use Audits (Multiple Locations)
DHS Programs:	Child Welfare
Status:	In Progress

Name of Audit:	Information Security Business Risk Assessment Report – 2015 (Department of Administrative Services Contract)
DHS Programs:	Information Services
Status:	Completed

Name of Audit:	SAIF Corporation JOBS Program Work Experience Rate Review 2015
DHS Programs:	Self Sufficiency
Status:	Completed

Name of Audit:	SAIF Corporation JOBS Program Work Experience Rate Review 2016
DHS Programs:	Self Sufficiency
Status:	Completed

Contracted Audits and Reviews

Name of Audit:	Child Safety in Substitute Care Independent Review
DHS Programs:	Child Welfare
Status:	Completed

Community-Based Needs Assessment of Oregon's Deaf and Hard of Hearing Communities: Final Report

Lead Investigator: Denise Thew Hackett, Ph.D, M.S.C.I.
Co-Investigator: Cheryl D. Davis, Ph.D.
Data Analyst: Sybille Guy, Ph.D.

12/30/2016

DHS Interagency Agreement #151333 (DHS-4131-16)
Western Oregon University
Regional Resource Center on Deafness

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Every one of you has helped to move mountains.

Executive Summary

Senate Bill 449 was introduced at the 78th Oregon Legislative Assembly during the 2015 Regular Session for the purpose of creating a Commission for Deaf, Deaf-Blind, and Hard of Hearing Services in the Department of Human Services (DHS). This Office would provide a centralized location for members of the public as well as state agencies to obtain assistance to ensure access for individuals who are Deaf, Deaf-Blind, and Hard of Hearing. The Ways and Means committee concluded from the revised SB 449a that a community needs assessment was needed to identify the social, health, and educational disparities experienced by the Deaf and Hard of Hearing Communities, and $200,000 in General Funds was granted to the Department of Human Services to support this effort. Western Oregon University's (WOU) Regional Resource Center on Deafness (RRCD) was awarded the contract as of May 1, 2016; with the final report due eight months later on December 30, 2016. The contract required the use of surveys, focus groups, and key informant interviews to collect data in nine domains across the state in a culturally appropriate and fully accessible manner. The purpose of this project was to identify for DHS and the Legislature the barriers that make it difficult for members of the Deaf, Deaf-Blind and Hard of Hearing communities to successfully engage in social, educational, and health services and to make recommendations for closing any gaps.

This study's findings support the recommendation that a Commission, such as the one proposed in Senate Bill 449a be funded. Options include expanding the current Oregon Deaf and Hard of Hearing Services providing interpreter referrals into a program with administrator and employees. Another option might be to fund a Commission through the Governor's Office using funding from the taxes on telephone subscribers as other states have done. Either way, the entity could begin the process of addressing the needs of the diverse populations of Oregonians with hearing loss.

The ability to communicate, to understand and to be understood, is the cornerstone of all areas of human development. It may look different from person to person, but without it, everything else is lost. Unfortunately, the general public's perception of hearing loss is not well informed given that untreated hearing loss has recently been discovered to be a public health crisis. The public's view of hearing loss is that it is something that one must just deal with, or is not that big of a deal (people should just try harder), or that hearing aids and cochlear implants will completely alleviate the problem prevents implementation of best practices. It is ill-advised to accept this status quo as a) at some point much of the general public will also become individuals with hearing loss, and b) the general public holds positions as gatekeepers to services, creating a number of access problems for Deaf and hard of hearing individuals. Untreated hearing loss has recently been deemed to be a public health crisis by the National Academy of Sciences (2016). The following is a summary of the findings from surveys, key informant interviews, and focus groups that lead us to this conclusion:

1. The needs of individuals who are Deaf, hard of hearing, deaf-blind, or who have additional disabilities are met in very different ways. The general public and service providers alike often do not recognize this, resulting in a "one size should fit all" mindset. This creates frustration and blame between consumers and service providers. When gatekeepers do not respect the individual's communication needs, discrimination follows.

2. Throughout their lives, literally starting at birth, policies, legislation, enforcement, and gatekeepers (or the lack thereof) impact whether or not Deaf and hard of hearing Oregonians will have the opportunity to participate in their lives to their full potential. Some examples of this include:
    a. **Infant screening:** many children are identified at birth with hearing loss because of this important legislation, yet parents still struggle with decisions about the best path for their child. Many do not feel they are provided the information they need regarding communication options or how those needs may change along the way. Indeed, they often must fight to get their children's communication needs met, no matter what the communication preference is.
    b. **Later detection:** After birth, identifying hearing loss is much more difficult. It often goes undetected for the years of the birth-to-five window of opportunity for maximal language development. Hearing losses are often mistakenly diagnosed as an attention deficit, developmental delay, or even purposeful bad behavior on the part of the child.
    c. **Personal device coverage:** Oregon law requires that if an insurance company will cover a single cochlear implant for a child, it must cover bilateral implantation if so advised. There is no similar requirement for hearing aids, which are extremely costly, often from $5000-$7000 per pair.
    d. **Foster care:** Oregon Child Welfare guidelines detail multiethnic placement, but do not have a priority or policy for placing Deaf or hard of hearing children in signing or otherwise hearing-loss aware families, further stressing the child and creating an additional negative impact on the child's development.
    e. **Educational structure:** The separate structures of Oregon's educational system for Deaf and hard of hearing children means that when a need for change in the child's educational delivery is recognized, it is slow to be implemented and further precious time is lost. Other states, such as Arizona, offer multiple options in a single location so that children move fluidly between programs as the need arises. This eliminates the need for the child to fail in one system before being able to try another, as well as the resulting toll this takes on the child and the family.
    f. **Options presented:** The Oregon School for the Deaf is often presented to parents as a 'last resort,' ignoring the value of Deaf and hard of hearing role models and peers for developing children, and the expertise of the personnel there.
    g. **Preschool policies:** Legislation prevents the Oregon School for the Deaf from holding preschool there (they are only able to serve ages 5 and older). Besides providing needed educational intervention, this is a missed opportunity for children and parents to interact with other families living with similar experiences.
    h. **Impact of Language delays:** Language delays caused by these issues will follow the individual throughout their lives, reducing educational opportunities, their ability to get and keep jobs, and their earning potentials.
3. Acquired hearing loss, in older children and adults, presents its own challenges. Many people begin their lives with 'normal' hearing, and at some point either gradually or suddenly lose it. It is commonly believed that hearing loss is simply something people

must accept, that there is nothing that can be done for it. They withdraw from friends, family, and other social stimulation that is vital to quality of life and maintaining mental health. For others, it is not acceptance but a fact of life as they cannot afford hearing aids and other technology that could help them stay involved and be thriving members of society. That many people with hearing loss, even though they have seen medical professionals about it, are unaware of the array of assistive listening, telecommunication, and alerting devices that keep them active in their lives is unconscionable. Identifying this population in order to inform them of the options available, such as the Public UC's Telecommunications Device Access Program and OVRS services can help them maintain autonomy and quality of life.

4. Deaf and hard of hearing individuals with other disabilities, such as vision loss, cerebral palsy, or other physical or health issues (i.e., DeafPlus) challenge systems that are set up for consumers without hearing loss. Whether it is in a child or an adult service system, most people do not have the training required to facilitate communication with these individuals. Besides a (hearing) interpreter, an additional certified Deaf interpreter may be required. Service providers need to understand basic orientation and mobility issues, have insight into what the individual does and does not have access to through his or her senses and how to accommodate this, and maintain respect for personal choice. While most people do not have these skills, support services providers (SSPs) provide this function as needed for individuals with hearing and vision loss or those who have additional disabilities. They interpret, provide environmental and communication information through touch, and help the individual stay connected and fully functioning in their environment. In addition, they provide basic services like shopping assistance and transportation. The state of Oregon must find a way to fund SSP services for these individuals as this is a population that is least able to purchase this service for themselves.
5. Access to mental health services practitioners who understand the cultural and communication issues involved for all aspects of the Deaf and Hard of Hearing Communities, and who can communicate directly with those consumers, is at a crisis level. Whether it is for crisis counseling, everyday issues, or a psychiatric disability, Oregon does not have the capacity to serve its Deaf and hard of hearing citizens who need these services.
6. Many Deaf and hard of hearing individuals in Oregon who have lived with hearing loss for majority of their lives earn less in wages or are unemployed. Financial barriers to purchasing necessary equipment such as fire alarms with flashing lights is a significant safety issue. High-speed internet or cell phones are critical to reach 9-1-1 emergency services. The state of Oregon must find a way to fund safety related equipment and telecommunication options for individuals with financial barriers.

American Sign Language, interpreters, an array of assistive technology, personal devices such as hearing aids and cochlear implants, captioners and support service providers are key to access for members of the Deaf, hard of hearing, deaf-blind, and DeafPlus communities. As the above list of issues reveals, the challenges these individuals present to service providers who are not familiar with their communication needs or culture are as complex as the solutions are empowering.

Background of Needs Assessment

Senate Bill 449 was introduced at the 78th Oregon Legislative Assembly during the 2015 Regular Session, led by the Oregon Association of the Deaf. It was sponsored by Senator Laurie Monnes Anderson and Representative David Gomberg (Chief Sponsors), and Senators Brian Boquist and Elizabeth Steiner Hayward; and Representatives Lew Frederick and Barbara Smith Warner (Regular Sponsors).

The bill would create an Office of Deaf, Deaf-Blind, and Hard of Hearing Services in the Department of Human Services (DHS). The purpose of this Office would be to provide a centralized location for members of the public and state agencies to obtain assistance to ensure access for individuals who are Deaf, Deaf-Blind, DeafPlus, Hard of Hearing, and persons with hearing loss. After some language changes, the Senate subcommittee hearing passed Senate Bill 449a, but it was held in the Ways and Means committee. The Ways and Means committee concluded that a community needs assessment was needed to identify the social, health, and educational disparities experienced by the Deaf and Hard of Hearing Communities. The Legislature granted $200,000 in General Funds to the DHS Aging and People with Disabilities Advocacy and Development Office to support a project to collect data via a statewide Community-based Needs Assessment (CNA).

DHS published the Request for Proposals (RFP) in January 2016. The RFP specified that the CNA data would be gathered via surveys, focus groups, and interviews with Oregon's Deaf and Hard of Hearing Communities, and that innovative, solutions-based responses were requested. Proposals were due Feb 22. Western Oregon University's (WOU) Regional Resource Center on Deafness (RRCD) submitted a proposal and later progressed to Round 2, held in March. RRCD's proposal was funded as of May 1, 2016; with the final report due eight months later on December 30, 2016. Funding for the project ends April 30, 2017. The total amount of the contract was $199,993.

Study Requirements

The RFP included requirements related to research procedures and data to be collected. This section reviews those requirements briefly.

Methods of Collecting and Reviewing Data

Definition of Population: The RFP section 2.2.2.5 defines the term Deaf Community as "the entire diverse Deaf population, including people who are culturally D/deaf, DeafBlind, Deaf Plus, Hard of Hearing, Late-deafened, hearing aid or cochlear implant users, and those experiencing hearing loss". However, this is not how the term is used in the field of Deaf Studies; rather, the term 'Deaf Community' refers only to those individuals who identify as culturally Deaf. This report then uses the term 'Deaf and Hard of Hearing Communities' in recognition of the distinct needs, preferences, and perspectives of these groups, and uses procedures to ensure that the voices of all groups are equally represented.

Survey or Questionnaire: The RFP requires the use of surveys or questionnaires to collect information from the diverse community across the state. It does not specify the medium (e.g., paper, on-line).

Focus Groups: The RFP required that the contract recipient conduct a number of focus group meetings to ensure data are collected from across the state from constituents of the Deaf and Hard of Hearing Communities. The contract recipient was to "make every effort to identify individuals from specific parts of the Deaf Community who may be disenfranchised and to reach these low incidence populations to include their voice in the service needs."

***Key Informant Interviews*:** The goal of these interviews is to determine the challenges public entities face and their satisfaction with the services the entities have been able to provide. Key informant interviews complement the focus groups. Specifically key informant interviews will be conducted with 1) members of the Deaf and Hard of Hearing Communities who are not well represented in the focus groups, and 2) state, county, city, and other personnel involved in the following service domains: Employment, health, mental health, alcohol and drug services, education, housing, transportation, police, fire, courts/legal, and other state, county, or city services.

Community Advisory Board: The RFP requires the contract recipient to develop and work with a Community Advisory Board (CAB), made up of diverse representatives of the Deaf and Hard of Hearing Communities to inform qualitative data analysis; to assist in interpretation and evaluation of data; and to review the processes to ensure the Deaf and Hard of Hearing Communities are being well sampled. The cost for providing accommodations is included in the budget proposal.

Domains: Nine domains or settings are identified in the RFP. For the purposes of this report, these domains are grouped by: 1) Education, 2) Employment, 3) Socioeconomic identifiers (i.e., Household Income, Safe Housing, Transportation), 4) Access to services (i.e., State, County, City Services; Emergency Responders; the Legal System), and 5) Quality of Life (i.e., health and mental health services, abuse, alcohol and drug treatment).

Cultural Competence: Finally, the RFP required that the recipient of this contract must exhibit cultural competence in the way the data are collected and reported. As it relates to hearing loss, cultural competence begins with understanding the different contingents included in the RFP definition. People who identify as Deaf, deaf, or hard of hearing do so because they hold different perspectives about hearing loss and communication preferences. The term Deaf-blind includes individuals who are totally deaf and blind, as well as individuals who are hard of hearing and experience vision loss, and every combination in between. They, too, vary in their perspectives and communication preferences, and may use spoken English, amplification (or cochlear implants), ASL, Braille, or large print. Support service providers (SSPs) are vital for many people who experience hearing loss and vision loss or additional disabilities to maintain their independence and autonomy, yet the only service provider most people are aware of is 'interpreter.'

Researchers without in-depth knowledge of the Deaf and Hard of Hearing Communities likely do not even realize the misinformation they function under. This leads to people who are hard of hearing being offered interpreters as an accommodation, culturally Deaf individuals being thought of as less intelligent because they do not use their voices or because their English is imperfect, and questions about barriers created due to one's hearing impairment, a term that riles many in the Deaf and Hard of Hearing Communities. To complicate matters more, many people with hearing loss do not claim an associated identity. They do not see themselves as having a disability (i.e., hearing loss), but rather think of themselves as simply not hearing very well. This makes them a difficult group to reach out to.

Areas of Focus

Demographics: The RFP defined demographics as (a) age, (b) county of residence, (c) race, (d) gender, (e) education level completed, (f) socioeconomic status, g) preferred identification within the Deaf and Hard of Hearing Communities, and h) primary or preferred means of communication. They required that data on demographics represent a valid sample size of the entire Deaf and Hard of Hearing Communities as listed in the Deaf Community definition. It was required that demographic results be categorized by the description listed in the Demographics definition. The on-line survey was used to collect these data.

Communication Access to Public Services: DHS also required information on the current availability and access to communication in public services, using the following: (1) Qualified or certified interpreters; (2) Computer Assisted Real Time systems; and (3) Assistive Communication Devices. Note: A number of emergency responders were listed in this section of the RFP. In this report they are covered in the section on access to public services. Information here was collected by the on-line survey of the Deaf and Hard of Hearing Communities, key informant interviews of the service providers, and focus groups of community members using these services.

Barriers and Strategies: The purpose of this project was to identify for DHS and the Legislature the barriers that make it difficult for the Deaf and Hard of Hearing Communities to successfully engage in social, educational, and health services and to make recommendations for closing any gaps. The nine domains specified were: (a) graduating from high school or obtaining a General Education Diploma (GED); (b) entering and completing college, or other higher education or vocational training; (c) earning a livable competitive wage; (d) obtaining health and mental health services; (e) keeping safe from abuse; (f) acquiring transportation services; (g) obtaining appropriate, affordable and accessible housing; and (h) accessing government services. In addition, information on accessing a variety of emergency responders services is included in this section. Information here was collected by the on-line survey of the Deaf and Hard of Hearing Communities, key informant interviews of the service providers, and focus groups of community members.

Communication Access: DHS also sought to ensure that the contract recipient used the applicable communication access services when conducting any activities to accommodate the different modes of communication used by members of the Deaf and Hard of Hearing Communities, including: (a) English (spoken) and English (written); (b) tactile or close vision signing; (c) signed English; (d) American Sign Language (ASL); (e) Pidgin Signed English (PSE); (f) non-standard or home sign language; (g) Spanish (spoken) and Spanish (written); and (h) other spoken and signed languages.

Methods

Overview

Once funding was awarded, the research team had eight months to complete the project from start to finish. Three survey protocols first had to be developed along with informed consent forms in order to complete the University's Institutional Review Board (IRB) Protection of Human

Subjects Protocol. The academic year ends in mid-June, and the IRB does not generally meet over the summer. This step had to be completed before the project would be able to move forward.

The three surveys were developed (i.e., the on-line survey for members of the Deaf and Hard of Hearing Communities), and the interview protocols for the focus groups and the key informant interviews). The development of the survey for the Deaf and Hard of Hearing Communities was a lengthy process for this project due to the need for a version in American Sign Language (ASL) and Spanish as well as written English. To reach community members across the state, the community survey was to be conducted on-line. The protocols for the focus groups and the key informant interviews were less involved because they were communicated one-on-one and live.

Simultaneously, CAB members and participants had to be recruited. This meant holding town hall meetings, attending events, and developing public relations materials for advertising. It was important to have the CAB established early to get their assistance in recruiting participants and providing recommendations for key informants. Focus group participants were recruited through an additional questionnaire after completing the on-line community survey. It was programmed so that the information it collected was completely separate from the survey responses.

Human Subjects Protections: During June 2016, Western Oregon University's Institutional Review Board (IRB) reviewed and approved the study protocol prior to data collection. The function of the IRB is to ensure that Dr. Thew Hackett (principal investigator) and all other members of the research team protect the privacy of participants. This includes destroying videotapes after they have been transcribed and redacting identifying information from transcripts.

The principal investigator of this proposal, Dr. Denise Thew Hackett, ensured that key informants understand their rights as research participants. In order to protect the privacy of those participating in the Community Needs Assessment (CNA), facilitators of the focus groups or key informant interviews and anyone involved with coding and analysis of data were required to complete the Human Subject Certificate program through the Collaborative Institutional Training Incentives (CITI) Program prior to any review or data analysis. Both the principal investigator and the co-investigators have completed this training.

Providing Communication Access: On-line surveys were developed in several modalities, including American Sign Language, written English, and written Spanish. In some cases, group administrations were used to allow community members without computers and those who are not familiar with computers an opportunity to complete the survey. This also allowed anyone who needed one-on-one support (e.g., with a Deaf interpreter or other service provider) an opportunity to participate.

Key informant and focus group participants were identified in advance to allow for setting up the appropriate accommodations. By nature, the communication modes within focus groups were somewhat homogenous; but requests for other accommodations were honored. All accommodation costs were built into the budget proposal.

Accommodations served the dual purpose of providing access and transcripts for data review. Interviews were audio-recorded, videotaped, and/or transcribed live. CART was provided for all hard of hearing focus groups. Transcripts from the CART output provided data for the study.

Videos of ASL focus groups and interviews, and tape recordings of spoken interviews were all transcribed. Transcription of the ASL videos required the services of transcribers who knew ASL.

Ensuring Participation from All Groups: The research team's process relied on established networks and CAB members to identify and connect with individuals who were members of the different target populations of this study. Specifically, the recruitment strategy focused on reaching individuals from the diverse Deaf and Hard of Hearing Communities (including parents), providers and agencies providing services to members of the Deaf and Hard of Hearing Communities, first responders, and communication access providers.

Key Data Collection/Data Checking Components

Community Advisory Board (CAB): CAB members were recruited from each population described in section 2.2.2.5 of the RFP, and include representatives who are cochlear implant users, veterans, parents of deaf and hard of hearing children, deaf and hard of hearing transition students, and senior citizens. Leaders were recruited from consumer and advocacy organizations with members of the Deaf and Hard of Hearing Communities, as well as communication service providers (CART, interpreters, ACDs, ALDs), first responders (e.g. police, fire, emergency medical technicians), and personnel from government agencies and other places of public access. Interested CAB members who completed the CITI training also assisted in some aspects of data analysis.

***Online Survey Development*:** The 135-item survey was developed based on the nine domains specified by the RFP. Survey items, response options, and skip patterns were all programmed into an online survey platform. On-line responses were captured using Qualtrics. Next, the ASL models taped two versions of the items, one that is simply an interpretation of the English, and another that provides additional explanation to incorporate many of the linguistic contexts that are critical to understanding for many ASL users. The video clips were then edited to be included in the questionnaire. After this point, it would not have been feasible to make any changes to the written survey as changing the signed version would have required extensive time and effort, and additional IRB approval. Finally, the survey was translated into Spanish text. Thus, users had the option of viewing the questions in English, Spanish, American Sign Language (ASL), and ASL with additional explanation. These processes were conducted in June and July. Several CAB members reviewed the survey and provided feedback. A final revision of the survey was submitted to the IRB for approval before the survey was launched August 1, 2016. It was available until September 15.

Focus Groups: Once someone completed the on-line survey, they were provided an opportunity to volunteer to participate in a focus group. As the person finished the survey, a screen appeared asking if the respondent would like to participate in a focus group. If the person responded yes, then a separate screen (with data kept separate from the survey) asked for their contact information, along with some demographic information to identify which demographic group they would participate in. Dr. Thew Hackett then sorted the responses by city and category, set up dates in the area, and let people know the focus group logistics. She then waited to hear who was available on the dates to attend. A number of possible participants were lost because they were on vacation on the scheduled days in their areas.

A discussion guide, checklist of topics, and expected order was used to direct the discussion. This discussion guide was developed by Dr. Thew Hackett and reviewed by the CAB. The

moderator guided conversation gently through each topic until the discussion appeared to become repetitive. It allowed participants to raise important issues and nuances that researchers often do not foresee. In a focus group, relatively homogeneous groups of participants have the opportunity to stimulate, support, and build on each other's ideas on the topic. Participants discuss the topic in their own framework and terms. As they become more sensitized to the topic and to each other, participants fuel each other to take the discussion beyond the rhetorical or habitual.

Key Informant Interviews: Simultaneous to the focus groups, key informant interviews were conducted by phone with service providers. These service providers included access providers, state agencies, and first responders. All interviews were recorded and transcribed. A Deaf team member conducted many of the key informant interviews over the phone with an interpreter. The interpreter and the speaker were audiotaped for transcription for later review.

Most focus groups included CART service for hard of hearing individuals, and transcripts from these were used for data analysis. Focus groups for American Sign Language (ASL) users were videotaped and transcribed by a company employing individuals who use ASL.

Recruitment: The Oregon Association of the Deaf held several town hall meetings in Eugene, Medford, and Bend in late spring and early summer, and invited Dr. Thew Hackett to participate to explain the project. At least 15 individuals attended each of these town hall meetings. During one meeting in Bend, an individual who is an Accessibility Manager attended and provided valuable contact information for key informants in the Bend and Central Oregon region. Drs. Thew Hackett and Davis presented at the Salem Chapter of the Hearing Loss Association-Oregon meeting held at Capital Manor Retirement Center June 29. Approximately 60 people were in attendance. Plans were made with Capital Manor to hold a Community Survey Event there to assist individuals to complete the survey. Capital Manor has approximately 450 residents with some degree of hearing loss.

As the development of the on-line survey neared completion, activities around ensuring we recruited respondents from all of the demographics ramped up. Individuals, organizations, and news outlets were solicited at both the Information Meeting for the CNA and from the CAB members. Drs. Thew Hackett and Davis reviewed the list for additions. A Graduate Assistant looked up contact information for any that were missing this information. A press release was developed by WOU Public Relations to ensure the information was available to statewide news outlets. At the same time, a website posting updates of the process and announcements was created. The press release and the email announcement included information on how to participate in the survey and the need for focus group and key informant interview participation. We received two requests for radio interviews (one from Lebanon, and one from Coos Bay), which were completed, and are aware of the story being published in several papers. The Oregon Association of the Deaf, the Hearing Loss Association of Oregon, and the Oregon Deaf-Blind Services Task Force assisted the project in sharing announcements through their listservs. Information was also shared through the listservs for the Oregon Association on Higher Education and Disability, public school regional programs, the Oregon Public Utilities Commission Telecommunications for the Deaf Access Program (TDAP) mailing list (which includes over 5000 emails statewide) and numerous others. These organizations also published articles in their newsletters. The announcements were shared extensively through social media. Finally, as word spread, we reached out to school programs to ensure that we

included parents of children with hearing loss. The Early Hearing Detection and Intervention (EHDI) program was instrumental in assisting us in recruiting for these groups.

Results

Community Advisory Board

An informational meeting was held in Salem on May 6, 2016. Because of time constraints and the need to have the meeting as quickly as possible, notice was disseminated by email and social media through organizations, including but not limited to the Hearing Loss Association-Oregon, Oregon Association of the Deaf, PUC Telecommunications Device Access Program recipients, Oregon Deaf-Blind Services Task Force, Oregon Association on Higher Education and Disability, Oregon School for the Deaf, and Tucker-Maxon Oral School. Even with the short notice, the meeting was attended by 40 individuals representing the diversity of the Deaf, hard of hearing, and hearing loss communities in Oregon. This meeting provided an overview of the process that brought the CNA to fruition, a description of the planned research project, and information about the CAB and the application process. American Sign Language (ASL) interpreters, certified Deaf interpreters (CDI), computer assisted real-time translation (CART), and assistive listening equipment were provided. The individuals attending represented parents of Deaf and hard of hearing children; teachers of the Deaf; Deaf and hard of hearing individuals, including cochlear implant users; individuals who are DeafBlind and deaf-blind; individuals who are deaf and have additional disabilities; senior citizens; and veterans with hearing loss. Attendees came from the Oregon Coast, Bend, Eugene, and Medford, along with the Portland and Salem areas. Information was collected from these individuals regarding their interest in applying to the CAB, and organizations/institutions to include in our outreach efforts.

An application form along with informational materials about the responsibilities of CAB members was developed by Dr. Thew Hackett. Information was disseminated to attendees of the informational meeting, along with the other listservs and social media outlets described above. Twenty applications were received and reviewed for representativeness of the diversity of the community, geographic area, ability to commit to the process, and ability to contribute to the process. Fifteen initial members were selected, although we continued to accept applications. The members included five individuals from the Portland area, five individuals from the Salem area, one from Eugene, two from Medford, and two from Bend. Each member potentially represented multiple target groups, including eight Deaf, six hard of hearing, five cochlear implant users, one veteran, five senior citizens, one DeafBlind, one deaf-blind, one Deaf plus, one late-deafened, one youth, and two parents.

American Sign Language (ASL) interpreters, certified Deaf interpreters (CDI), computer assisted realtime translation (CART), and assistive listening equipment were provided for each CAB meeting. CAB meeting locations rotated to ensure participation from the most distant members.

CAB meetings were held in June, August, and November. CAB members assisted in identifying locales or demographics where numbers were weaker, and provided suggestions for spreading the word. At the November CAB meeting, members reviewed a data set of all items by identity. The process involved review of output, brainstorming of research questions, evaluation of

limitations, and identifying areas of interest or concern. Because of the confidentiality of the data, participants were not allowed to take the printouts with them after the meeting.

Focus Groups

The project held a total of 12 focus groups with hard of hearing participants, with a total of 16 participants (1-2 per group); and 15 focus groups with 35 Deaf participants (1-5 per group). Six additional hard of hearing focus groups were held where the scheduled participants did not show up. Focus groups were held in Salem, Eugene, Roseburg, Klamath Falls, Medford, Bend, and Portland. Three of the one-on-one interviews were conducted over the telephone due to geographic distance (Northern Coast and outside of Central Oregon).

The short timelines of this project required that data be collected over the summer with the fall to analyze it and write up the results. Summer is a challenging time to recruit people to participate in something like a focus group. The Deaf community is well organized around this, and indeed sees it as an opportunity to interact with others who are similarly Deaf. Hard of hearing individuals are not typically eager to discuss their hearing losses. This can be seen in the number of people attending the focus groups.

Multiple attempts were made to host focus groups in Eastern Oregon and Coastal Regions, for both face-to face and tele-meeting (e.g. phone, Skype, videophone) with only two participants willing to participate.

We also found that we needed to alter the way we collected data from parents of children with hearing loss. The Early Hearing Detection and Intervention (EHDI) organization contacted us with feedback saying that they were hearing the survey questions were for the most part not a good fit for children's experiences. Indeed, most items addressed services that would most likely be accessed by adults. As a result, we scheduled five focus groups for the purpose of collecting data from parents and their children.

Key Informant Interviews

A total of 19 key informant interviews were completed, including emergency personnel, legal services for the state of Oregon, disability services providers in higher education, personnel in elder care, and vocational rehabilitation services providers. Key informant interviews were done utilizing the semi-structured interview guides with a focus on systemic issues as a provider or service.

On-line Survey

A total of 1,140 survey responses were collected. During database preparation, 168 responses were deleted as they did not qualify for the survey. An additional 89 responses were deleted as the respondents answered only a few preliminary questions. The final database contains 883 responses. Most respondents took the English version (n=773), another 110 took the on-line ASL version, and an additional 2 took the Spanish version.

Survey support labs were held in multiple locations to assist people who do not have access to computers or who may have disabilities that would impact their ability to respond to the survey.

These labs were held in Salem, Eugene, Roseburg, Klamath Falls, Medford, Bend, and Portland, alongside focus group meetings. There were two to twenty participants in each lab.

There were a few unexpected events during the data collection. First, Google abruptly took the ASL videos down and would not reinstate them. They provided no explanation. One of our editors worked tirelessly to get the videos reformatted and transferred to another system, and the survey was up and running again after a day and a half.

In the process of working with people in completing the surveys during the survey support labs, project staff discovered an interesting interpretation of one of the questions meant to screen out people who were not eligible. The item was: “Do you have a hearing loss?” Senior citizens, sometimes with mild losses, sometimes more severe, often interpreted the question as “Have you lost your hearing?” They reasoned that they still had some hearing, so they would answer “no.” This would immediately exit them from the survey. Although it is impossible to know exactly how many people outside of the labs may have exited the survey because of this interpretation of the question, 99 respondents were exited because they responded ‘no’ to this item. This quirk of interpretation is a perfect example of the challenges of conducting research on a population that often does not embrace a label.

Demographics

Residency

In addition to experiencing hearing loss, in order to participate in the survey, respondents also had to live, work, or use services in Oregon. Nearly all respondents (98.0%; N=865) live in Oregon; 60.2% (N=532) also seek services in Oregon. Seven out of 10 respondents from outside of Oregon (N=18) live in Washington State; one participant was from Idaho, and four live in California.

Not unexpectedly, Marion county and Multnomah county provided larger portions of respondents than other counties (15.5%; N=134 and 19.5%; N=169, respectively).

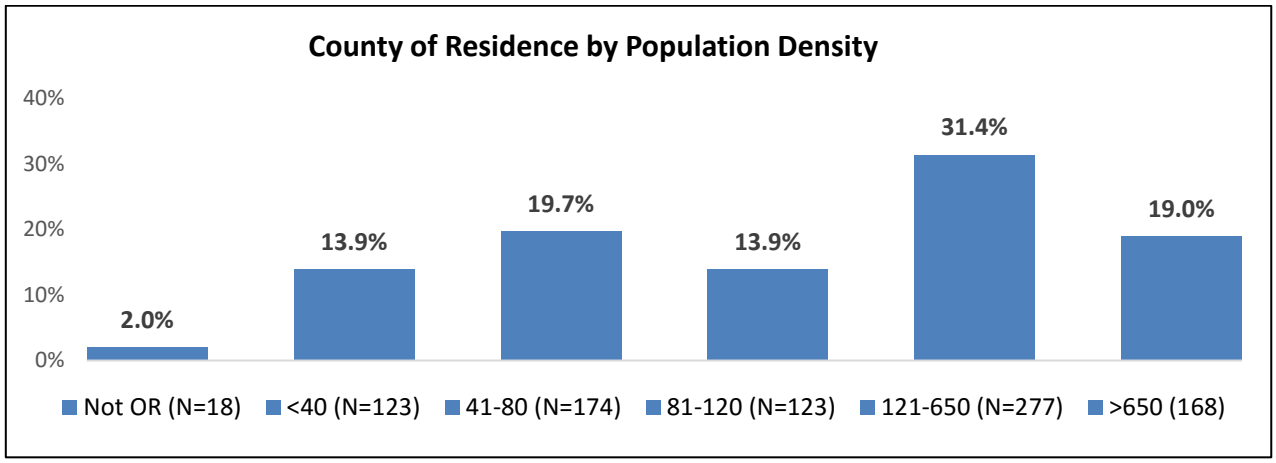
Table 1: County Density and Response Rate for each County

Oregon County Residency (Base: Lives in Oregon) (N=865)	Density	Percent	Count
Multnomah	>650	19.40%	168
Marion	121-650	15.50%	134
Washington	121-650	8.90%	77
Polk	81-120	8.50%	74
Clackamas	121-650	7.60%	66
Lane	41-80	7.40%	64
Jackson	41-80	6.50%	56
Deschutes	<40	6.50%	56
Benton	81-120	4.00%	35
Linn	41-80	2.40%	21
Douglas	<40	2.20%	19
Josephine	41-80	1.80%	16

Yamhill	81-120	1.60%	14
Klamath	<40	1.00%	9
Columbia	41-80	0.90%	8
Lincoln	41-80	0.70%	6
Coos	<40	0.70%	6
Tillamook	<40	0.70%	6
Crook	<40	0.60%	5
Wasco	<40	0.50%	4
Clatsop	41-80	0.30%	3
Hood River	<40	0.30%	3
Lake	<40	0.30%	3
Umatilla	<40	0.30%	3
Baker	<40	0.20%	2
Grant	<40	0.20%	2
Jefferson	<40	0.20%	2
Malheur	<40	0.10%	1
Union	<40	0.10%	1
Wallowa	<40	0.10%	1

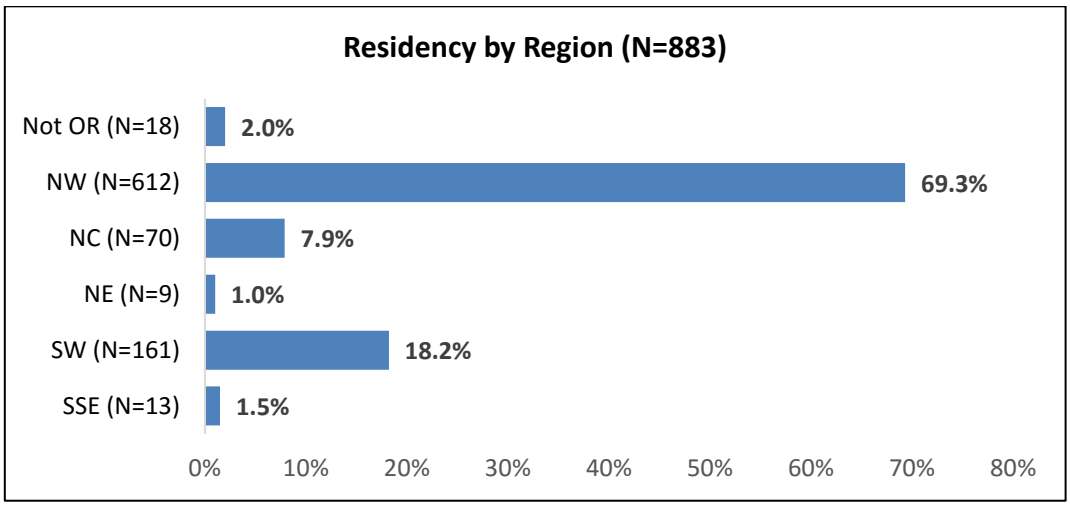
The population density (number of people per square mile) for each county is listed in the above table. Figure 1 indicates the number of residents in each population zone. Nearly one in three respondents (31.4%; N =277) live in counties with a population density of 121-650 residents. It is also notable that almost 50% of the population lives in areas with 120 persons or less per square mile.

Figure 1: County of Residence by Population Density



By far, the largest proportion of respondents live in the northwest region (69.3%; N= 612). The southwest region is represented by 18.2% (N=161) of respondents, mimicking the state's population distribution. A correlation of .92 was found between the number of respondents in each county and the county population. This provides further evidence that the survey sampled the state well.

Figure 2: Residence by Region



Race/Ethnicity

Almost 85% of respondents self-identify as White (83.9%; N=736). This is identical to the ethnic makeup of Oregon (i.e., 83% https://suburbanstats.org/population/how-many-people-live-in-oregon). Because the counts were low in the individual categories of all other racial and ethnic identities, they were combined into 'Other' (16.1%; N=141). The largest portion of this category is Hispanic or Latino/a (N=52). The next largest were American Indian or Alaska Native and Black or African American (N=25 and 22 respectively). The other racial and ethnic identity categories had fewer than 20 respondents each.

While the majority (72.0%; N=636) say neither themselves nor their parents were born outside the U.S., a sizable portion (13.7%; N=120) of respondents were. Likewise, 19.4% (N=168) have at least one parent born outside the U.S., while 6.7% (N=59) say both themselves and their parents were born on foreign soil.

Table 2: Citizenry of Parents and Children

Born Outside the U.S. (N=877)	**Percent**	**Count**
Yes	13.7%	120
One or Both Parents Born Outside of the U.S (N=867)		
Both parents	10.7%	93
One parent	8.7%	75
Respondent/Parents Born Outside the U.S. (N=883)		
Neither	72.0%	636
Parent(s) only	12.3%	109
Respondent only	6.9%	61
Both respondent and parent(s)	6.7%	59
Information incomplete	2.0	18

Gender

Less than half of respondents (40.1%; N=318) are men; a few (0.8%; N=6) identify as transgender, and 1.1% (N=9) prefer not to provide gender information.

Table 3: Gender

Gender (N=793)	Percent	Count
Female	57.8%	458
Male	40.1%	318
Prefer not to answer	1.1%	9
Transgender	0.8%	6
Other	0.3%	2

Age

Almost 34% of respondents (N=298) are age 65 and above. Respondents under 18 years of age account for 8.2% (N=71) of the respondents. While this may seem unbalanced compared to ages of individuals in Oregon, it does follow national trends in hearing loss, with 30% or more over the age of 65 experiencing enough of a loss that it interferes with their lives. Although not shown specifically in Table 4, seven children (.8%) were under the age of 5 at the time of the study. Parent comments were collected in focus groups.

Looking at the age groups in extremely general terms, there were 71 (8.1%) respondents under 18 (non-working), 87 (9.9%) in their early working years (18-34), 173 (19.6%) in their middle working years (35-49), 252 (28.7%) in their later working years (50-64), and 298 (33.9%) of retirement age (65 and older).

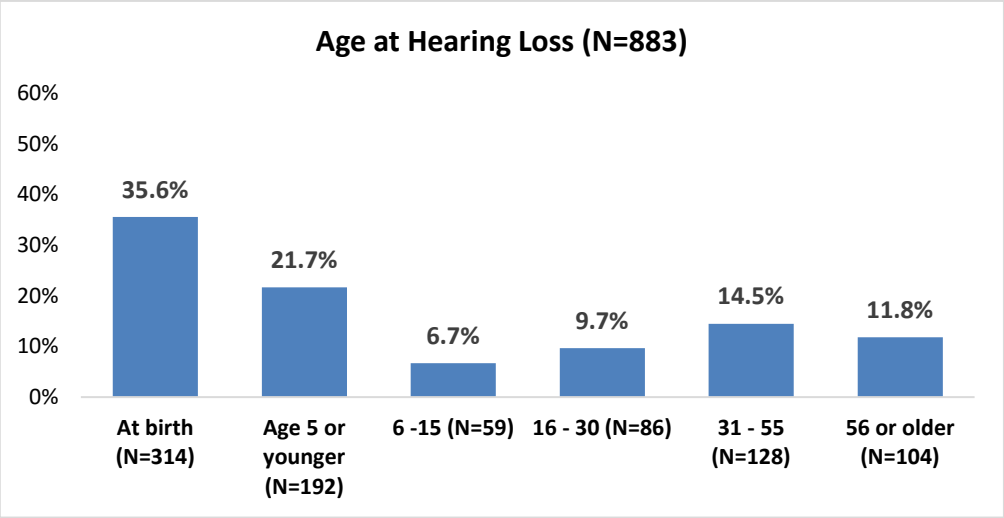
Table 4: Age of Respondents at the Time of the Survey

Age (N=879)	Percent	Count
Under 18	8.1%	71
18-24	4.2%	37
25-29	3.0%	26
30-34	2.7%	24
35-39	7.1%	62
40-44	4.8%	42
45-49	7.6%	67
50-54	8.4%	74
55-59	9.9%	87
60-64	10.4%	91
65-74	16.5%	145
75+	17.4%	153
Net 65+	***33.9%***	***298***

Age at Hearing Loss

Figure 3 indicates over one in three (35.6%; N=314) were born with hearing loss or deafness; and another one in five (21.7%; N=192) lost their hearing after birth but before the age of 5. This is significant because birth to age 5 is considered to be the prime 'window of opportunity' for language development. Over one third of respondents (36.8%; N=314) described their hearing loss as progressive. As the figure below indicates, over 90% of individuals in this study have or will experience hearing loss through their prime education and work years.

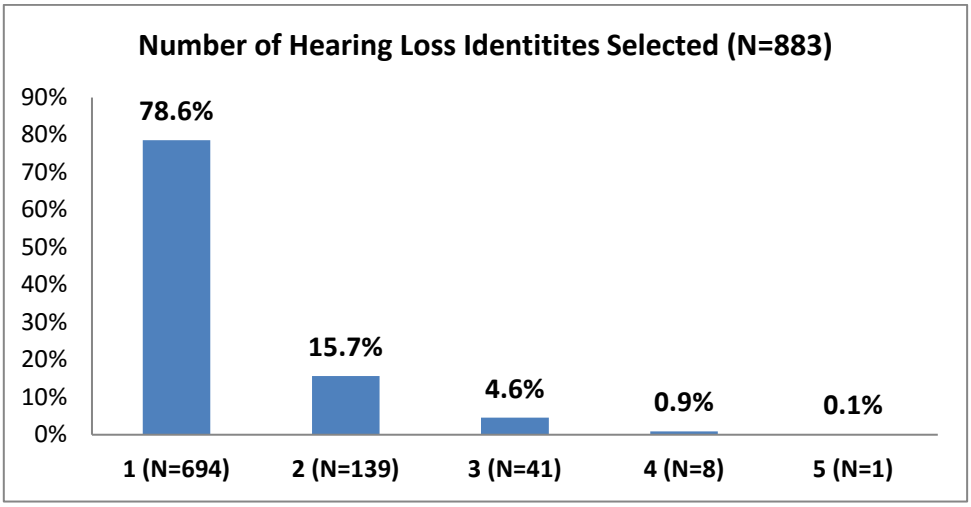
Figure 3: Age at the Time of Hearing Loss



Hearing Loss Identity

Respondents were asked how they identified themselves with regard to their hearing loss. Multiple options were provided; indeed, the RFP listed nine different identifiers. Clearly, the majority of respondents (78.6%; N=694) identify with one label, but 22% selected more than one label.

Figure 4: Identities Selected by Respondents to Describe their Hearing Loss



Nearly 37.9% (N=335) identify as hard of hearing. One in four (25.9%; N=229) identify as hearing impaired, and almost 30% (N=262) identify as culturally Deaf. The long list of options was included in an effort to capture as many ways people identify as possible, and as requested in the definitions in the RFP. Clearly, though, labels and identities do not always align as the definitions would predict. At least three individuals indicated in open-ended responses that they also had severe vision losses, even though they did not identify themselves as Deaf-Blind or DeafBlind. Several people identified as both culturally Deaf and hearing impaired. This is unusual because most people who describe themselves as culturally Deaf shun the label hearing impaired. This speaks to the diversity of beliefs and attitudes in the community and may also indicate that some people are not familiar with all of these labels. (See Appendix A for explanations of the labels in Table 5.)

Table 5: Chosen Identity with Regard to Hearing Loss

Identity with Regard to Hearing Loss (Multiple Response) (N=883)	Percent	Count
Hard of hearing	38%	335
Culturally Deaf	30%	262
Hearing Impaired	26%	229
Deaf (not culturally)	14%	119
Oral Deaf	6%	53
Late-deafened	5%	44
I don't label myself as somebody with a hearing loss	3%	27
Deaf Plus	3%	23
DeafBlind	2%	15
Deaf-Blind	1%	12
Other	1%	10

Communication Preference

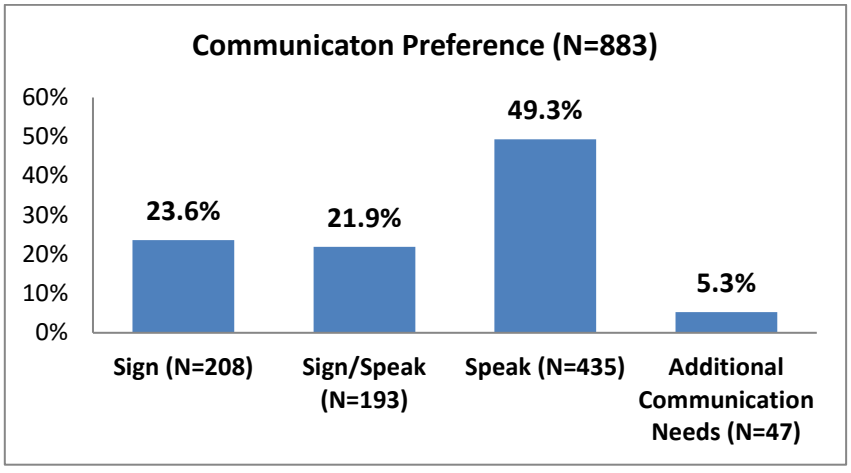
Spoken English (both speech and lip-reading) is the preferred communication mode for two-thirds of respondents (67.7%; N=594), followed by American Sign Language (35.3%; N=310). Both writing (28.4%; N=249) and texting (28.5%; N=250) are used by over one in four respondents. Total communication or Sim-Com (14.4%; N=126) or PSE (Pidgin Signed English) (12.6%; N=126) round off the most widely used communication modes. (See Appendix A for explanations of the labels in Table 6.)

Table 6: Communication Modes used by Respondents

Communication Modes Used (Multiple Response) (N=878)	Percent	Count
Spoken English (speech and lip-reading)	67.70%	594
American Sign Language (ASL) only	35.30%	310
Texting	28.50%	250
Writing	28.40%	249
Total communication or Sim-Com (using both sign and speech at the same time)	14.40%	126
PSE - Pidgin Signed English (Some ASL signs with English sentence structure)	12.60%	111
Other spoken language (speech and lip-reading)	1.70%	15
Tactile ASL or other tactile sign language	1.30%	12
Other	1.30%	11
Cued Speech	1.10%	10
Braille	0.70%	6

By evaluating response options of those who had requested interpreters and those who provided information about their communication preferences in other items, participants were reassigned to one of four groups: People using mainly spoken language, those mainly using sign language (without speech), those mainly using a combination of sign and speech, and those with additional communication needs (i.e., individuals with hearing and vision loss, and those with additional disabilities). Half of respondents (49.3%; N=435) prefer speech as their communication mode. Over one in five (23.6%; N=208) prefer to sign; another 21.9% (N=193) prefer a combination of sign and speech.

Figure 5: Communication Preference

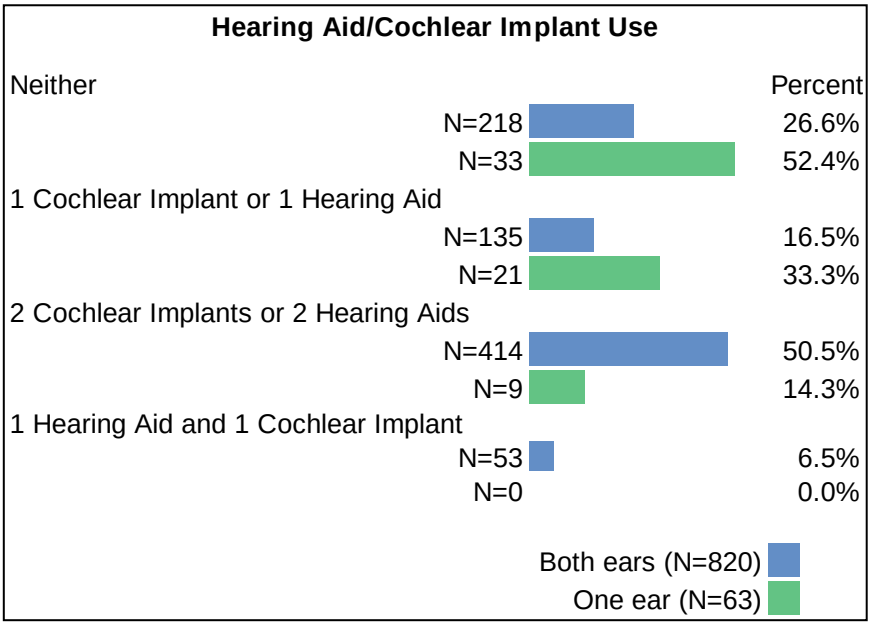


Hearing Aid and Cochlear Implant Use

Among those respondents who indicated they use cochlear implants, three in four (76.3%; N=106) have one (unilateral) implant only. Respondents with hearing aids were more likely to aid

each ear (70.5%; N=383). While 93% of respondents (N=820) experience hearing loss in both ears, only half (N=414) aid both ears. Fewer than half with a loss in one ear aid it. Three individuals with cochlear implants indicated they do not use them, as well as 11 individuals with hearing aids. The most common reasons for no longer using hearing aids was that they need new ones and could not afford them.

Figure 6: Use of Hearing Aids and Cochlear Implants by Loss in One or Both Ears



More respondents who use cochlear implants are extremely or very satisfied with their devices than hearing aid users (57.4% vs. 38.2%). Another 16.2% (N=22) are dissatisfied to some degree with their cochlear implants, and 19.7% (N=105) are dissatisfied with their hearing aids. People who were dissatisfied with their cochlear implants were mainly dissatisfied because they did not have the speech perception they desired and still had to rely on speech reading. Although no one listed expense as an issue with cochlear implants, 22 respondents did in the follow-up question related to hearing aids. (Expense is also brought up in several other places in the survey, and in focus group sessions.) Eighteen mentioned problems with hearing in background noise, but 62% (N=186 out of 296) were dissatisfied because of their lack of ability to perceive speech with them. Many use this as a rationale not to replace them as they are perceived to be not worth the expense.

Figure 7: Comparison of Satisfaction with Hearing Aids and Cochlear Implants

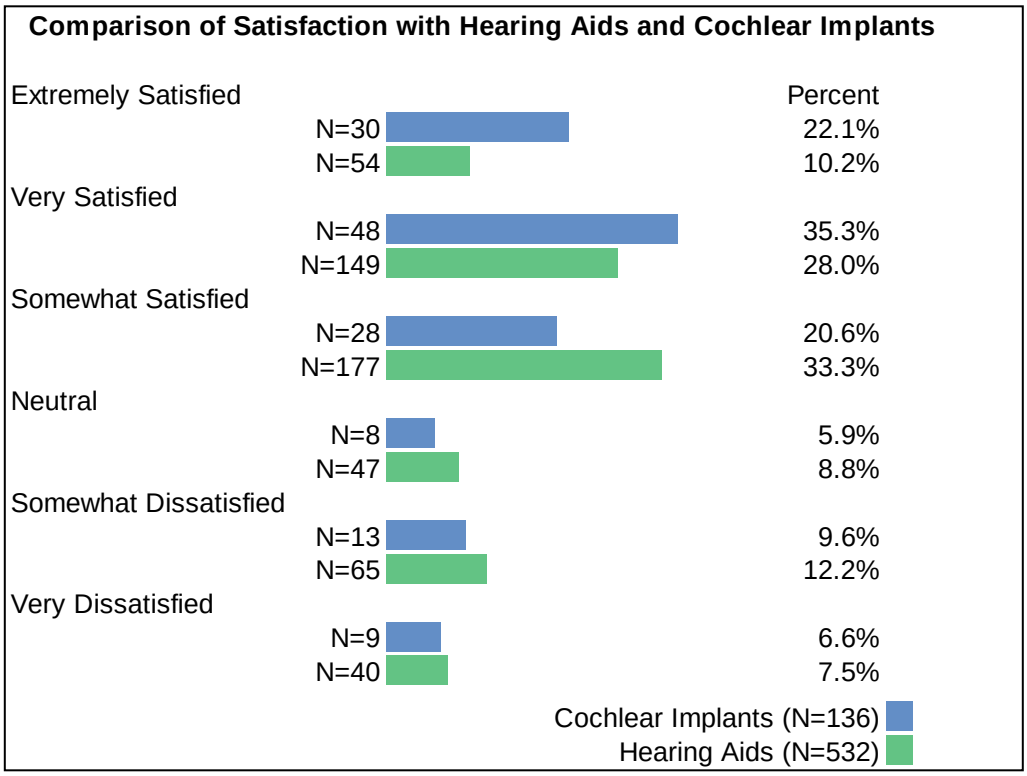
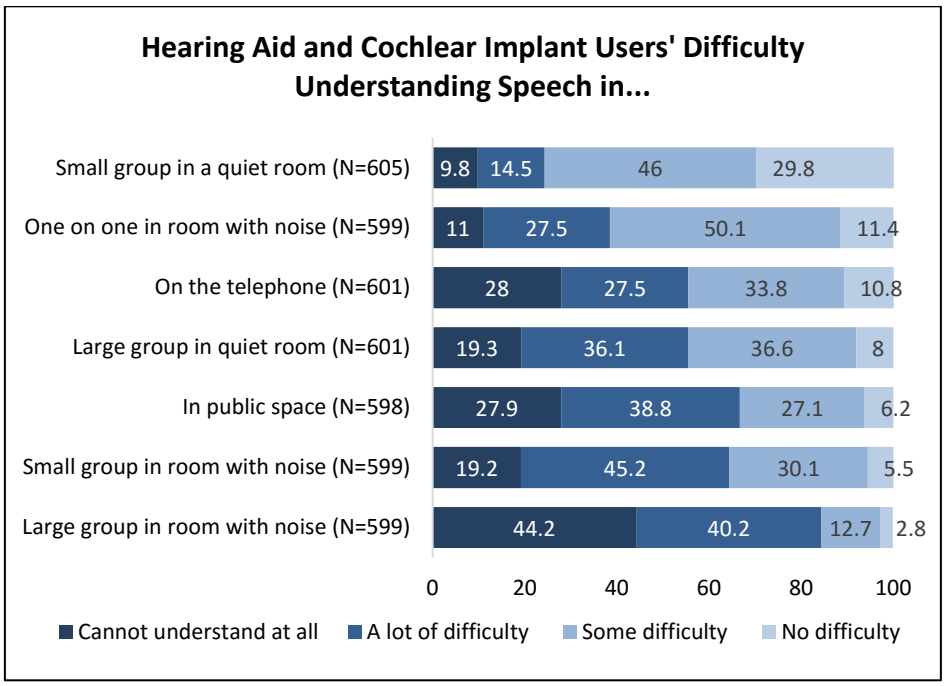


Figure 8 is a revealing glimpse into the communication challenges faced by individuals with hearing loss. Limited to those who are using hearing aids or cochlear implants, respondents were asked about the difficulty of understanding speech and environmental noises in settings with and without background noise. For one on one in a room with noise or on the telephone, close to nine in ten have some level of difficulty understanding either speech or environmental sounds.

Respondents experience difficulty understanding speech in many settings. In most situations, about ninety percent or more experience difficulties understanding. Even in a small group in a quiet room, understanding speech presents difficulties for seven in ten respondents (70.2%; N=425).

A large group in a room with noise means no understanding of speech at all for 44.2% of the respondents (N=265), even using hearing aids or cochlear implants. Over one in four cannot understand speech on the phone (28.0%; N=168) or in public spaces (27.9%; N=167).

Figure 8: Hearing Aid and Cochlear Implant Users' Ratings of their Speech Perception



A male senior citizen with progressive hearing loss who identifies as hard of hearing and relies on spoken language shared his positive experience with an audiologist who had proper training and shared critical information that he wished many other hearing aid users would benefit from knowing. *"One huge help for me was some information that decreased my expectations. And that they said was to aim for 80 percent of normal hearing because if they do it louder, the ambient noise blocks your understanding [of speech and environment sounds]. So you don't get 20/20 hearing the way you get 20/20 eyesight with glasses. That has been a huge help. I didn't expect to have normal hearing. I'm just very grateful that it's better."*

ASL interpreters are most widely used in hearing environments by over two in five respondents (44.8%; N=380). Caption is used by three in ten (31.7%; N=269). Seven percent of respondents use nothing in a hearing environment (7.1%; N=60).

Hearing aids (62.6%; N=550) are the most commonly used devices, with 19% (N=161) using only a hearing aid or a cochlear implant. While many people are not aware of the various assistive technologies (see Appendix A for explanations of the labels in Table 7), some people short-change themselves, as demonstrated by this female hard of hearing participant:

"I have not asked for CART. I figure these are nonprofit organizations with limited budgets. If I was—I'm not contributing enough for them to be able to afford that. That's my own personal decision."

Table 7: Assistive Technology (including Interpreters) in Any Hearing Environment

Use of Any In Hearing Environment (Multiple Response) (N=848)	Percent	Count
ASL interpreter	44.8%	380
Caption	31.7%	269
Only hearing aid or cochlear implant	19.0%	161
Assistive listening device (FM system, loop)	16.6%	141
Mobile Apps for smartphones and tablets	15.1%	133
CART	11.8%	100
Certified Deaf interpreter	8.1%	69
I do not use anything	7.1%	60
Support Service Provider (SSP)	3.4%	29
Brailler, CCTV, other vision loss equipment	3.1%	27
Captel/vp	3.1%	27
Ask someone to help (family, friends, etc.)	2.2%	19
Close vision interpreter	1.5%	13
Other (doorbell signals, hearing dog)	1.5%	13
Intervenor	1.2%	10
Haptics	0.8%	7
Protactile	0.7%	6

A hard of hearing female from Central Oregon shared a common reaction related to technology, *"I think for some people – it is sort of frightening to use technology. So again, somebody to walk them through it, get them comfortable with technology would help."*

Accommodations in Public Settings

The common theme of accommodations arose several times among focus groups. A hard of hearing female summarized, *"CART not only eases the burden of those for people like myself, it allows us to recruit more people who have hearing loss into the field. In fact we find foreign visitors or attendees whose mother tongue is not English are actually using the CART system because they gain a lot out of it too. If it's good for a particular disability population, it's actually good for everybody, not just that one particular population. So the complaint is it's too expensive or too difficult. I think people [running businesses] are not aware of the positive impact of making these particular accommodations. And I think the legislature needs to understand the positive impact that is far beyond the community in question, it will have an impact."*

A cochlear implant user who uses primarily spoken language discussed his recent event at the Moda Center, *"The customer service staff was not aware that FM systems were available and it was not until I insisted that I speak to supervisor that it was possible and made available. It made my whole night but that's the kind of thing where the event planners are not being educated. They don't educate them or their and volunteers or workforce to know what is truly available. …Sometimes when you request FM systems [anywhere] and they don't work or have missing parts."*

A Southern Oregon male with progressive hearing loss, as well as many other hard of hearing participants, reported on the value of CapTel (a telephone displaying a text screen).

Financial Barriers Related to Hearing Aids

A young hard of hearing woman who uses both ASL and spoken language in her employment setting reported wanting to buy an FM system to help block out unwanted environment noises but was told "*money is not available right now*." This same person had to keep her hearing aids for 12 years because of financial barriers said, "*I have to wait for 12 years to buy new hearing aids. 12 years I have had my old hearing aids because they are expensive. Then I finally got insurance coverage with hearing aids, but it was covered like 20% - the insurance benefit was $1500 while the cost of hearing aids was $5000, so I had to save about $3500.00."* Because of a financial barrier related to hearing aid cost she took many necessary steps to protect her new hearing aids from damage until, "*I was running recently, the sweat was going into the hearing aids and broke the hearing aids. I bought the hearing aids 2 years ago with Kaiser Insurance but now because I don't have that insurance anymore [because of a job change], I can't go there for repairs. The warranty is not good anymore*."

A male cochlear implant user who works in medical setting and primarily uses spoken language reported, "*I really do think the people, the population of people who benefit from hearing aids would have a greater use of hearing aids if there was some sort of mandates for insurance coverage for hearing aids and it's not happening yet and not happening nationwide. The state of Oregon is a health leader in the nation and that would really improve the situation for those who would be willing to use hearing aids, if they didn't have to pay out-of-pocket for them all of the time."*

Education

Although one in ten (9.8%; N=84) respondents indicated they did not finish high school, 61 of these individuals are under 18, and another 7 fall into the 18-24 category, and thus may be in the process of completing; another 12.7% (N=108) did finish their education with a high school diploma. Forty-two percent (N=319) graduated from an Oregon high school.

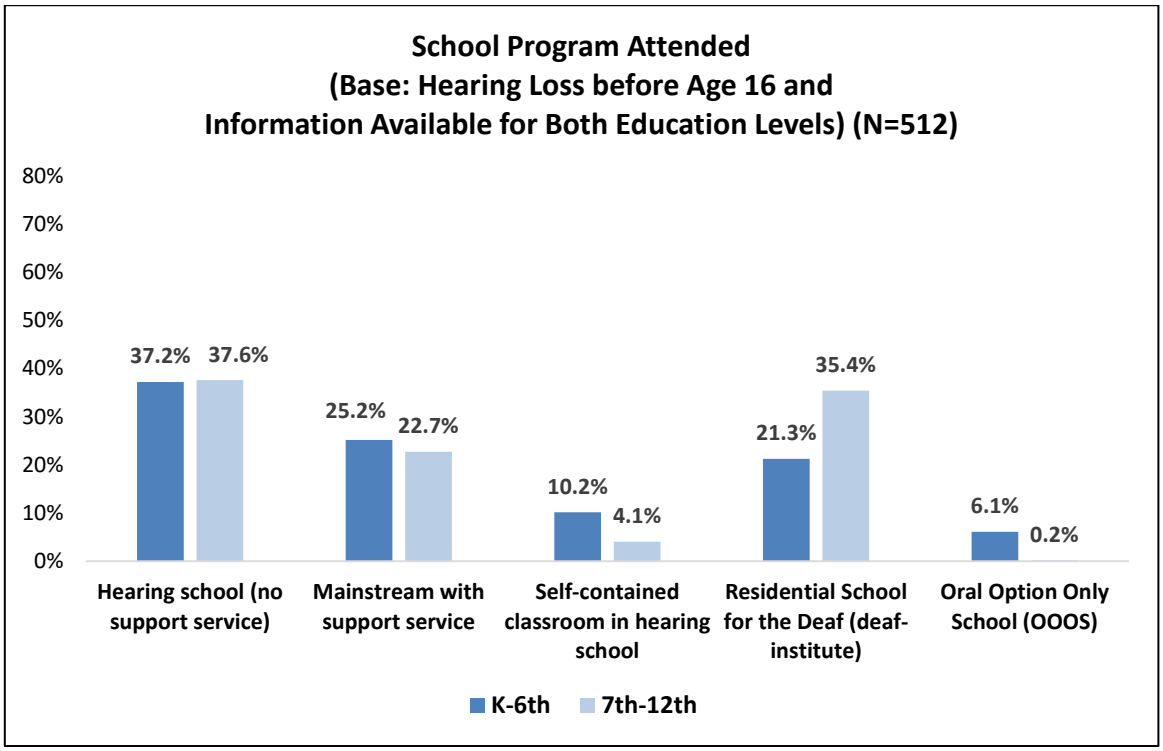
Nearly half (48.2%; N=411) achieved a 4-year or higher college degree. Among respondents who attended college, three-fourths (74.0%; N=490) completed their training/degree.

Table 8: Highest Level of Education

What is your highest level of education? (N=853)	Percent	Count
Currently in high school	7.0%	61
Did not complete high school	3.0%	23
Completed high school	12.7%	108
Currently in college	6.0%	49
Completed some college but not degree	14.0%	122
AA/AS or trade degree	9.3%	79
BA/BS (4 year college)	20.2%	172
MA/MS (Graduate)	22.2%	189
Terminal degree (e.g., Ed.D, Ph.D., JD, MD)	5.9%	50

Over one-third of respondents attended a regular hearing school without supports for K-6th grade (37.2%; N=194) and for 7th-12th grade (37.6%; N=196). Residential schools for the Deaf saw the largest increase from elementary to high school. While 111 (21.3%) attended a residential school for the Deaf for their early schooling; the number increases by 14% or 72 students for 7th-12th grade (35.4%; N=183). Of these students, 34 moved from mainstream programs with support, 23 moved from regular schools without support, 16 from self-contained classrooms, 8 from oral programs, and 2 from 'Other.' Only 8 students left residential programs, 7 moving to regular hearing programs and 1 moving to a self-contained classroom. This trend is common to the state. Oregon School for the Deaf reports their elementary program is very small, and they experience a large number of transfer students in the higher grades.

Figure 9: School Program Attended



Education Barriers Related to Learning Needs Accommodations

A hard of hearing adult with a mild hearing loss who attended University of Oregon recalled the significant barrier to her education, *"Most barriers [I experienced] are related to education barriers because I used ASL interpreters growing up but many people think that I do not need ASL interpreters because I can speak well."*

She further recalled her experience on how the Disability Service Center at the University took away her autonomy in determining her learning needs, "*Being able to speak doesn't mean how well you can hear. So, some can speak well, but still cannot hear well. For me, in classrooms, if there were noise in the background, I can't follow the instructor's voice or if the instructor talks and a student made a comment in the background, I would turn around and see who was talking and I*

would miss information and then need to catch up. Or if I want to write notes and I am looking down as I write notes and then I would look up and miss something or when I am writing notes and I would miss comments from a student in the background. So, an ASL interpreter will help me not miss as much information. Then they said no you do not need it. You should try closed caption services from distance [caption via remote]." Then they offered different services such as CART, "it was harder with CART to follow the conversation in the classroom. An ASL interpreter would be able to point out the people who is talking back and forth and I can understand who said this and that allows me to follow the conversation better."

She continued to fight for two semesters to advocate for her needs, "*When they finally provided interpreter, the interpreter they provided was hard of hearing and I thought that was strange. It seemed like that the interpreter was missing information as well, so I approached the interpreter and said, 'Do you know that you are not interpreting everything that they are saying?' She said, 'Oh I am hard of hearing and I must have missed.'…That did not make sense to me so I went back to the disability services. That was before the certification for ASL interpreters, so they did not have any certified interpreters. They just found somebody who was a parent who could sign and happened to be hard of hearing to interpret my 300 level English Course!"*

A young woman who identifies as both Deaf and Hard of Hearing shared her excitement related to starting college this fall in Oregon but experienced a familiar battle as many other Deaf and hard of hearing students related to advocating for their learning needs, *"I will start at OSU this fall, so right now, I'm meeting with the disability services on campus and I requested different accommodations for me to succeed in class. I asked for interpreters, extended test times, FM access in the classroom. The woman worked in that department for 20 years with Deaf students. When I asked for the extended time in class, she said, 'Why?' I explained, but she still didn't understand why I needed that. Yeah, so the college doesn't really understand why I need all these different accommodations in classes."*

Barriers Related to Education Options and Information

A teacher who uses both ASL and spoken language remarked, *"The key is communication in ASL. This access will improve communication, jobs, and education. The key is communication. They can communicate and speak, and write, and then in school they can understand. And then that will lead to future job opportunities. That will improve jobs, and the key is language. Where is the language? It's missing [in this equation]. Hearing people are pushing it aside, and making it all about the ear. They say, 'Speech will help,' but no, no, they forget that the eyes come first for visual access. For example, if you give an apple and an orange to a blind person, either deaf-blind or blind, they'll feel it and won't be able to tell which fruit is which. You'd have to tell them, or they could smell the orange or taste it, yes. But with visual access, you immediately know which is the apple and which is the orange. Why shut out our visual access? It's the same for Deaf and blind people. Visual access, signing. Deaf-blind people are more experienced in how to communicate using this system, which is known as ProTactile. That impressed me. The answer is right there. Why stop that access and remove it?"*

The parent of a 6 year old oral child shared her frustration related to lack of options, *"I want to get it there [in records] that Portland Public Schools does not have a truly oral option. They have total communication option and sign language option, they don't have an oral education option, I find*

that to be breaking the law for Deaf and hard of hearing students where they don't have fully oral option if that is the communication mode that parent has chosen for that child."

A parent of 8 year old child asks: *"In Portland Public School it is $25,000 per kid which is why they don't want to release that money [to pay for other options]. They want to keep it in the school and they feel that they can use the IEP and spend the money that way. I use that in quotation marks but 15 minutes of speech a week for an investment of $25,000 for ten months of the school year, what's my ROI?"*

A parent of 8 year old daughter who goes to Oregon School for the Deaf expressed her struggle with the system at the school district, *"There's no real happy medium. …She can't go into two different programs or go half day to one school [OSD] and another half day at another [mainstream at hearing school], or different ways of combining them. At that young age, there is no way the parents are going to know what the best fit is yet for their child."*

"We see a lot of Deaf children being very isolated. So they're in the neighborhood school but they're not really integrated into the community because of the language barrier and we're seeing a lot of mental health problems in the Deaf community because of their isolation," expressed a parent of a Deaf child who is also a teacher.

Many more concerns were expressed by parents of Deaf children, *"There is a lot of training for hearing teachers. I don't know if you know that concept of 'you have to be Deaf to get it.' Takes one to know one kind of thing. As a Deaf person, I know what the Deaf experience is like and the same thing goes for any deaf teachers. So they understand what a Deaf child is experiencing…their world view and their world experience. It's so nuanced. It's so different from interaction with non-deaf people. And it's so easy for someone who is not Deaf to miss these very small subtle aspects in facial expression and body movements that are so meaningful."*

An interesting point made by parents of Deaf children, *"You know, we have all these policy makers, almost all of them are hearing and so they're making decisions that greatly impact Deaf people's lives without understanding their Deaf world and the Deaf experience."*

"The way the system is currently designed forces parents to choose that school or this school, this whole idea of placement options. And parents have to gamble. Sometimes they just take a guess, pick a school randomly because they have no idea what's going to be best for their children yet. They haven't experienced any of these or certainly not all of them. It's like playing a game. It's taking a gamble with them. Resources and tools are not provided all in one place for a diversity of needs. And so a child gets pulled out of one school and thrown into another the next year. Instead of all these different approaches being allowed to be provided in one place."

The parent of an adopted 7 year old hard of hearing child with progressive vision loss in Southern Oregon shared, *"My child was originally put in a program for children with severe delays or disability. I pulled him out after 2 days because he is not autistic and didn't fit in the category as a Deaf individual. The classroom was full of stimulation [meaning lots of adults and children talking at the same time] going on and the Deaf child will miss out all the information because the information is not being communicated to him directly."* He was eventually put into a different school with self-contained classroom but did not have an audiologist coming in until the parent fought with the district, *"He was receiving speech therapy via a computer which was obviously ineffective. After a lot*

of negotiating and pushing and pulling and documenting, I finally got a speech therapist to come in once a week to work with him at the school. I felt we like we lost six to eight weeks because of this. I also feel like here in this county I have to fight for everything. As a result, he doesn't know how to interact with hearing children because of his delay and isolation is a struggle. He's not able to do things that other kids get to do, like go to camp. Because they won't have an interpreter. Even doing Boys Scouts, you know, not having an interpreter for Boy Scouts [they have asked for one multiple times]…He watched his older brother [hearing] going to camps and Boys Scout all summer and it hurts."

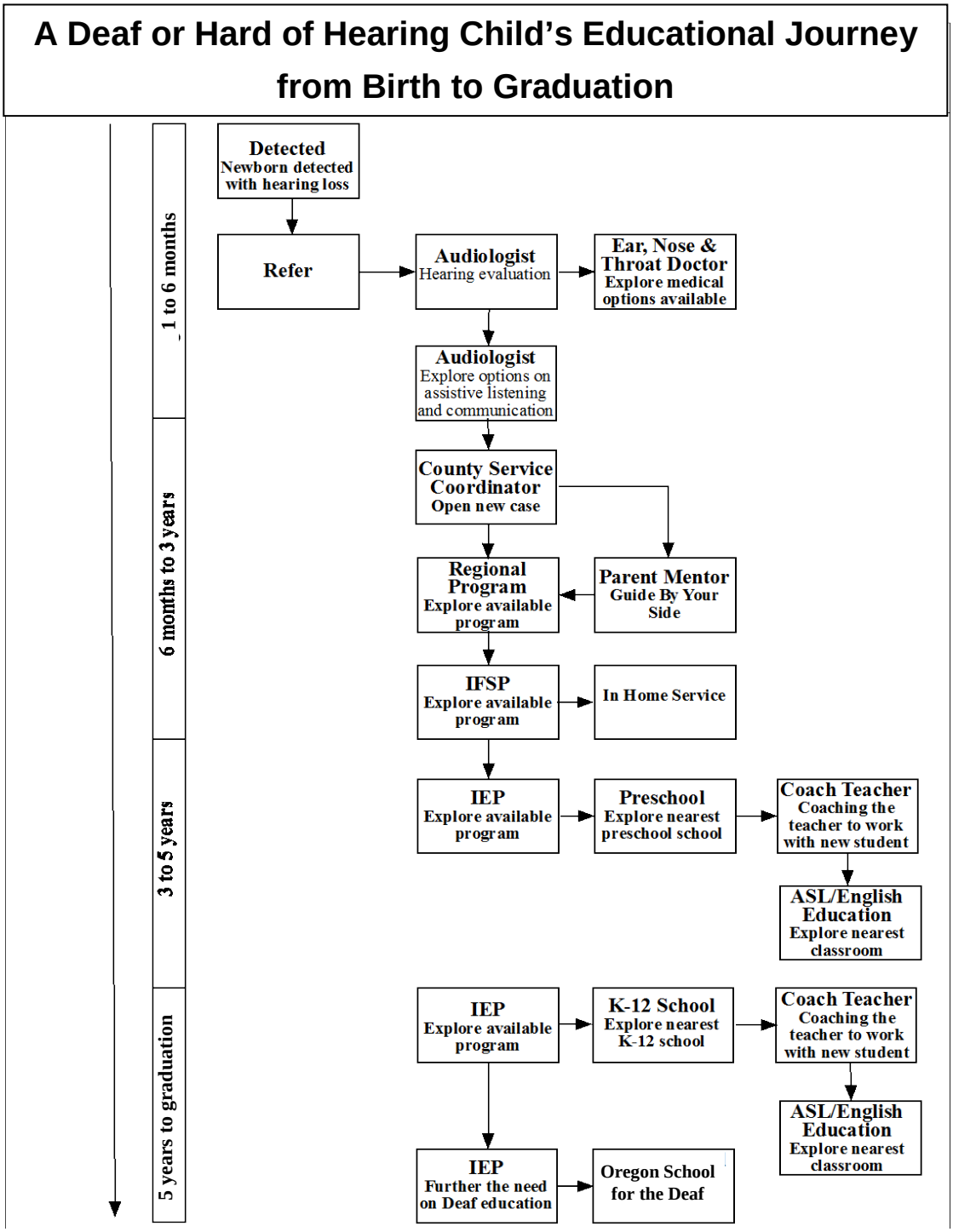
A parent of 7 month old baby expressed her frustration with an early intervention program on communication, *"The early intervention preschool right now, the only preschool I could get a hold of that had any sign support and with a hearing specialist, doesn't get it."*

Another parent with a Deaf child who uses both ASL and spoken language who is involved with the Hand and Voice expressed frustration with a recent incident in Central Oregon, *"I hear and see a lot of really, really confused parents. And depending where you are in the state, I'm so sad to hear, early intervention tells parents there [in central Oregon] they need to sit on their hands and not sign to their babies because their babies will never speak if they do that. And that's coming from early intervention and it's still happening. So part of the issue there is there are no certified Deaf and hard of hearing specialists in the early intervention program in many of the rural parts of the state. Huge barriers. So what we're talking about is these children growing up many times very frustrated."*

The parent of an adult hard of hearing child who uses both ASL and spoken language shared, *"There's this window in there, there's this problem where kids aren't getting language. And I'm not talking about sounds. Because what I'm seeing is they're not getting language. And when they finally get [the hearing aids] on, they're being told to not sign. And so there's just this big gap and for me that's a huge barrier as children go forward and I would just like to see, you know, the system to be able to support whatever it is that parents are dreaming of and wanting for their children. I'd like to see babies with lots of language."* Another parent of a 5 year old hard of hearing child continued, *"That sounds so crazy to me that they're not encouraging signing because even for kids without hearing loss now it's like baby signing, baby signing. They can communicate what they want to you instead of crying. It seems very odd that anyone would advocate the opposite."*

The following flowchart and description was developed based on data from several Focus Group interviews with Parents of Deaf, deaf, and hard of hearing children. Comments from parents and teachers are interwoven in the description and italicized.

Figure 10: Flow Chart of Services Involved in Child's Education Path



In Oregon, when a baby is born, a hearing screening takes place to determine if the newborn experiences any range of hearing loss. Once it is determined the baby potentially has a hearing loss, the newborn is referred to an audiologist for further testing. After an audiologist confirms the hearing loss, the audiologist will discuss assistive listening devices and communication options available to

the newborn baby. Typically, families may choose to explore options that involve surgery, for example, cochlear implants, although this would not occur until the baby is older.

After the personal devices (e.g., hearing aids and cochlear implants) and communication options are considered for the baby, the family will be referred to the County Service Coordinator to open a new case. They will work with the family to explore the appropriateness of the nearest regional school program.

Many parents expressed frustration with limited information on communication options from ENTs and other professionals; as one parent of a 7 year old deaf boy who relies on an oral approach stated, *"When you go to the doctor and the doctor tells you your child is deaf, you don't hear anything about the next step, which is to choose a communication method. And the idea that there is an entire method that is oral wasn't actually presented…I was presented with cued speech, which is dead. I mean nobody uses cued speech and there is nobody to even teach you that and I spent months and months researching cued speech on my own until I found other options."*

At age 6 months to 3 years, the family with a toddler living with hearing loss will work with a representative from the Regional School Program to determine the nearest possible program available to this family. If the parents wish to have a Parent Mentor to work with them, the County Service Coordinator will make another referral to a Parent Mentor through the program Guide By Your Side via Hands and Voices of Oregon. The parents will attend the Individual Family Service Plan (IFSP) meeting through the Regional Program. The IFSP is a plan for special service for young children with disabilities from birth to age three. After the age of three, an Individualized Education Program (IEP) is put into place. The IFSP plan is often carried out at the Deaf or hard of hearing child's home.

An annual meeting for IFSP is hosted with the Regional School Program and the parents to discuss the education path. This IFSP evolves into an IEP once the child turns three until graduation or it is no longer needed. Parents expressed frustrations for not being provided the entire range of options related to education for the Deaf and hard of hearing individuals. For example, in the Metro Portland area during the child's time at age of three to five years old, the Regional School Program allegedly withheld the information that there is a classroom for Deaf or hard of hearing students. Many parents reported not being aware of a Deaf classroom or other options for their child.

The parent of a 1 year old son who uses both ASL and spoken language observed: *"There seems to be a rift down the middle; one is oral and one is ASL, and they are very much against one another but I want him to be able to speak and so he can hear and speak to other people, but I want him to be with his Deaf roots and be able to do sign language. I want him to be multifaceted. Why can't we do that?"*

The parent of a 5 year old Deaf boy complained: "*When my son was diagnosed as Deaf, they [the early intervention team] looked at us and said ASL or oral, you need to pick one and you can't do both. They said we will confuse him if we do both ASL and oral. You look at people who have hearing infants and they say teach them sign language for teaching them to eat and sleep but they are telling me I can't do that with my Deaf child. You don't know where to get information, but you feel like you are forced to have to make a decision for your child at that stage."*

The Regional School Program provides placement in a classroom. The placement includes coaching the teacher who works with the child in mainstreamed classrooms (i.e., the Deaf or hard of hearing child is placed in a hearing classroom with supports). The County Service Coordinator leads the meeting and makes the recommendation to place the child in a special class or mainstreamed program. (Note: if a child needs additional supports, classes for children with developmental disabilities or behavioral challenges are often not prepared to support a Deaf or hard of hearing child.) Many parents reported that they did not know about the possibility of an ASL and English classroom until much later in the child's education.

It is standard to have a Parent Mentor through Guide By Your Side to accommodate parents at every meeting that involves a County Service Coordinator and Regional School Programs. The Parent Mentor can advocate and ensure that parents of a Deaf or hard of hearing child receives all kinds of information, options, and resources that are made available to them.

Some parents expressed frustration that their child had to fail in other settings before the option of Oregon School for the Deaf was presented. This puts Deaf and hard of hearing child at risk for persistent language deprivation, and the lack of academic growth can be pronounced and severe in comparison to their hearing peers.

According to parents, the Oregon School for the Deaf is perceived as the last resource to work with the Deaf child over other academic programs. This results in information about this option being withheld until much later in the child's life.

A parent who is involved with the Hands and Voice organization with an adult Deaf child who uses both ASL and spoken language shared, *"Even if you're getting the language in [auditorily], there are still holes. Even if you have really good hearing aids, it's that Swiss cheese effect. You're not always getting perfect language. Our kids are still going to need lots and lots of visual support as well. So these are barriers throughout their whole life."*

Another parent of an adult hard of hearing student added, *"I always hear the phrase hearing aids are not like eyeglasses. You know, they don't give you 20/20 hearing. Are you finding that the people you work with understand that? Do their teachers understand that? Even now, we still have to educate school districts on this. They [mainstream programs] do not understand. They don't get it. They still think that the [Deaf or hard of hearing] kids just don't listen. They're the ones not listening."*

Financial Barriers to Education

A parent of 5 year old deaf daughter who choose the oral only option at Tucker-Maxon stated, "*I live in Portland. Oregon City is paying for students who go to Tucker-Maxon. My daughter comes here. Portland Public Schools never paid, so I am out of luck. I had to apply for scholarships and go through this huge process to find a financial help."*

Another parent of a Tucker-Maxon student*, "That's why I came to this focus group. I want Portland Public to pay tuition as an option because I have seen what they do with children in Portland Public Schools system. Put all the deaf kids in one room and they 'integrate them at lunch.'"* This parent reported she refinanced her house in order to pay for the tuition.

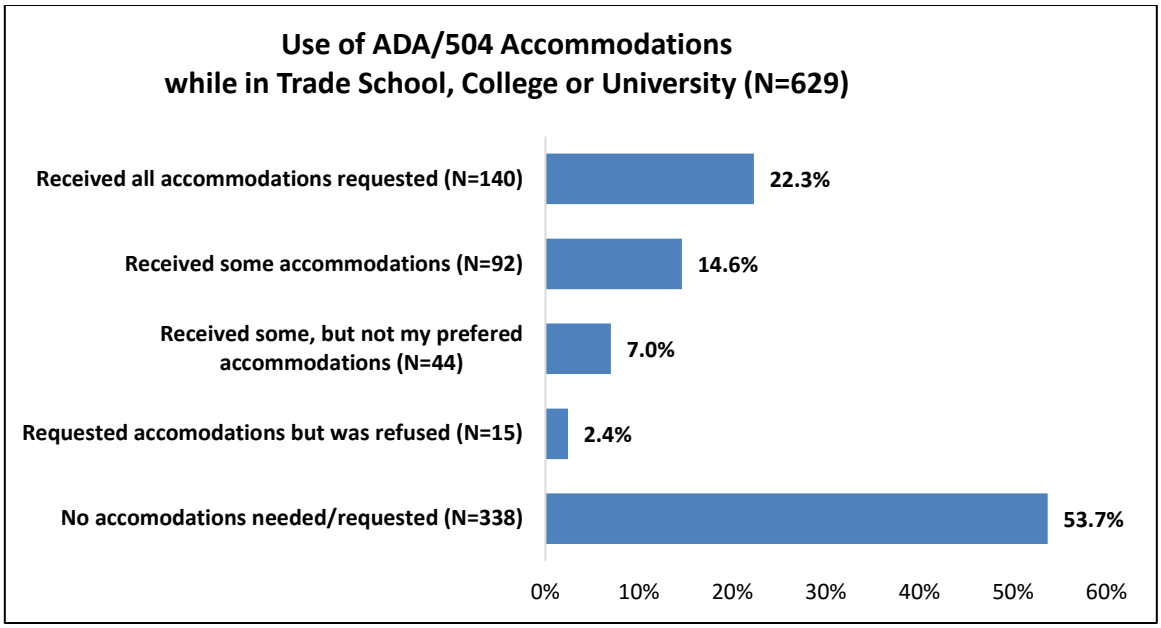
Another angry parent of a Deaf child stated, *"I think that Portland Public Schools wants my daughter to fail and fail badly before I could look at another option before they were pushed hard enough to move."*

An angry parent requested to have this on record, *"Tuition is $17,000 a year at Tucker-Maxon, 10 months and if you are a full time working parent, which you have to be to pay for that it's another $400-600 a month, so it's insane. We need support [reference to financial support]."*

Postsecondary Educational Settings

The requirements of postsecondary settings are very different from secondary settings. In the public school system, children with disabilities are identified, have individualized education plans developed, and are provided accommodations based on this. In postsecondary settings, it is up to the individual to request an accommodation, which also entails knowing what accommodations might be most useful in this new setting and how to use them effectively. Students also must provide documentation of the need for the requested accommodation. Nearly half (46.3%; N=291) of respondents have requested ADA/504 accommodations while in school. Of these, just 22.3% (N=140) received all requested accommodations. Fewer received only some accommodations (14.6%; N= 92) or not their preferred ones (7.0%; N=44).

Figure 11: Use of Accommodations in Postsecondary Settings



ASL interpreters (68.8%; N=185) and note takers (69.1%; N=186) are the most widely used accommodations in trade school or college by respondents who received accommodations. Note: The number of people who did not request accommodations is inflated by the number of people who lost their hearing post-college. Because we do not know at what age participants attended college, we did not remove any respondent age categories from this analysis.

Table 9: Accommodations used in Postsecondary Education Settings

Accommodations Used (Multiple Response) (N=269)	Percent	Count
Note takers	69.1%	186
ASL interpreters	68.8%	185
CART or other caption service	21.2%	57
Other (please specify)	19.0%	51
Personal listening devices (e.g. FM system)	13.8%	37
Oral interpreter	3.7%	10

Among those respondents who used accommodations while in school (N=269), a sizable portion state that these accommodations were not sufficient for their education or training (15.2%; N=41) or were unsure it helped them (13.8%); N=37). Thus, almost one-third of those attending postsecondary education programs felt they could have had more effective accommodations than they received.

Employment

Respondents were asked several questions about their employment status, if they were seeking work, and if they believed hearing loss has had any impact on their ability to get, keep, or be promoted on the job. Over one-third (36.0%; N=302) were employed for wages at the time of the study; with another 7.5% (N=63) self-employed. Eleven percent (N=95) were out of work at the time of the study. Nearly two in five (38.5%; N=323) were retired.

Table 10: Employment Status

Are you currently… (Multiple Response) (N=838)	Percent	Count
Employed for wages	36.0%	302
Self-employed	7.5%	63
Out of work for a year or more	8.6%	72
Out of work for less than a year	2.7%	23
A homemaker	5.7%	48
A student	13.1%	110
Retired	38.5%	323

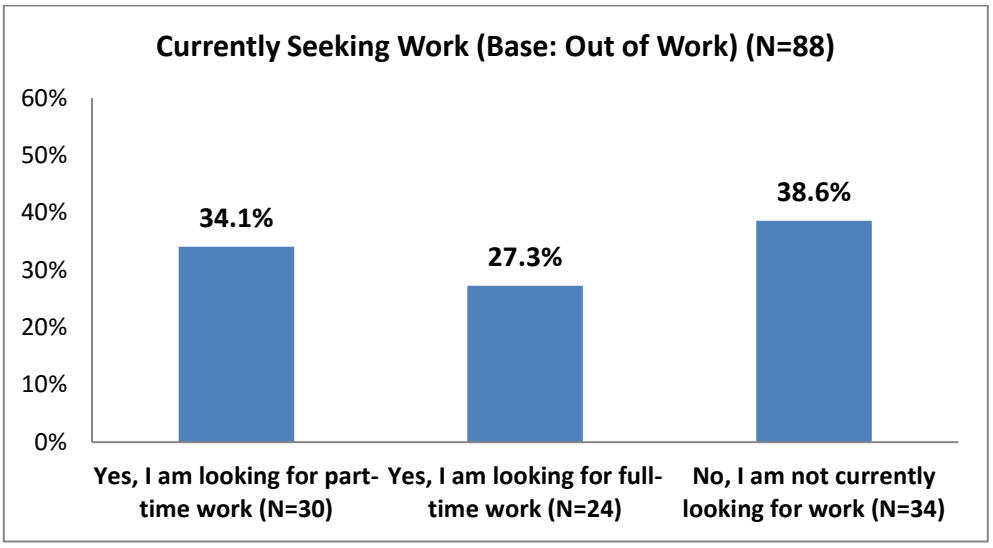
Four in ten (40.0%; N=342) were employed at the time of the survey. Another one in ten (10.0%; N=84) were out of work. Half (50.1%; N=428) were out of the labor market.

Table 11: Employment Status

Employment Status (N=854)	Percent	Count
Employed	40.0%	342
Out of work/looking	6.3%	54
Out of work/not looking	3.3%	28
Out of work/unspecified	0.2%	2
Out of labor market (e.g., retired, student, underage)	50.1%	428

Among respondents who are currently seeking work, just over one-fourth (27.3%; N=34) want a full-time position. Thirty-nine percent (N=34) are not looking for work at the moment.

Figure 12: Currently seeking work



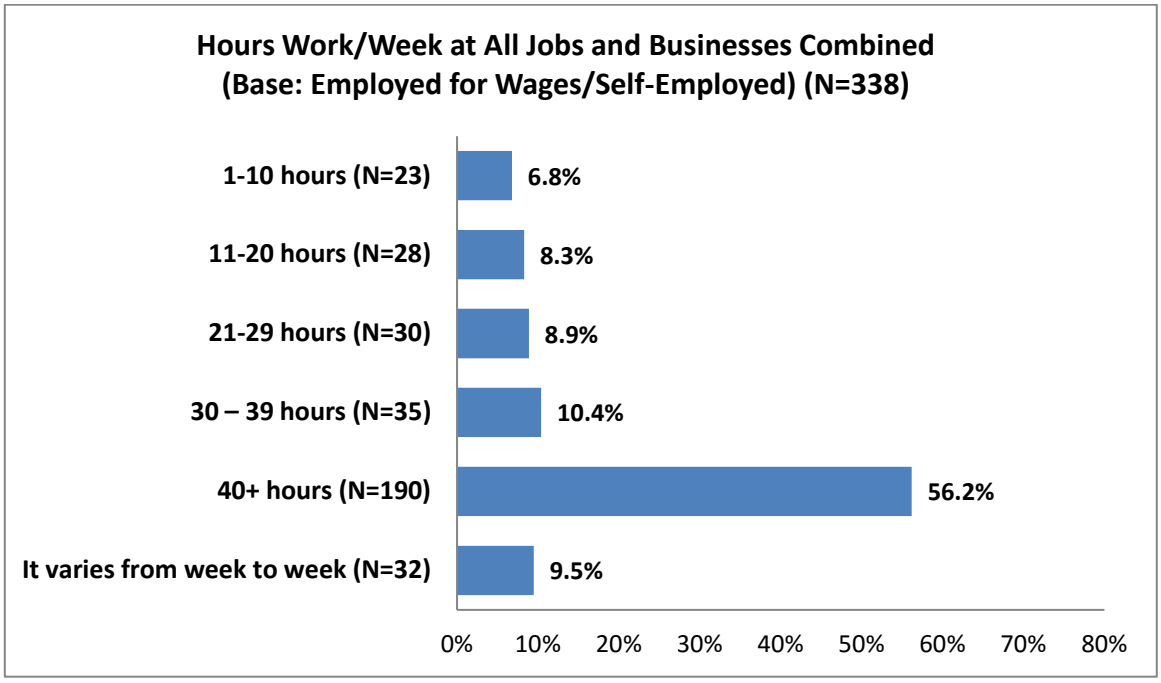
Employment, household income, and housing are all closely related. Respondents who indicate they live alone are significantly more likely than others to report an annual income from all sources below $35,000.

Table 12: Annual Household Income by Number in Household

Annual Household Income from All Sources (N=769)	Live Alone (N=188)	Others in Household
Under $25,000	43.1% (81)	25.0% (145)
$25,000 - $34,999	20.7% (39)	11.0% (64)
$35,000 - $49,999	10.1% (19)	11.6% (67)
$50,000 - $74,999	12.8% (24)	19.5% (113)
$75,000 - $99,999	8.5% (16)	12.8% (74)
$100,000 - $149,999	3.2% (6)	13.6% (79)
$150,000+	1.6% (3)	6.6% (38)

Over half of respondents who are currently employed for wages or self-employed work 40 or more hours per week (56.2%; N=190). A smaller portion (15.1%; N=51) works 20 or fewer hours, while about one in ten work a variable schedule (9.5%; N=32).

Figure 13: Hours Worked per Week at all Jobs



Half (49.4%; N=165) of employed respondents are hourly workers, while two in five (41.6%; N=139) are salaried. The remaining 9% are paid on commission or some other way.

Fully one in five respondents (21.5%; N=176) report that they have left employment previously because of their hearing loss. Among those, 17.8% (N=31) say they felt strongly encouraged to take early retirement due to their hearing loss. An equal portion (17.2%; N=138) of all respondents feel that they were previously laid off or fired due to their hearing loss.

Table 13: Perceived Impact of Hearing Loss on Employment

Impact of Hearing Loss on Employment	Percent	Count
Believe they were ever laid off/fired due to their hearing loss (N=803)	17.2%	138
Left employment because of Hearing Loss (N=819)	21.5%	176
Felt strongly encouraged to take early retirement due to their hearing loss *(Base: left employment due to hearing loss)* (N=176)	17.8%	31

Among those respondents who are currently out of a job (N = 91), 16.5% (N=15) have turned down a job in the past 12 months. While they included a number of reasons for this, five respondents cited reasons centered on their hearing loss, such as their inability to hear or the lack of accommodations at the job site.

Misconceptions about what Deaf and hard of hearing people can do is by far the most commonly cited reason for not finding a job among respondents (31.3%; N= 198). Another 21.3% (N=135) think it is because of their hearing loss.

Table 14: Causes for Not Finding Job

Reasons Experienced Why Cannot Find Job (Multiple Response)(N=633)	Percent	Count
Other	44.2%	280
Misconceptions about what Deaf and hard of hearing people can do	31.3%	198
I think it is because of my hearing loss	21.3%	135
There are not many jobs that I am qualified for in my area	20.1%	127
I do not have enough education for many jobs	18.0%	114
I think it is because cost of interpreters or captioning	14.5%	92
I need qualified ASL or other interpreters and cannot get one	13.0%	82
Most jobs do not pay enough	12.6%	80
A need for employer provided equipment	7.7%	49
I have restricted hours for work	7.0%	44
A need for support person at work	6.5%	41
A need for ongoing supervision or assistance	5.2%	33

Workplace situations can be difficult for people who are Deaf or hard of hearing. About three in five say department/staff meetings (62.3%; N=442) or socializing with co-workers (58.9%; N=418) can be difficult due to their hearing loss. In-service-training (47.6%; N=338) or working/ communicating with the public (57.0%; N=405) are also viewed as difficult situations. Lack of ability to satisfy social norms are significant even if a person is doing their job well. It has a negative impact on the individual's self-esteem and on coworkers' desires to engage with the person on projects.

Table 15: Difficult Communication Situations in the Workplace

Difficult Workplace Situations (Multiple Response) (N=710)	Percent	Count
Department/staff meetings	62.3%	442
Socializing with co-workers	58.9%	418
Working with and/or communicating with the public	57.0%	405
Work related social functions	50.1%	356
In-service/training	47.6%	338
Receiving instruction and supervision	33.8%	240
Other	20.7%	147
Performance evaluation	20.1%	143

Treatment at Work

A hard of hearing woman shared her common frustration while at work during large meetings where she relies on induction loops or FM systems for communication access, "*People don't want to use the microphone…They can holler all they want but if it doesn't come into the microphone you're not going to hear it. So it's either one or the other, and they'll go, 'I can talk loud enough', and they'll quit talking in the microphone."*

A hard of hearing male reported he quit working at a health care organization before anticipated, "*Because it was difficult for me to hear under most circumstances, like in a conference room, and I could not get accommodations that worked for me*." He continued to share a common dilemma that many Deaf and hard of hearing individuals experience at the workplace, "*I don't know of any other organizations other than the Hearing Loss Association that can provide that sort of comprehensive information to individuals that are hard of hearing in terms of employers. But I think mostly it takes self-advocacy to get it happen and a lot of people are afraid to confront an employer and say I need special phone, I need this, I need that. Because they are afraid they're going to get canned*."

Barriers Related to Employment

A hard of hearing woman who lives in the Northern Coast region, who relies solely on spoken language, shared her significant employment barriers, "*The hearing aids that I bought in my late 30's and early 40's were getting more helpful. But I still had a lot of problems working. …I have my Bachelor's Degree in Sociology and my Master's in Library Science, and I did fine in school. But to try to find a job was something else entirely. And I knew that I'm not going to be able to hear well, I'm not going to be able to answer the phone, because I wouldn't be able to get even just phone numbers right or names spelled right. Just a simple message like that. And a couple of jobs I had, I had to fill in for the receptionist, but I couldn't do it. I just fell apart. And so they, so they modified the job for me, but I still had problems. I used the services of rehabilitation, and my counselor thought to put me in a secretary job. And I didn't do well at all. I worked about twice as hard as I had to, but the supervisor still told me that my performance is pretty bad.*" Then, after she received her Library degree, she thought she had a new employment opportunity but continued to struggle, "*I thought, well I can't be sitting at the reference desk and saying, 'What? What? What?' or any kind of front desk. So they modified the job for me, like that, but I still, I just didn't, I had a lot of problems. They had modified the job so much that they decided it just isn't going to work out. I interviewed well, and so I could get jobs. But I couldn't keep them*." As a result she took an early retirement at age of 47, "*because I couldn't take it anymore."*

A young Deaf ASL user shared her employment barrier in Southern Oregon, *"I had a job interview with the Oregon Department of Transportation in Medford. They contacted me a week and half later before asking if I was still interested. Sure, so for the interview, I let them know I was Deaf. They hesitated; I asked for an interpreter to make everything more fluent for everyone. They said, 'Okay.' They actually asked if I could bring someone, like my friend or family, and I told them it wasn't professional, and that my family and friends weren't certified. I wanted to keep my personal and business lives separate. Their response was, 'oh…'."* Upon her arrival, there was not an interpreter present, so she offered to communicate by typing on her iPad. She stated this was not as

effective but the only option at that time. This person was not offered the job and experienced similar incidents with other State level jobs. Ultimately she was hired with the US Forest Department in Oregon, a Federal level job.

A Deaf engineer reported a barrier related to lack of qualified interpreters in employment setting, *"I'm an engineer and I need someone who knows the jargon because that could cost me my job. If they are incompetent, they can make me look bad and people won't realize that [it's really the interpreter's problem]."*

A deaf-blind male with Usher syndrome who relies on spoken language shared his struggle on employment, *"Because I made aggressive use of the assistive devices, I was able to complete my education and even get some employment, although it was very difficult getting employment."* He had a stable job until he had to retire early due to his hearing and vision difficulties, *"I retired early because of my hearing and vision loss… it was definitely getting harder for me to read literature thoroughly and this slowed down my productivity, which I didn't want to continue."*

Socioeconomic Indicators

Although this project was not able to collect data to construct a true socioeconomic status (SES) value for each respondent, information was collected on the number in the household and the household income. In addition, because they are closely related to SES, information on ability to obtain safe, affordable housing and transportation are included in this section.

Number in Household

Nearly one-fourth of respondents (23.9%; N=199) live alone. Over one in three (36.8%; N=306) have one other person in the household.

Table 16: Number Living in Household

Number in Household(N=831)	Percent	Count
Lives alone	23.9%	199
1	36.8%	306
2	16.2%	135
3	11.0%	91
4	4.8%	40
5 or more	7.2%	60

Household Income

Three in ten (29.4%; N=226) reported an annual household income from all sources of under $25,000. This category also had the largest proportion of respondents regardless of how many members there are in the household. Over half (54.0%; N=415) have an income under $50,000.

Table 17: Annual Household Income from All Sources

Annual Household Income from All Sources (N=769)	Percent	Count
Under $25,000	29.4%	226
$25,000 - $34,999	13.4%	103
$35,000 - $49,999	11.2%	86
$50,000 - $74,999	17.8%	137
$75,000 - $99,999	11.8%	91
$100,000 - $149,999	11.1%	85
$150,000+	5.3%	41

Another way of looking at this data is to compare the household income with how many people are living in the house. While only 7% (n=55) of those reporting their income are possibly living at the federal poverty level (our data are reported in ranges), fully 30% are earning under $25,000/year, many with three or more people in the household.

Table 18: Household Income by Number Living in Home

Number in home	Under $25K	$25-34.9K	$35-49.9K	$50-74.9k	$75-99.9k	$100-149.9k	$150k or more	Total
Self	81	39	19	24	16	6	3	**188**
1	61	38	35	64	26	37	21	**282**
2	39	8	12	22	17	17	4	**119**
3	18	6	10	13	14	17	8	**86**
4	11	2	4	4	7	5	4	**37**
5 or more	16	10	6	10	10	3	1	**56**
Total	**226**	**103**	**86**	**137**	**90**	**85**	**41**	**768**

Housing

About half of respondents stated that they owned the home they live in (51.8%; N=423). Another 22.7% (N=185) rent their current home. One in seven (14.3%; N=117) live with family members.

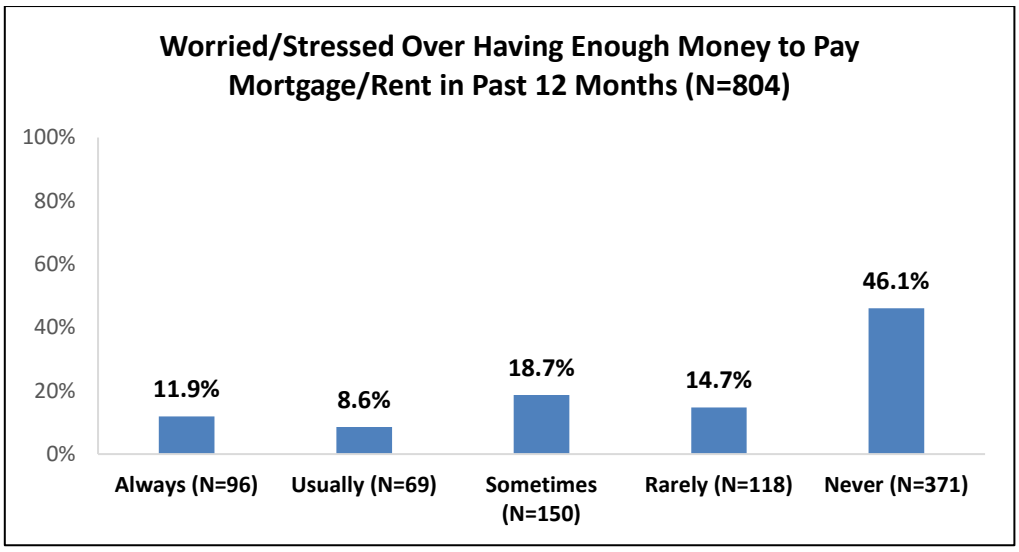
Table 19: Current Living Situation

Living Situation (N=816)	Percent	Count
I own the home I live in	51.80%	423
I rent the home I live in	22.70%	185
I live with other family members	14.30%	117
Other	7.10%	58
I live with roommates (not friends or family)	2.70%	22
I live with friends	0.90%	7
I sleep on sofa or floor at someone's house	0.20%	2
Transient (moving around often)	0.10%	1
Homeless	0.10%	1
Migrant	0.00%	0

The majority of respondents have not moved in the past year (78.4%; N=633), and 13.5% (N=109) have moved once. A small portion 5.2% (N=42) has moved three or more times in the last year, indicating instability in their home lives.

While over two in five say they never worry or stress about having enough money to pay their rent or mortgage (46.15; N=371), a sizable portion (20.5%; N=165) say they worry or stress always or usually.

Figure 14: Concerned about Ability to Pay Mortgage/Rent in last 12 months



Forty-six respondents (5.6%) indicated they do not feel safe where they live. Safe affordable housing is out of reach for many as they are not employed (16.3%; N=87) or they do not get paid enough (24.7%; N=132). Another 22.6% (N=121) have too many debts or a bad credit score (16.3%; N=87). Even with low incomes, many say they do not qualify for affordable housing (20.6%; N=110).

Table 20: Difficulties in Obtaining Safe, Affordable Housing

Challenges to Safe Affordable Housing (N=535)	Percent	Count
Costs too much, my job does not pay enough	24.7%	132
I have a lot of debts (loans, credit card, etc.)	22.6%	121
I don't qualify for affordable housing program	20.6%	110
Costs too much as I don't have a job	16.3%	87
I have a bad credit score	16.3%	87
Long waiting list for affordable housing	13.1%	70
Other	10.5%	56
I don't understand the application procedure for affordable housing program	5.6%	30
I don't have references	4.7%	25

Other Barriers Faced in Housing

A Deaf ASL user who has fostered Deaf and Hard of Hearing children shared, *"With my foster kid, the DHS took care of the interpreting process. They're [DHS] very strict [about regulations], which is good. We had one smoke alarm that wasn't acceptable because we're Deaf. She was right; it would just beep and we wouldn't know if there were a fire, you know what I mean? So I had to change it to a visual alarm, so I was glad she knew that. The alarm also had to be with a carbon monoxide detector. It had to have a light. So, it's sad that a regular smoke alarm is maybe $20, but for Deaf people, the detector is $179. Wow. I had to pay for that and we need several of these in the house. Luckily, our costs were covered [by DHS] so that helped us do it sooner, but that was interesting. I know this will be a financial barrier for many Deaf and hard of hearing people."*

A young hard of hearing male who wears hearing aids and uses ASL expressed his frustration, *"I'm renting an apartment, and when I started the lease two years ago, I requested visual alerts for the doorbell and fire alarm. They said they'd provide it for me, but then the management said I had to pay for it myself. I thought they were obligated to provide it, but they said I had to pay for it."*

A Deaf parent relayed this about the cost of equipment: *"I'm looking for a motion-sensing system for my child to alert us if needed during middle of the night. We might not know if he gets up during the night, so I've been looking for a motion-sensing thing, but there doesn't seem to be one with a flashing light. If you buy something, you can connect it and transfer it to the clock, but it's a small thing for sensing motion. And it's costly, so it's a long process. We're not able to find that. There's one company, Weitbrecht Communications, that has a kit for anything for your apartment like alarms, doorbells, everything. It's $700!"*

A deaf-blind male senior citizen shared his barrier as a homeowner, *"I passionately love my yard. I work in my yard as much as I can but it is very hard doing that. And I can barely afford the amount of extra help that I pay for."*

Then he shared his frustration over a recent home repair. *"When I had the ceiling repaired, it was a huge controversy. It was a huge battle with contractors 'cause the contractors said, 'Well, we think we fixed it good enough.' And so I asked the neighbor and the neighbor said, 'I don't think that's good enough. I couldn't look and decide for myself [because of significant vision loss]. So, eventually I hired another contractor and he basically said, 'It's good enough. I think I can just put one coat of paint on it.' There's a big repair in the area and it could have certainly been done better but I can't see it well enough. So it puts a lot of stress on me to know who to trust."* This same area leaked again during a recent downpour.

Transportation

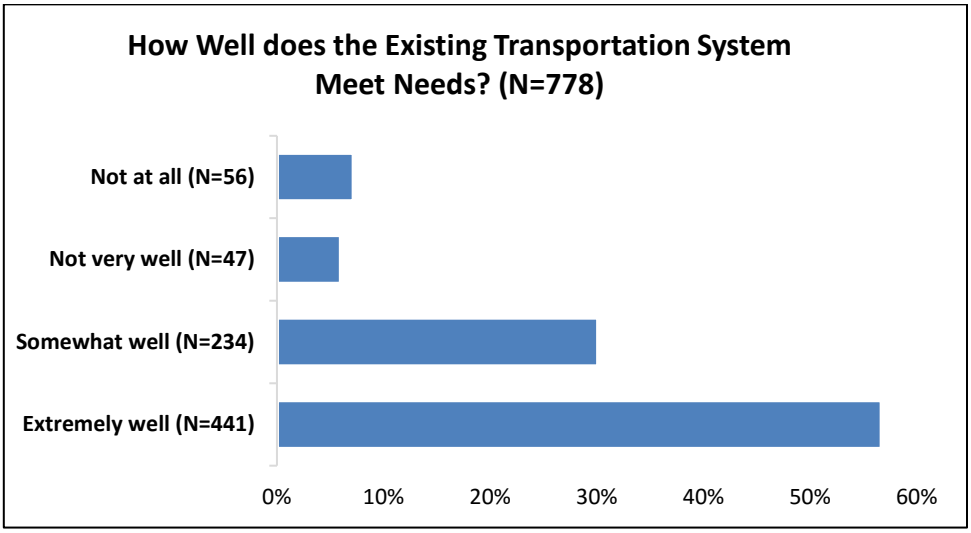
By far, respondents rely mostly on cars for their transportation needs (74.0%; N=81). One in ten (10.0%; N=81) relies on friends or families for their needs.

Table 21: Transportation Most Frequently Used

Most often used Transportation (N=814)	Percent	Count
Car or other motorized vehicle	74.0%	602
Friend/Family	10.0%	81
Public Transportation – BUS	6.1%	50
Public Transportation – Light Rail	3.1%	25
Walking	2.6%	21
Bicycle	1.6%	13
Paid support service provider	1.6%	13
Public Transportation – Other	1.1%	9

The existing transportation system, including transit, bikes, or highway, seems to meet over half of respondents' needs extremely well (56.7%; N=441). A sizeable proportion (13.2%; N=103), however, does not get their needs met at all or not very well.

Figure 15: Does Transportation Meet Needs?



Among those who use public transportation (bus, light rail, or other) (N=83), just over two in four (43.4%; N=36) say the system serves them extremely well; with another 45.8% (N=38) stating it serves them somewhat well. Another 10.8% (N=9) do not believe the existing transportation system serves them adequately. Most responses about issues with transportation relate to being in a rural area where there is no public transportation or only limited times and stops, and not being able to get to the stops.

Transportation Barriers

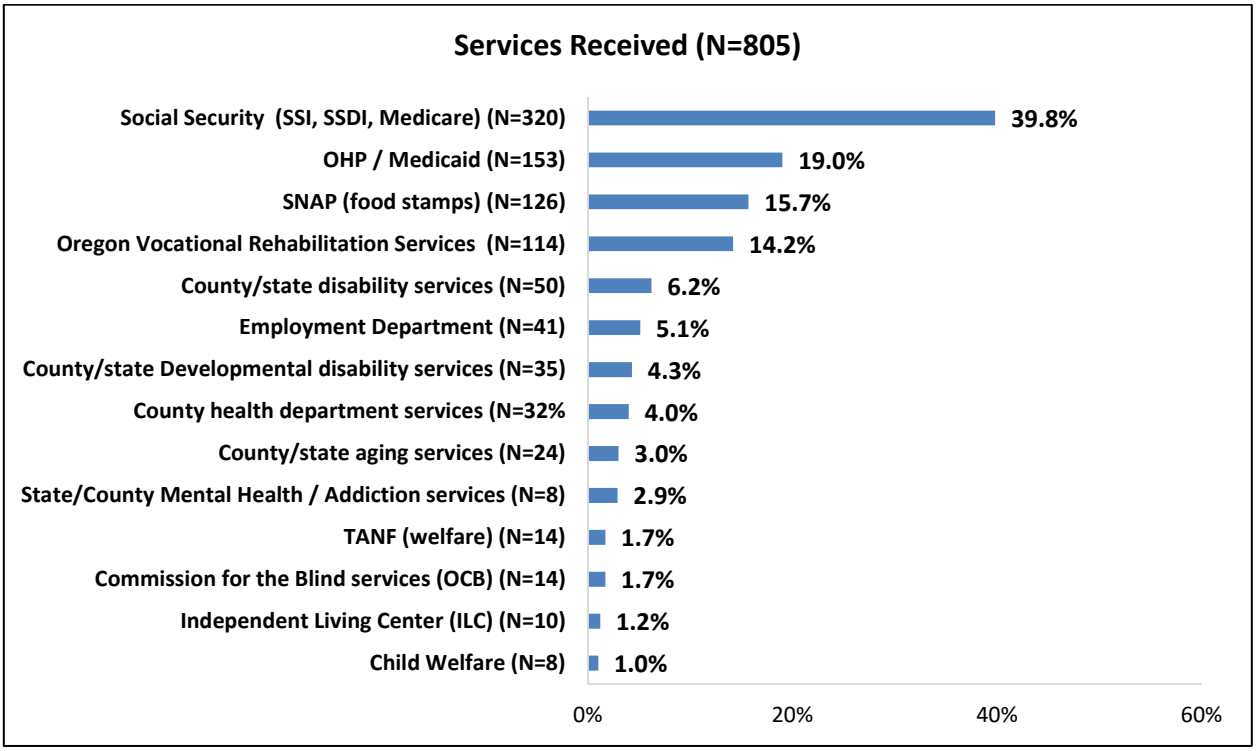
A DeafBlind person shared her significant barrier in transportation living in a rural town, *"Because of my hearing loss and my vision loss, my biggest barrier is transportation. I love this town and I would like to settle here if I can but the biggest problem is transportation. If I want to go food*

shopping, I have to find a friend who would be willing to drive me to the grocery store or hire a SSP to drive me." She also discussed significant social isolation because of a transportation barrier by depending on the person's schedule in order to plan any activities. *"If I had an awful day or feel overwhelmed, I can't [just] go out."* Limited bus schedule is a barrier for many who rely on public transportation and often feel isolated during evenings and weekends, *"There is a bus but it is very, very limited. It only works Monday through Friday and for a limited time period per day. The last bus to [the bigger town] is 5:30PM. The first bus is in the morning and it runs every 50 minutes."*

Public Services

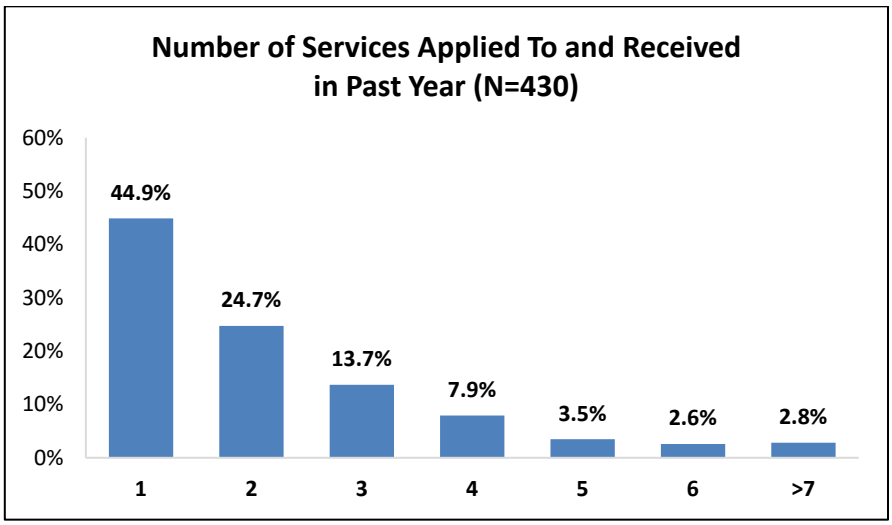
Respondents were asked about their use of 14 different public services over the past year. Overall, 39.8% (N=320) received services through social security, and another 19.0% (N=153) received services through OHP/Medicaid.

Figure 16. Services Received



Of the 805 respondents who answered the questions about which of 14 public services they have applied to in the past year, 42.7% (N=344) did not apply to any service. Among the 430 respondents who did receive services, 44.9% (N=193) applied to and received one service. The average number of services received is 2.24.

Figure 17. Number of Services Applied to and Received in the Past Year



Respondents were asked if they had applied for any of these services in the past year only, in order to ensure responses and any concerns that were brought up were current and relevant. In the chart below, the bars on the left indicate the percent who did not apply in the past year, and the bars to the right indicate the percent who did apply for the service in the past year. Note: they may already be using the service from an application in a previous year.

Figure 18. Overall Agency Usage

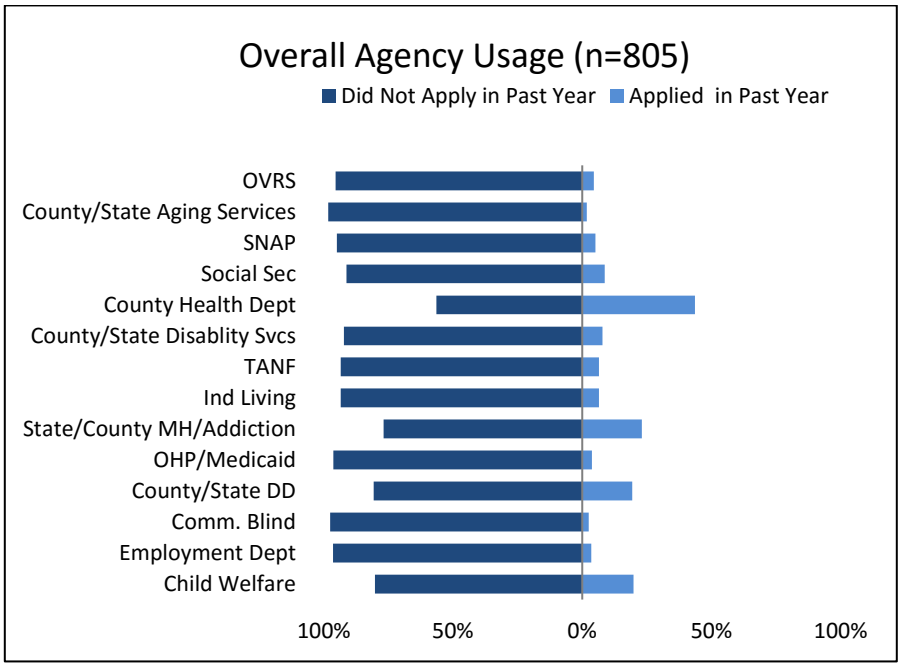


Figure 19 breaks down those who applied for services and what their current application status was. The darkest color on the far left are those waiting for a response, the middle segments

are those who have applied and did not receive services, and the far right segments are those who applied and were approved for services. Note the N, listed next to the agency, varies greatly for each program.

Figure 19. Agency Application Status

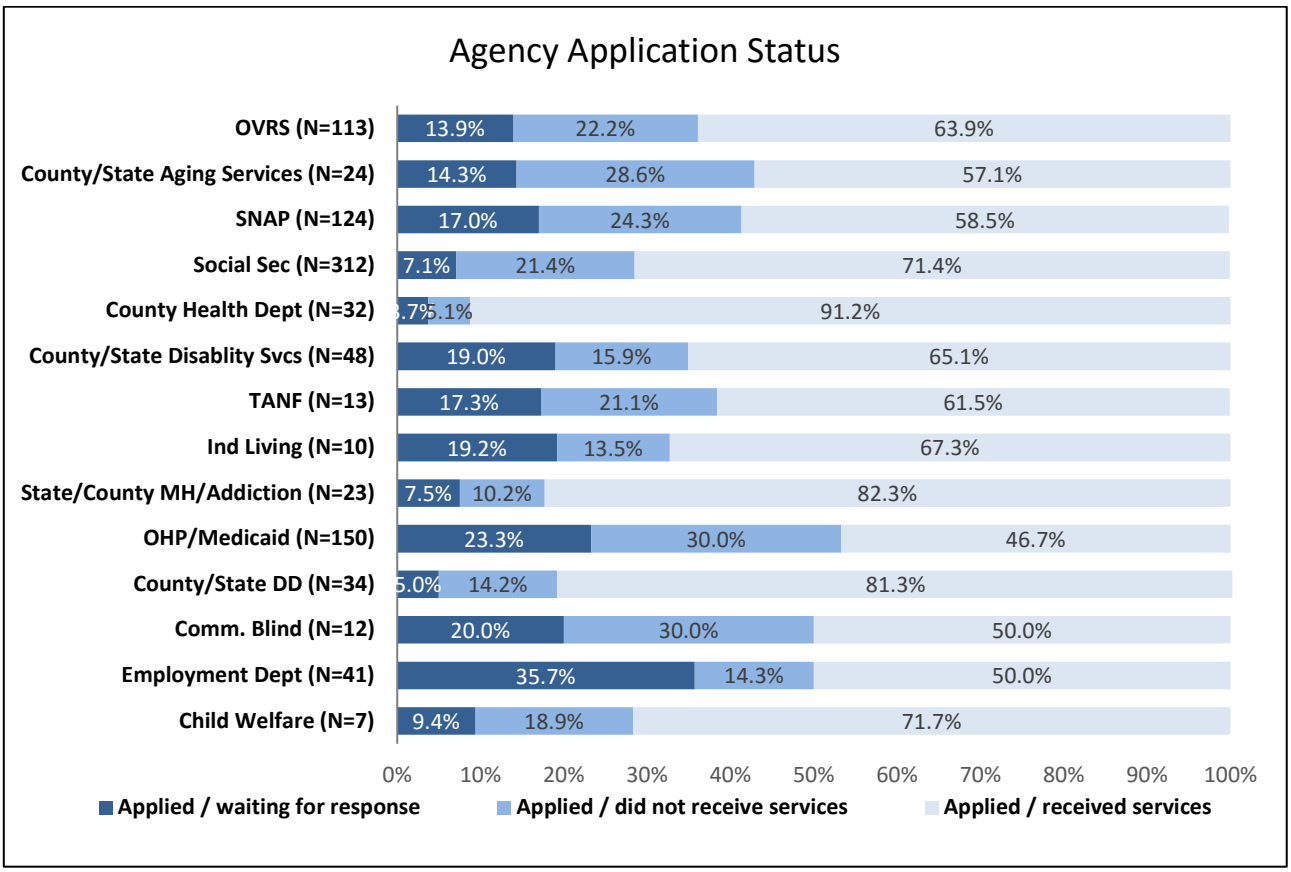
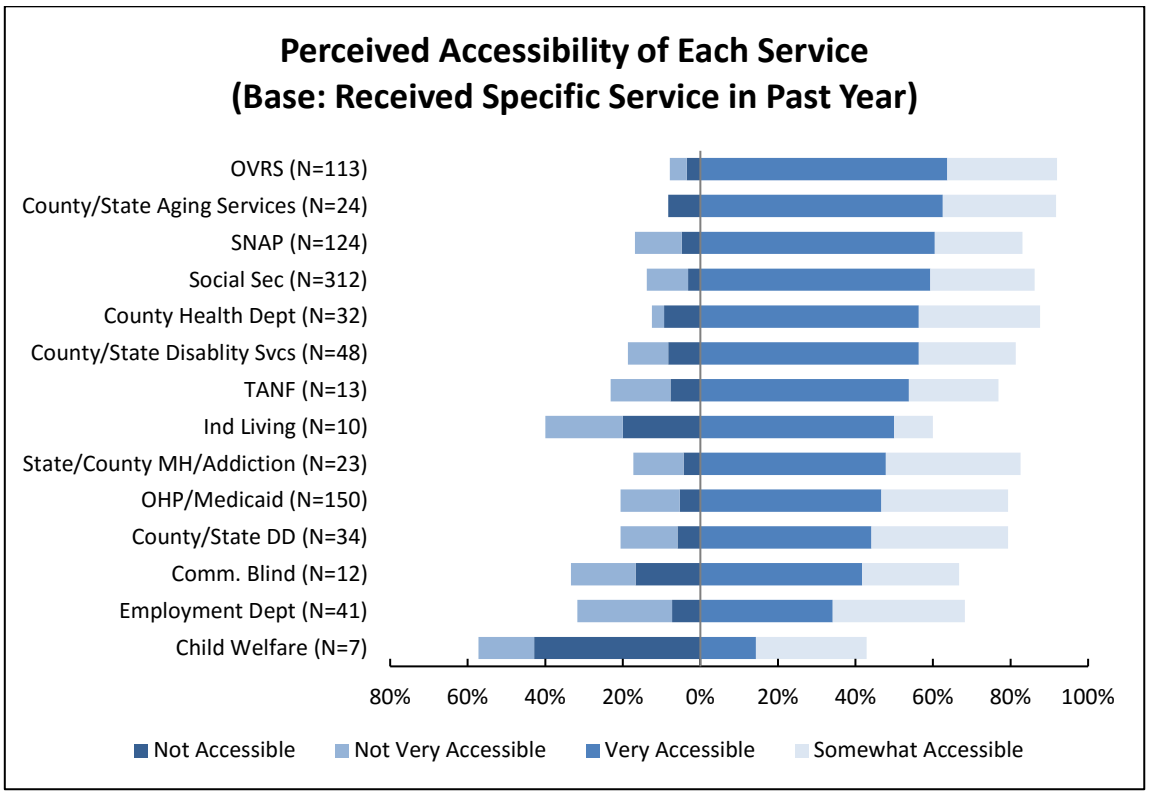


Figure 20 reflects how accessible consumers of state and county services perceived them to be. To the right of the midline are the Very Accessible and Somewhat Accessible responses, and to the left are Not Accessible and Not Very Accessible responses. The baseline for this question is limited to individuals who received services from the agency, thus the N's vary widely. Total N's are listed next to the agency. Among respondents who received specific services, the Oregon Vocational Rehabilitation Services were seen as most accessible (92.0%; N=104). Least likely to be viewed as accessible was the Child Welfare office (42.9%; N=3).

Figure 20. Perceived Accessibility of Each Service



One-third (34.8%: N=247) of the total respondents to this item report having no difficulties when accessing public services. Of those who did face challenges, people impatient with communication (45.7%; N=196) or the lack of available interpreters (40.3%; N=173) are among the main reasons that make access to public services difficult for respondents.

Table 22: Difficulties in Accessing Public Services in the Past 12 Months

Difficulties in Accessing Public Services –Past 12 months (Multiple Response) (N=429)	**Percent**	**Count**
Person impatient with communication	45.7%	196
No interpreter available	40.3%	173
System too complicated/procedures and rules too confusing	31.0%	133
Interpreter not qualified	25.6%	110
Automated phone system not accessible	21.7%	93
No CART or caption services available	17.9%	77
Requests for accommodations ignored/denied	14.2%	101
No FM/Loop/Personal assistive listening system	11.4%	49
No certified Deaf Interpreter	9.6%	41
Other	1.7%	12
Another person does all communication and work for me	1.4%	10
Space/facility not accessible	1.1%	8

Vocational Rehabilitation Services

Oregon Vocational Rehabilitation Services provides services to Oregonians with disabilities to obtain and maintain employment. The only exceptions are legal or total blindness or deaf-blindness. Deaf-blind individuals are served by the Oregon Commission for the Blind. OVRS currently has Rehabilitation Counselors who have Masters Degrees in rehabilitation counseling with a focus on Deaf and hard of hearing services in 8 out of 30 offices. It is reported that FM systems are available in each of the 30 offices located in Oregon. They reported they provide accommodations when requested by the Deaf and hard of hearing individuals for meetings, but pointed out challenges related to finding qualified interpreters.

When asked about what desired changes they would like to see in OVRS, one Rehabilitation Counselor for the Deaf stated, *"I'm hoping to be able to expand and do some targeted things with the Deaf students that are not necessarily in the school for the Deaf. We've got a really strong program for the Oregon School for the Deaf kids. But once they get out into the mainstream system we tend to lose them."*

She continued, "Finding qualified partners to provide services at all is a challenge in most of the state, but for providing accommodations generally it's finding qualified interpreters. Generally for us, policy wise, that means certified. We want RID [Registry of Interpreters for the Deaf] certification or any certification. There's specific levels of certification that we consider acceptable. We do on occasion stray from that -- especially if the consumer says, 'I want this interpreter because this interpreter is the best match for my communication style.' We do not allow friends or family members to be interpreters -- that's just not okay. We work with clients when they are saying, 'Well, so and so could just interpret.' It's like, 'No. And here's why' and this is an opportunity to educate the Deaf or hard of hearing consumer who may not be aware of the issues or potential harm."

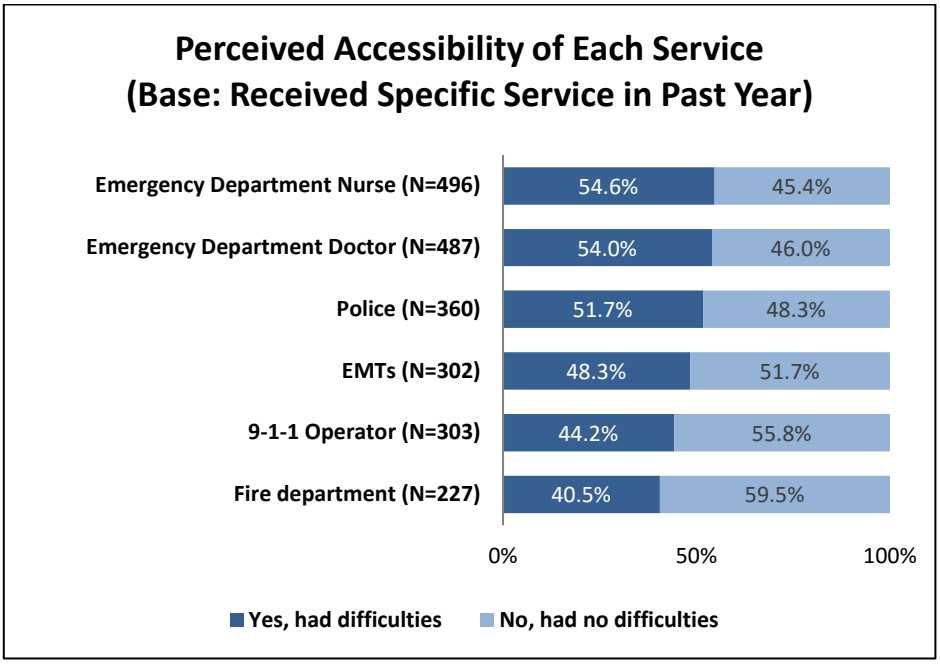
Barriers Related to Public Service Agencies

An organization that works closely with the DHS to provide services to the DeafPlus population shared both success stories and barriers related to accommodations and information access for their staff who are Deaf and hard of hearing: *"Much of our training is very discriminatory against folks who are Deaf. Oregon Developmental Disabled Services contracts with a company called OTAC. Oregon Technical Advisory Committee or something like that. They do all our training. …They provide specific training on autism or other characteristics, other developmental disabilities. They have a very comprehensive training program that they provide in English. They have webinars all the time. And they have refused [to make them accessible]. They have been asked in writing, verbally, we've asked them if there was any way to change that. We've tried to go through DHS to get some kind of accommodation [like the interpreter in the 'picture in picture' option on your webinar. Hey, at least have closed captioning--although that's really not the way to go because that's still English. And they have refused. So, I go to the training [because I am hearing] or I send my [hearing] assistant. We learn all the trainings and then we have to teach it to our [Deaf] staff."* This requires additional resources and time for the organization.

First Responders

Respondents also experienced difficulties communicating with or receiving assistance from first responders in an emergency situation. Responses varied slightly from 806 to 821. The greatest number of respondents had interactions with emergency department doctors and nurses (60%). Respondents had the fewest interactions with fire departments (28%). Among those who used any of the services, over two in five stated they found it difficult to receive assistance from or communicate with first responders. Especially troubling are the percentages for situations involving emergency departments where over half had difficulties with either the doctors (54.0%; N=263) or the nurses (54.6%; N=271).

Figure 21. Difficulties Communicating with Emergency Responders



Text to 9-1-1

Several participants mentioned some incidents related to text to 9-1-1: *"The truth of the matter is any Deaf person will tell you that when they try to call 9-1-1, and this is something that we're currently changing and you may be very well aware of. But if you try to call 9-1-1 on TTY it hangs up on you. It hangs up on you again and again and again and again. Just because there's the delay. They think that there's nobody there anymore. So, text is the way to go. Talk to text. Text to talk is the way to go. Just within the last couple of weeks, Multnomah County, the north end of Oregon, and the southern end of Washington began a text to 9-1-1 system just within the last couple of weeks. We've been talking with both the city and the county for a very long time about text to 9-1-1. And as soon as I heard that they were doing it up there, I contacted Lane County here and they're waiting to see how it goes up there. But we really need it down here. It's just unbelievable that they don't have it. Not only for my Deaf staff. I have Deaf staff in the community. When an emergency happens -- we have smart phones for when we go out in the community and there's Sorenson on*

that phone so that they can make a videophone call from the cell phone. But that's still not as good as text to 9-1-1. So, we're looking forward to it."

A lieutenant paramedic who was interviewed stated, "*Another thing that will help on the 9-1-1 side is direct texting with 9-1-1 for emergency calls rather than going through video relay. I think that would really speed up the emergency response, which I believe some counties are doing, texting 9-1-1, but not all of them."*

A website was developed to share information related to the text to 9-1-1 call in Oregon: www.nwtext911.info. Several videos with closed captions are posted on this website, as well as an ASL version (with subtitles). In addition, NG9-1-1 (next generation 9-1-1) is coming, and should be explored for Oregon. It will have options that will provide multiple ways to contact 9-1-1 that will help people with a variety of disabilities.

Fire Alarm Devices

A Deputy Fire Marshal from Central Oregon was interviewed related to accommodations for the Deaf and hard of hearing. This Fire Marshal initiated a program in 2005 to provide smoke alarms with flashing lights to Deaf and hard of hearing individuals. During the past year, 10 devices were provided to Deaf and hard of hearing individuals in the region.

A lieutenant paramedic from the Lower Willamette Valley was interviewed and mentioned that his department provided the smoke detector with a flashing light for the Deaf and hard of hearing population few years ago, but it was just a one-time opportunity.

During 2016, Portland Fire and Rescue Service (PF&R) received a $95,239 grant from the Federal Emergency Management Administration (FEMA) and then PF&R contributed additional $4,761 to make the total project amount to $100,000 to purchase and install specialized smoke alarms for the city's Deaf and hard of hearing residents. (More information can be found at: https://www.portlandoregon.gov/fire/article/570048.)

Emergency Management

Several emergency management individuals were interviewed in Oregon. Many confirmed that they were not sure if the videos related to emergency were captioned, nor could they confirm if any videos were provided in ASL for individuals who rely on visual language.

Foster System Barriers

Although not specifically listed in the state agencies list, several focus group participants shared stories related to the current foster system:

A Deaf woman in her late thirties who uses ASL *stated, "I have a barrier not for me, but for my foster child [who is Deaf]. We got a foster child who is six years old last June. We are his sixth family — he was with a different family each year. The number one barrier is probably communication. It's frustrating. He is Deaf and has a cochlear implant, but hasn't had an opportunity to learn how to use it. He doesn't know how. He's only six. With us, my husband was certified in 2012 [to take in foster children], and we specifically asked about Deaf children around Oregon. They said there was no way they could know if a child was Deaf, that they couldn't disclose that*

information. That means his life was almost ruined because he hopped from hearing family to hearing family who couldn't communicate with him. We're fortunate. Oh my God, I have a broken heart seeing what he's gone through and how he's become a product of that, his hopping from family to family. So we have a really tough time with him. He's signing, but he's making up signs that aren't decipherable. We can't understand him, and he makes faces in frustration, because he's trying so hard to speak and sign. — The point is, his barriers. Why didn't he get a Deaf family? I did ask the case worker if there were any other Deaf people interested in this, and she said there were three families: one hearing, a Deaf woman and hearing husband, and then a woman. The first family wasn't qualified because of the housing situation not fitting that child in terms of safety. So is it possible that your research [referring to this CNA report] could find a way through DHS to make sure that we in the Deaf community can know if Deaf foster kids are available out there. We could be the first to take those kids — often there aren't enough Deaf families, foster Deaf families."

A young woman in her early twenties who uses both ASL and spoken language, and uses a cochlear implant, shared her personal story as a foster child for almost three years with four different families, **"***I went through the foster system, when I was a young kid. My mother was arrested, so the police had a few hours to place me and my brother, so they found the first family who was all hearing and didn't know sign. I didn't know how to communicate with them and all that. They couldn't find someone who knew sign, then a week later, they placed me with another family — it was two ladies, a mother and daughter. They didn't know sign. The daughter knew some signs, but it was still hard for me to communicate. We have a need for more qualified people who can sign in foster care. My barrier was that I didn't know what was going on in my case."* She was eventually placed with her relatives who did not sign and communicated mostly by writing. "*I want to see more foster care parents who can sign, or they could be Deaf, either way*."

A hearing mother who uses both ASL and spoken language in Southern Oregon adopted a Deaf son from the foster system, "*DHS never explained what happened [child's history]. When he came to me [at age of 3], he couldn't eat, he didn't know how to play, he couldn't hold his body yet. He was like a newborn baby…He had no body strength at all. Even when I would hold him, he'd just flop… I suspected he was in a crib for two years and was severely neglected. He did not have any language."*

Barriers to Housing Services for Individuals who Need Additional Services

People needing specialized housing for the Deaf who also have intellectual developmental disabilities expressed several frustrations with many barriers experienced in the state: *"They [Deaf residents] live in group homes with speaking staff and speaking roommates and they're isolated. They either get frustrated or fight and then they get ostracized for fighting or they isolate themselves and hide. The service we provide is opening up the world to them in their own language. I guess the best way to put this is that if you can imagine a situation where someone spoke French or Portuguese and they were in a house that only spoke English. That makes no sense. Well, it makes no sense to have somebody that uses American Sign Language to be in a house that speaks English. It's useless. You can't provide services to them at the same level as the speaking peers.*

"It's really a discrimination issue. Truly. There's no regulation or mandate for any of the providers to provide to folks who are developmentally disabled and deaf in their own language. They

continue to only hire speaking folks and who don't know ASL. There are some exceptions to that where there's a person here and a person there knows some sign language.

"And it goes beyond that because Deaf culture is very different than the speaking culture. So, having Deaf-to-Deaf is really important. It also makes sense because a Deaf person can learn how to be a direct support person in three to four months and be pretty good at it. But if you have a speaking person who's going to learn ASL, it's going to take four to six years. But even then, that's better than nothing. There's no funding for these.

"Here at this site, we pay for it ourselves and we have interpreters for everything that they do. Medical places, doctors and dentists and things like that, through us, have learned that they need to have interpreters and we mandate that they have interpreters because that's all disabilities access. It's the law.

"I can tell you, for sure, that other agencies do not. DHS does not. ODDS does not. I have a case manager that comes into this house every few months to do monitoring. For either behavioral stuff or medical stuff or whatever and they don't bring an interpreter with them.

"I actually saw a case manager, now they call them service coordinators, but I've seen a case manager come and when I have a new resident move into my house, she had the paperwork for him to sign. She didn't show up with an interpreter. She didn't want me to interpret. She spoke to the Deaf gentleman in English and pointed at things for him to sign where there's no way he could understand. It's just absolutely frustrating and wrong. You know, I get angry."

A 70 year old Deaf female who lives in Central Oregon who suffered from a stroke on her right side, expressed frustration with the Department of Human Services and believes that a lack of qualified DHS staff and ASL interpreter has been making it difficult for her to acquire an available bed at Chestnut Lane (a senior citizen housing that serves Deaf, hard of hearing, and deaf-blind in Gresham, OR*), "DHS won't let me go to Chestnut Lane. They [DHS] rejected me. They came to my home and evaluated me. Then they said I can't go to Chestnut. I was shocked. I need it because I have many health issues and I must live in assisted living. Right now I live at home by myself. I fall a lot and no one can help me. DHS say no to everything I asked for. For example, I asked for a caregiver and a [fall alert button]. I said I needed it and they [DHS] said I didn't need one. What?! I live by myself but they said sorry, if you want one, you can rent one. That was an insult. They knew I can't afford it. I barely can walk to bathroom. I cannot feel anything on my right side from the stroke, and I'm also half-blind from macular degeneration."*

She continued her story and shared a recent incident when she fell and struggled to call for help, *"A female manager of [the fire] department installed the alarm. She showed me how to use it. It was outstanding. She also put a lockbox outside that could store my house key. No one can access it except for the fire department in case of fire. That way they can use it if I'm inside and can't open the door. This is because I fell one time and had to use videophone. The video interpreter couldn't see my face but could see my hands. I said that I had fallen and needed someone to come to help me, but to not break in because it isn't my house. They said okay, but how do we come in? They asked if I could crawl to the door. I hurt my knee, but I did crawl to the door. I was hopeful I could reach the doorknob, and I did open it to the two men outside. They lifted me to a chair. I hurt my knee and they wanted me to go to the hospital, but I didn't want to because I had my dog in the*

house. I couldn't just leave the dog stuck in the house, so I insisted on staying. They thought I broke my knee. It's still tender today. This is why I need to live at Chestnut Lane."

The Court System

Respondents were asked about their ability to complete legal forms (such as contracts) on their own, and were asked about their experiences (if any) with the court system. A small portion of respondents (16.0%; N=120) say they have trouble completing legal forms; with another 15.6% (N=117) not sure that they can complete forms on their own. Of the 778 responding to this item, 22.2% (N=169) indicated they were involved in the court system within the past five years.

While over one-third (37.3%) of respondents who were involved with the court system were invited to jury duty in the past five years, almost one quarter (23.1%) appeared as defendants.

Table 23: Reasons Involved in Court System

What are the reasons you were in court? (Multiple Response) (N=169)	Percent	Count
I was invited to do jury duty	37.3%	63
I was a witness	14.8%	25
I was a defendant	23.1%	39
Other	50.3%	85

Other reasons for court involvement involved traffic court (9.5%; N=16), divorce (9.5%; N=16) or child custody or support (4.1%; N=7), and financial issues (4.7%; N=8) of various types. Nine (5.3%) went to support family members who had court dates.

Out of the 63 respondents who were invited to serve on a jury, 23.8% (N=15) served, while the majority (76.2%; N=48) were excused. Among these, one in three (34.0%; N=18) believe they were excused because they had requested accommodations for their hearing loss.

Half (49.0%; N=75) of the respondents indicated they had no accommodations provided while in court. Certified American Sign Language interpreters are the most widely available accommodation.

Table 24: Accommodations used in Court Settings

Did you have any of the Following Available when in Court? (Multiple Response) (N=153)	Percent	Count
No accommodations were requested	49.0%	75
American Sign Language Interpreter (certified)	36.6%	56
Assistive Listening Devices (e.g., FM or Loop Systems)	8.5%	13
American Sign Language Interpreter (not certified)	5.2%	8
Video remote interpreter (VRI)	5.2%	8
CART/caption software	4.6%	7
Certified Deaf Interpreter	2.0%	3

Even though the above requests were provided, they did not always work as they should have. Four of the thirteen using assistive listening systems in the courtroom complained they were provided but did not work. Among those respondents (N=8) who had a video remote interpreter (VRI) available in the court, the experience was mostly perceived as negative (N=6), with the monitor too far away to see or the image freezing.

Respondents are noticeably unsure about the policies and availability of interpreters and assistive technology in the court system in their county of residence. Respondents were asked if their counties have policies regarding how courts notify people about the availability of interpreters or accommodations like CART, FM system, loop; if they've been encouraged to bring their own interpreters or assistive technology to court; if they understand the need for interpreters and assistive technology; if there is a designated person to contact for access; if the county court has a courtroom that is looped; and if information about accommodations is posted in public spaces. Between 62 and 82% of respondents who had been in the court system and had requested accommodations responded they were not sure if their counties had these policies or requirements.

ADA in Court System

Court ADA coordinators were interviewed throughout the state. The current training model involves statewide ADA training once every four months for new employee orientation. ADA coordinators at each of the courts in the state are responsible to provide ADA accommodations for all individual with disabilities who submit a request. Currently there are approximately 40 State ADA coordinators in Oregon*. "We have some information available. Website accessibility, accessibility, ADA. It describes on our internet page how to request an accommodation. Our policies aren't attached to this page, specifically. It guides them to how to request an accommodation, how to contact the ADA coordinator for each court and office of the State Court Administrator's office. And there's a request for an accommodation to use website information. And then we also provide an ADA complaint form and a court language access complaint form."*

Barriers Related to Legal System

A Deaf woman who uses ASL shared her frustration related to meeting with a lawyer in Willamette Valley, *"I'll share one topic, that I'm not sure about the lawyer knowing the ADA law. That law means you provide interpreters for any situation regardless of factors —court, everything, the lawyer provides it. So I met with a lawyer. I have two lawyers, and I met with one to discuss something, and I wasn't billed for the interpreter even though it was kind of a hidden fee. So I paid [the bill]. Everything was okay and worked out. But the different lawyer, I was asked if I needed an interpreter, and I said yes. They said they'd provide one, so I went ahead and met with him for a consultation. Later, I got the bill and saw that I had to pay for the interpreter! Hey! He gets the write-off, but I have to pay? I went to argue with the lawyer, but he said it wasn't in his hands, and I ended up having to pay. So what's really the law? It's supposed to be that we ask for interpreters and get them, without paying for them? That's my question."*

A Deaf woman in her forties who uses ASL shared her experience with the police when her sense of agency was lost, *"Two years ago, I was in a serious car accident, where the car was totaled. So at the site of the accident, the police showed up. Me and my best friend are both Deaf, so we didn't know what was going on. We requested an interpreter, but the cop said, 'No, well, sorry,*

we can't do that.' And it was hard for me to read his illegible handwriting, so we had to wait for my best friend's [hearing] parents to show up to be able to help by talking with the police and exchange information."

A Deaf mental health professional shared a concern related to incidents where Deaf individuals are not being properly evaluated for competency related to the court system, "*There are a lot of barriers related to the legal and mental health system. You have to be 100% competent [to stand trial]. Because [culturally] Deaf people are one percent of the population, we should have that percentage [to evaluate]. But, if you think about it, a lot of the things causing deafness cause other things, so we should have more Deaf people showing up. They don't really understand the language or the court process, and things that cause deafness often cause mental health or other problems. We should have at least 1% but we don't. That means we know there are people out there in the world who are not identified and not competent to go to court. They're being swept under the rug in the system. …Some Deaf people are a bit more complicated [to evaluate] because [their language dysfluencies are mistaken for] mental health issues. Sometimes we can be creative with labeling them, like saying 'communication disorders' if we need to help the person develop competency. But sometimes the lawyer doesn't realize that the Deaf person does not understand. Deaf people often will fake it, nodding and pretending, when in reality they're not understanding of what is happening. We need a proper specialist to evaluate their competency."*

He continued: "So there are Deaf people who are breaking the law, and their lawyers either don't notice or don't understand that the Deaf person isn't competent for court. Basically, these Deaf people do not meet the requirement for legal proceedings without some help. Many are in prison, but should have been sent to the OSH. They do not have access to communication in prison."

A former inmate who is hard of hearing and relies on ASL for communication shared his incident at the Washington County jail, *"I often attend classes and treatment in jail such as Alcoholics Anonymous (but I was never diagnosed with alcohol abuse). They wouldn't provide an interpreter. I just sit there and am lost because I was required to attend this 90 day in-patient treatment when I didn't have alcohol issue."* His partner also shared stories of where she became his advocate because of the barriers he experienced while in jail, *"I was a college student at that time. I remember how burned out I was, driving back and forth, fighting for him, taking care of my baby. I had no time for myself. I had postpartum depression, which deeply impacted me that summer. I couldn't take care of myself. I had to focus on the system, on him, fighting for him. The point is they didn't provide him with services he needed. They kept bluffing, and saying they couldn't give him a TTY but they would use him to interpret for other Deaf inmates. I was so pissed off. I got his hearing aids, he can't live without his hearing aids. There are current legal actions with the jail system in Oregon for similar issue."*

A DeafBlind male with tunnel vision who relies on ASL from Southern Oregon shared his recent incident with a police officer, *"The police came and arrested me July 2, and wrote me a citation, and I went to court. My communication barrier came when the police showed up. The police parked, and I told them I couldn't hear. I informed them I was Deaf, but the police kept commanding me to get down on the ground. I cooperated and put my hands behind me. They handcuffed me, and as I was on the ground, the police began asking me questions. I couldn't talk! I just shrugged and tried to verbalize that I'm Deaf, I'm Deaf, I'm Deaf. The police then asked, 'Can you read lips?' I shook my head no. They asked me questions on paper, and I shrugged because I couldn't write with*

my hands in handcuffs! They put me in the car and drove to the police station. They put me in a room, not a cell, but a room, where they removed the cuffs and explained what happened. They let me go with a citation. They also didn't read my Miranda rights."

Quality of Life

The final set of variables were grouped into the category 'Quality of Life.' This category includes questions related to health, mental health, bullying and harassment, freedom from abuse, and alcohol and drug use.

Overall Indicators

Three quarters of respondents describe their physical and mental health, as well as the quality of their life, as either excellent or good. Quality of life especially is seen as excellent or good by 79.0% (N=622), while 70.6% (N=558) feel their mental health is excellent or good. Just a small percentage feel that either their health or quality of life is poor or even grave.

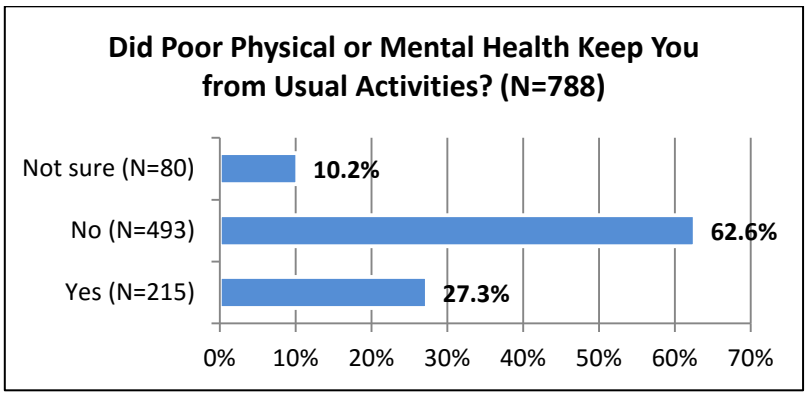
Table 25: Overall Quality of Life Indicators

Description of Overall Health and Quality of Life	Excellent/ Good	Fair	Poor/ Grave
Your overall physical health (N=791)	76.4% (604)	19.3% (153)	4.3% (34)
Your overall mental health (N=790)	70.6% (558)	22.8% (180)	6.6% (52)
Overall quality of life (N=787)	79.0% (622)	17.7% (139)	3.3% (26)

Health

Over one in four (27.3%; N= 215) respondents say their poor physical or mental health kept them from doing their usual activities, such as self-care, work, or recreation. Another 80 (10.2%) were unsure of the impact of their health or mental health on their usual daily activities.

Figure 22: Physical or Mental Health Interference with Usual Activities



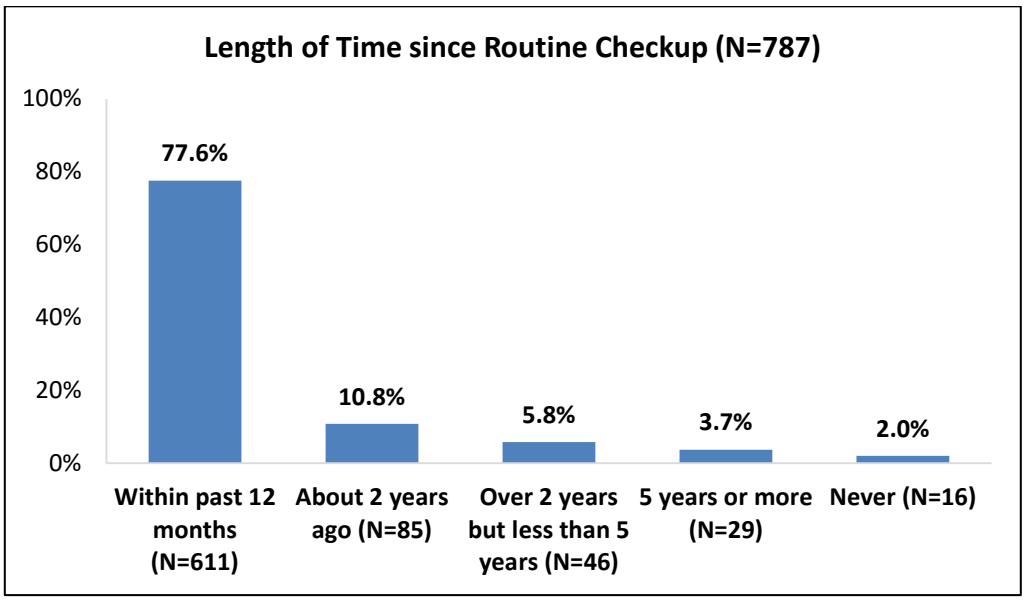
While the majority of respondents have medical coverage through Medicare (49.2%; N=3.83) or Medicaid (15.8%; N=123), over one-fourth (27.7%; N=216) buy their plan themselves or through a family member. One in five (21.2%; N=165) receive health insurance through their employer. Only 2.8% have no coverage.

Table 26: Type of Medical Coverage

Type of Medical Coverage (N=779)	Percent	Count
Medicare	49.20%	383
An individually purchased plan	27.70%	216
Plan through employment	21.20%	165
Medicaid / Oregon Health Plan	15.80%	123
Military/VA	6.70%	52
Affordable Care Act (ACA)	2.80%	22
No coverage	2.80%	22
Other	0.80%	6
Alaska Native, Indian or Tribal Health	0.50%	4

Even with insurance, out of 786 respondents, one in five (20.9%; N=164) delayed a doctor's visit at least once in the past twelve months because they could not afford the costs. Three-fourths (77.6%; N=611) have received a routine physical checkup within the past 12 months. However, a small portion have not received a checkup in over two years (9.5%; N=75), with 2.0% (N=16) stating they have never gone for a routine physical exam.

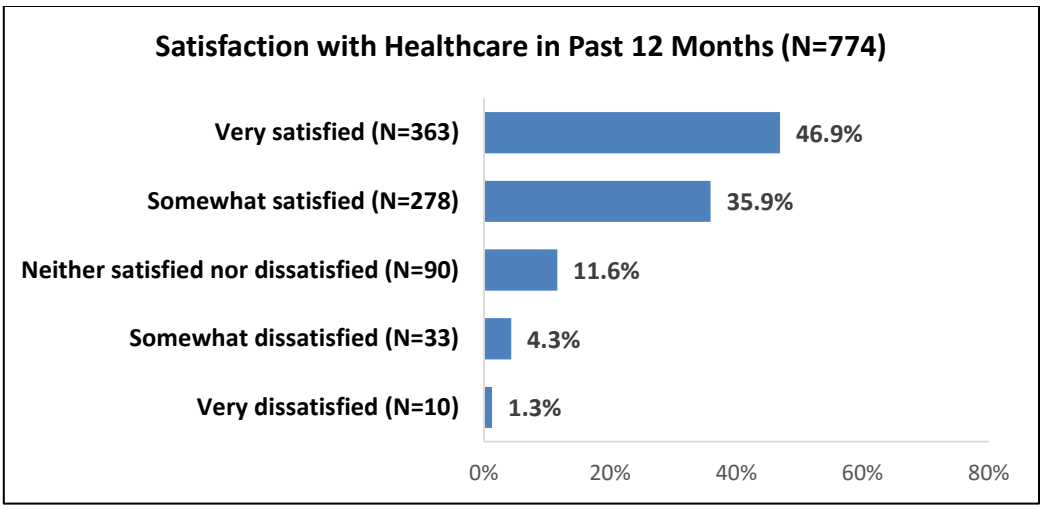
Figure 23. Length of time Since Routine Checkup



Respondents were also asked if they had experienced delays in medical treatment. While untimely appointments are the main reasons medical care was delayed (17.3%; N=121), respondents also mentioned interpreter availability or doctors not sensitive to their communication needs as reasons to not seek needed care (16.4%; N=115). Fifty-nine percent (N=413) did not experience delays in medical care or did not need any care.

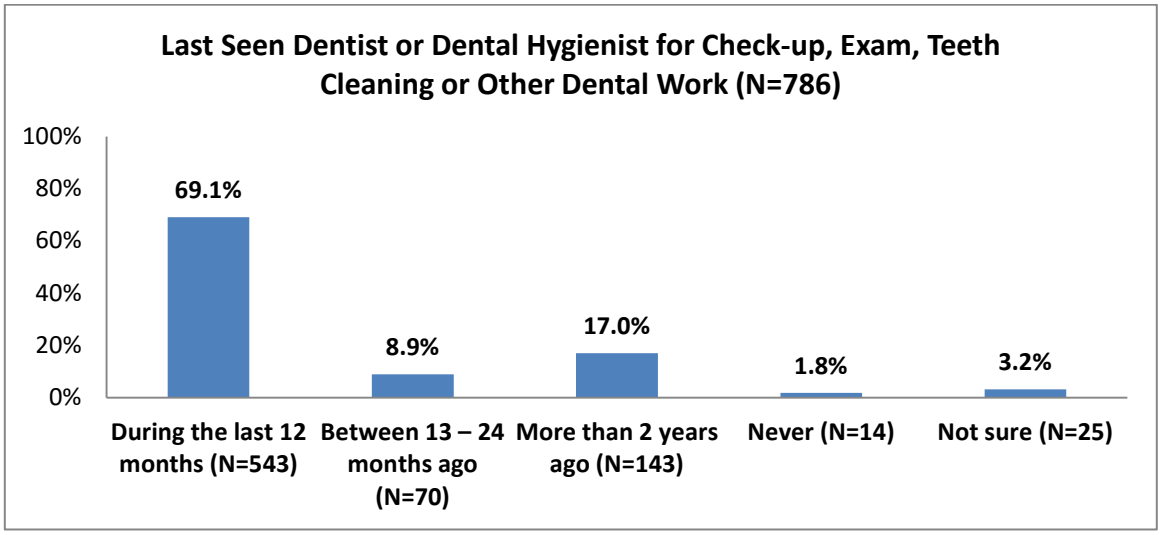
Almost half (46.9%; N=363) are very satisfied with the healthcare they have received in the past 12 months. Few (5.6%; N=43) express dissatisfaction overall.

Figure 24. Satisfaction with Healthcare in Past 12 Months



While seven in ten (69.1%; N=543) respondents have visited a dentist in the past 12 months, a smaller portion has not done so in over two years (17.0%; N=143). A few (1.8%; N=14) have never visited a dental office for a checkup, cleaning, or other dental work.

Figure 25. Timeframe of Seeing Dentist



Respondents are nearly split when it comes to their healthcare treatment and their hearing loss: While 9.1% (N=70) feel they were treated worse than others due to their hearing loss when they sought health care, nearly as many (6.9%; N=53) feel they were treated better. Overall, the majority feels they are treated the same as others (84.0%; N=646).

Table 27: Treatment in Healthcare Settings

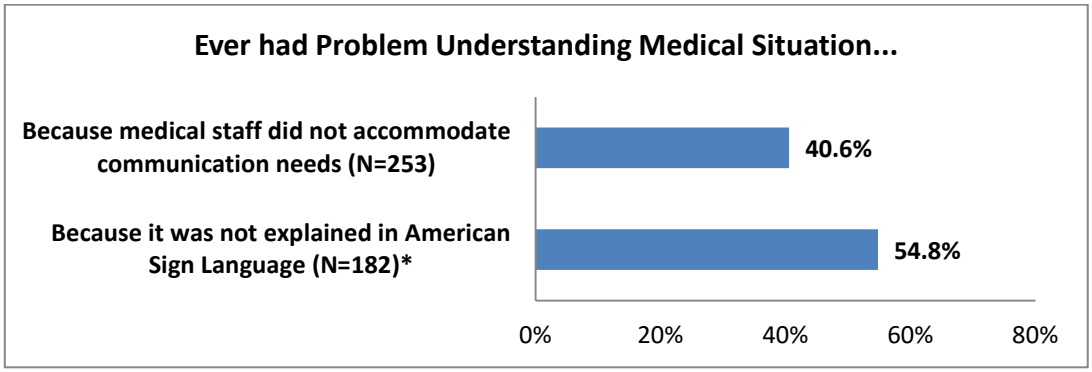
Within the past 12 months, when seeking healthcare, do you feel you were treated worse than, the same as, or better than other people without hearing loss? (N=769)	**Percent**	**Count**
Worse than others	9.1%	70
The same as others	84.0%	646
Better than others	6.9%	53

It is unclear on what the participants based this valuation. They did not seem to relate it to communication. Of the respondents who use ASL, tactile ASL, or SimCom (N=334), only half (N=170) report their doctor provides an ASL interpreter. Another 2.4% (N=8) report direct communication with their doctors (i.e., their doctor uses ASL him or herself). In the open-ended responses (N=579), 124 (21.4%) take a family member or friend with them to assist in communication. The majority of these respondents are people who would identify as hard of hearing and who do not use ASL for communication. Only 5 (.9%) indicated they used assistive listening technology in the doctor's office, while 30 (5.2%) indicated they use writing.

Overall, two in five (40.6%; N=253) report they had a problem understanding a medical situation because the medical staff did not accommodate their communication needs. Among those who use ASL (N=332), over half (54.8%; N=182) had a problem because the situation was not explained in ASL.

A sizable portion of all respondents also state their doctor has asked them to bring their own interpreter or a family member to help with their communication needs (17.0%; N=130). Nearly three in four (72.6%; N=599) say their doctor accommodates them by speaking slower or making sure he or she speaks directly to them face to face.

Figure 26. Problem Understanding Medical Situation

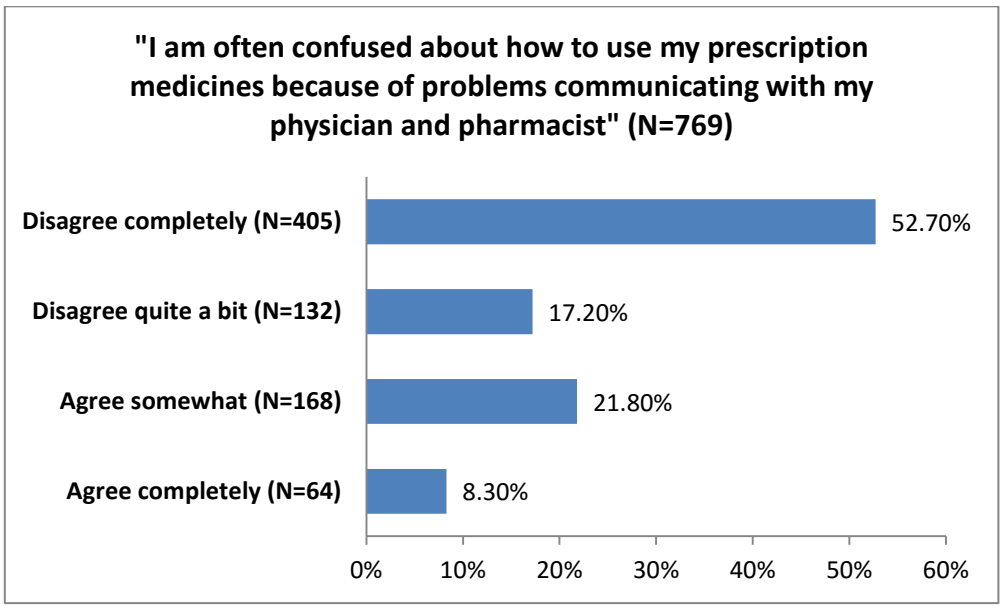


**Note: the base for the top item is people who mainly use spoken English (N=623) and the base for the lower item is respondents who communicate via American Sign Language, Total Communication, or Tactile American Sign Language (N=332)*

A hard of hearing male in his sixties shared his frustration and negative experience with the medical profession*, "The medical profession is really not good at providing assistive listening devices. We [HLAA] worked heavily with medical health and got them at least in the hospital to make some things available to hard of hearing people. But if you go to see a doctor and he's talking about what he's going to prescribe for you or what you should do for this condition or that condition and you don't understand but you think you've understood, it can be dangerous. They don't provide assistive devices."*

Further, when asked if they have experienced confusion about the use of prescription medicines, one-third (N=232) agree that they have been confused about how to use a prescription because of communication problems with their doctor or the pharmacist. In addition, 9.1% (N=71) say they have gotten sick or had a bad reaction to a prescription medicine because they did not understand the instructions.

Figure 27. Confusion about Prescriptions because of Communication



Communication Barriers in Medical Settings

A Deaf ASL user who grew up oral [spoken language methodology] and currently lives in Southern Oregon shared a situation that happened to her frequently when attending doctor's appointments, "*I call ahead of time and request for sign language interpreter. 'Sure, okay, we'll get one' and then I say 'Thank you.' Then I would show up [at the doctor's office] and ask 'Where is the interpreter? And they would respond, 'Oh there is no interpreter.' They act like they didn't know anything about my request but they do. They've seen me from before but they also know that I can talk. 'You can talk. You don't need an interpreter.' I would tell them that my mouth is not broken but my ears are*."

This same woman shared her frustration related to her speaking ability, "*People have told me that my speaking ability is awesome and is like a hearing person's ability and I say 'thank you' but really, it is a curse because they don't give me an interpreter because I've been told many times that I speak fine, and that I don't need an interpreter. My mouth does not need an interpreter, my ears do!"*

A senior citizen ASL user in Willamette Valley shared her medical setting barrier, *"I had a doctor perform surgery on my foot. I asked for an interpreter, and was told they would take care of everything. I showed up, and there was no interpreter. The nurse said, 'Oh, we don't need to. We can write back and forth.' The woman knew a bit of sign, and I was caught off guard. It was okay, better than nothing. …But for more details, she couldn't understand. I had to repeat myself over and over. I didn't like that, no. I wanted to emphasize certain things, and she couldn't understand. I preferred an interpreter, but they said we didn't need one. I wonder if they were trying to save money by using this woman who worked at the doctor's clinic."*

Several participants expressed their struggle using Video Remote Interpreting (VRI). A few expressed that this can be a helpful resource when a live interpreter is not available, however, it should not be used in many medical settings. Several stories were shared:

A Deaf woman who uses ASL from Southern Oregon shared situations where the doctor's office uses the VRI equipment for Spanish-language users and reported that Spanish-speaking patients often get priority: *"I went in [doctor's reception] and signed in. I asked where the interpreter was. The interpreter should have arrived by now. 'Oh, we didn't get one.' I told her, 'I called in advance and requested one.' The person goes to speak to someone else then comes back and says, 'We don't, ah, we have to wait until you're in the back. We can get you VRI from the back, not from the front.' I said, 'Well, you gave me a lot of paperwork to fill out.' And she said, 'You can do that here in the waiting room.' Well, there were a lot of questions on these papers. I go ahead and fill out the paperwork but didn't get it all done in time. Then I go in to the back and there is no VRI. They said, 'We couldn't get it. There is another Spanish family using it.' I notice with VRI, they use it a lot with Spanish families…Spanish-speaking patients…than with Deaf. They get priority over Deaf people. I notice that has happened a number of times. And even in the middle of my using the VRI, someone came in and took away the device saying, 'We have to use this for a Spanish-speaking patient.' They took it away from me. I was left feeling helpless. It has happened to me several times."*

A Deaf woman from Southern Oregon who uses ASL wanted to share her story on VRI barriers*: "My primary doctor was wonderful. I had her for many years. She used to allow live interpreters. Awesome. Until one year ago, Asante made the decision that they would no longer use live interpreters for Deaf patients. Only VRI. Which is hard because sometimes VRI freezes, freezes, freezes. And, sometimes, it's not available which means having to cancel appointments. [A friend told me] this story: They brought the VRI into the room and told the Deaf person to hold the monitor close to his face. They passed it around and then told the Deaf person to hold it. They did not include the stand to hold the monitor. It was a laptop. So, the Deaf person had to struggle with holding the laptop in one hand and signing using the other one hand. It was so ridiculous!"*

Another ASL user reported her struggle with using VRI in an emergency room, *"We need live interpreters. An example is in the ER. I know VRI is a backup for the ER. We need it. That's fine when no live interpreters are available. But, sometimes, it is not convenient. Like, one time, two or three months ago, I went to the ER. I was hit with a terrible migraine. It was a mini-stroke. At that time, I was bent over with my fists clenched. I could not use VRI. I wish at that time, I had a live interpreter to be able to get down to my eye level and sign to me. It would have been perfect. But it was impossible. There were no interpreters."*

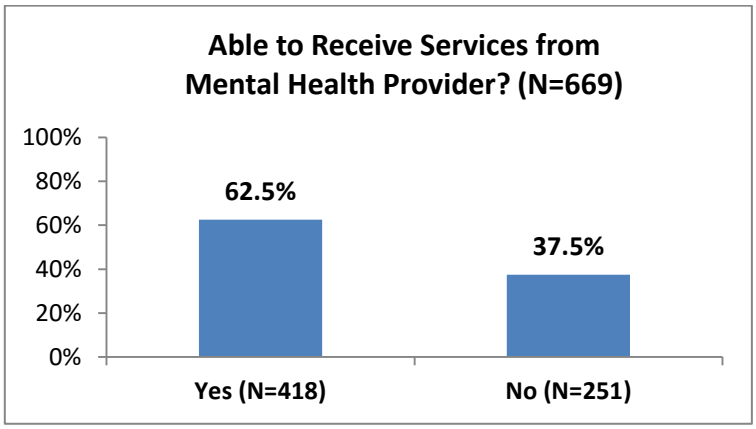
A Deaf person shared an emotional story related to her frustration at the hospital with her family member who is Deaf with vision loss issues*. "My Deaf mother was in hospital and the hospital staff said the VRI must stay at the end of the bed. My mom was sitting up in bed with her legs outstretched. They wanted to put the VRI at the end of the bed just past her feet. She can't see. She can't see. She is blind in her left eye. Her right eye was blurry. She'd just had a stroke. That is why she was in the hospital. My dad…my dad's Deaf. So he told them to adjust the VRI so that it was facing him so that he could sign and could talk for my mom. They said 'No. No.' They said my dad could not touch the screen. They said he would have to direct his comments to my mom. My dad then yelled and said. 'SHE CAN'T SEE! She can't — she's relying on me!' They ignored him and started speaking. The interpreter on the screen is continuing to sign. My dad becomes frustrated. My*

mom was just sitting there staring at the screen blankly. It just so happened my sister — she's from the area — she came in and saw what was going on. She started telling them how it needed to be done, that the screen needed to be turned to face my dad. They said, 'We can't. It's our policy. We can't turn the screen for others to see. The screen must be facing the patient only.' My dad — oh, he was so angry. We had to appease my dad and tell him, 'We're in the hospital, calm down, calm down.' Then we turned to my mom: 'You need to watch the screen. Do you understand?' Then my hearing sister just started interpreting. She basically just took over."

Mental Health

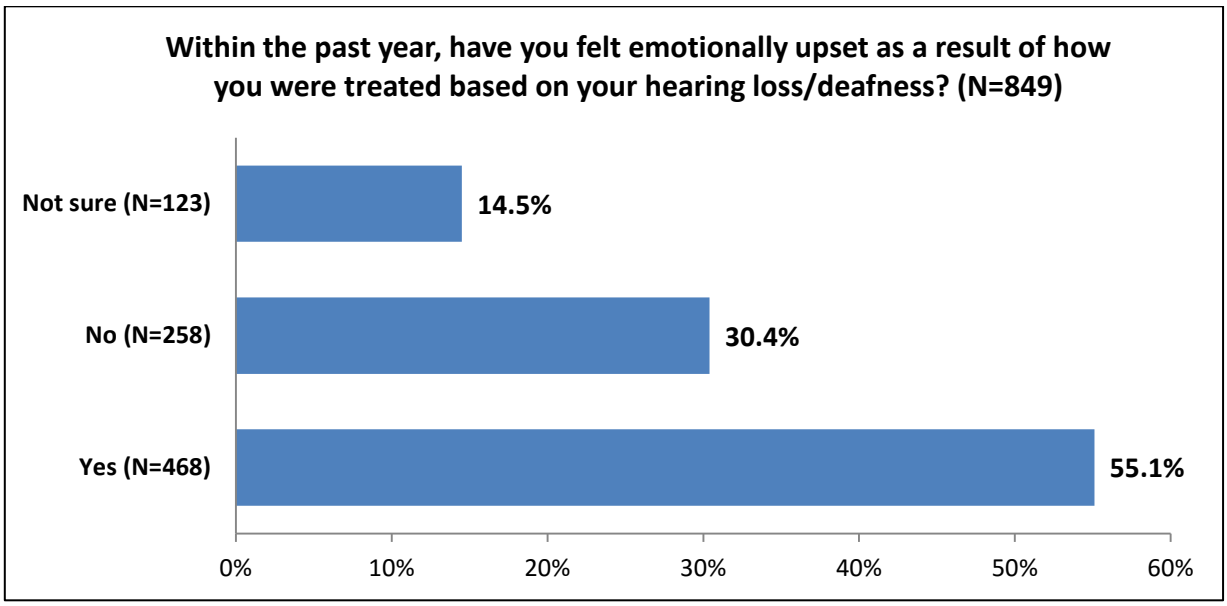
Respondents were asked several questions about their mental health and their use of mental health service providers. Over one-third (37.5%; N=251) of respondents say they were not able to receive services with a mental health provider to help them deal with stress or mental health issues. Among those who were able to (62.5%, N=418), just 60% (N=233) say their provider accommodates their communication needs.

Figure 28. Able to Receive Mental Health Services



Over half of respondents (55.1%; N=468) say they have felt emotionally upset over their treatment due to their hearing loss or deafness in the past year. Another 14.5% (N=123) are unsure if they have felt upset for this reason.

Figure 29. Felt Emotionally Upset over Treatment Based on Hearing Loss/Deafness



Over half (55.8%; N=467) think about their hearing loss or deafness at least daily. Only 17.3% (N=145) say they never think about it. Nearly as many (16.7%; N=140) say they constantly think about their hearing loss.

Table 28: How Much Thought given to Hearing Loss

How Often Think about Hearing Loss or Deafness (N=836)	Percent	Count
Never	17.3%	145
Once a year	8.3%	69
Once a month	8.6%	72
Once a week	9.9%	83
Once a day	11.4%	95
More than once a day	24.5%	205
Once an hour	3.2%	27
Constantly	16.7%	140
Net: weekly or more	***65.8%***	***550***

Availability of Mental Health Services

A state employer reported, "*The mental health services here in the state are abysmal. There literally are four private practice counselors that I know of who are either CODA's [children of Deaf adults] or Deaf themselves, culturally Deaf themselves and, most of those, you know, are full up or they only serve a certain part of the state or they can't take insurance or they don't take Oregon Health Plan which is the insurance that most folks who are receiving social security are on. Addiction treatment is nonexistent accessibly. There's still frustrations with employers and even some training*

institutions not being willing to provide interpreters because they think it's an undue hardship, which generally it's not, but they -- they don't want to provide the interpreters because of the cost."

Isolation as a Mental Health Issue

A deaf-blind male who relies on spoken language expressed grave concern related to research that indicated individuals with combination of hearing and vision loss are considered at a higher risk for depression, *"I can definitely understand that now…The loss of independence."*

A hard of hearing female who lives in the North Coast region expressed her social isolation like this: "*Trying to make friends with people…nobody understood me, or they just didn't want to bond with me. …going to a movie and not being able to make out what they're saying or what the movie is about. Sometimes announcements in public places, I couldn't make them out. Lectures, if I go to anything like that, I couldn't hear anything they're saying. Maybe if I sit way in the front. That's how I got through school, just sitting in the front and studying. But I wasn't developing social skills, which I didn't realize until much, much later in my life. Because I kind of stayed away from people, and they stayed away from me. I missed out on social opportunities, business opportunities, and professional opportunities. Opportunities to have fun, like going to a movie. Hearing loss affects my whole life. It isolates you. Hearing loss is very isolating."*

A hard of hearing senior citizen with a unilateral hearing loss [hearing loss in one ear] who lives in urban setting stated, "*The mental health system [is where most barriers exist] primarily because most mental health professionals are not used to working with individuals with hearing loss, and the impact of hearing loss or whatever the mental health issue is. One obvious one is that hearing loss itself is causing isolation and depression because of the lack of human contact, or the person is being isolated for another reason and hearing loss is making it worse because they don't know how to reach out."*

A male cochlear implant user who uses primarily spoken language explained, *"Self-advocacy is really important. Effective self-advocacy is very much dependent on self-confidence. Having a disability or just generally not fitting in any way erodes self-confidence and make it so much harder to be able to participate fully in society."*

A Southern Oregon male in his forties with progressive hearing loss echoed a familiar statement, "*Hard of hearing people have a tendency to withdraw and isolate themselves*," mainly to avoid stress, "*When my wife wants to go to something and I know I'm not going to understand it, I drag my feet if I am not able to get myself out of the situation*."

Mental Health System Barriers

Currently there is a significant shortage of mental health providers with specialized training to work with the Deaf and hard of hearing population, and who are considered fluent in ASL.

A Deaf professional with mental health training discussed the current significant shortage of mental health providers who specialize in working with the Deaf and hard of hearing population, *"Compared with other providers of living and training, services here are nonexistent. We have three licensed mental health providers here in Oregon, and one doesn't really do clinical work anymore. One provides services [to Deaf and hard of hearing individuals] who receive Medicaid, but the other*

two cannot because of not being set up for Medicaid with Oregon Health Plan. With the current establishment here, private employers can't work with that system unless they want to provide services for free."

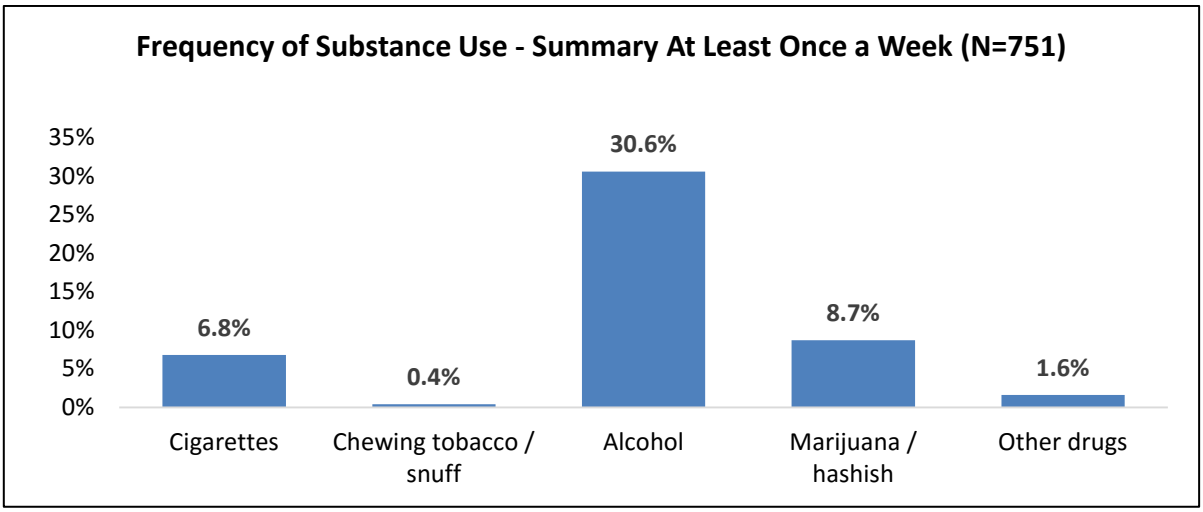
A Deaf woman who lives in an urban setting and uses ASL expressed anger with the shortage of Deaf counselors or mental health workers who uses ASL. *"A serious barrier for me is not being able to get the mental health services I need because of insurance limitations. I don't want to see a hearing counselor."*

Substance Use and Treatment

Respondents were asked to indicate which substances they had used and how often they used them, ranging from 'never' to 'daily.' With the exception of alcohol, the majority of respondents indicated they had never used the listed substances (e.g., 96.3% never use 'other drugs').

Nearly one in three (30.6%; N=230) use alcohol at least once a week; 6.8% (N=51) smoke at least once a week; and 8.7% (N=65) use marijuana/hashish at least once a week.

Figure 30. Frequency of Substance Use (at least once a week)



Among respondents who indicated any substance use and replied to the follow-up questions (N = 469), 6.2% (N=29) have considered treatment services or have been counseled to do so. Among these respondents, 59.4% (N=19) have used treatment services for alcohol or drug issues.

Of those 19 respondents who have used treatment services for their alcohol or drug issues, half (52.9%: N=9) received interpreters or other communication accommodations. The majority received ASL interpreters.

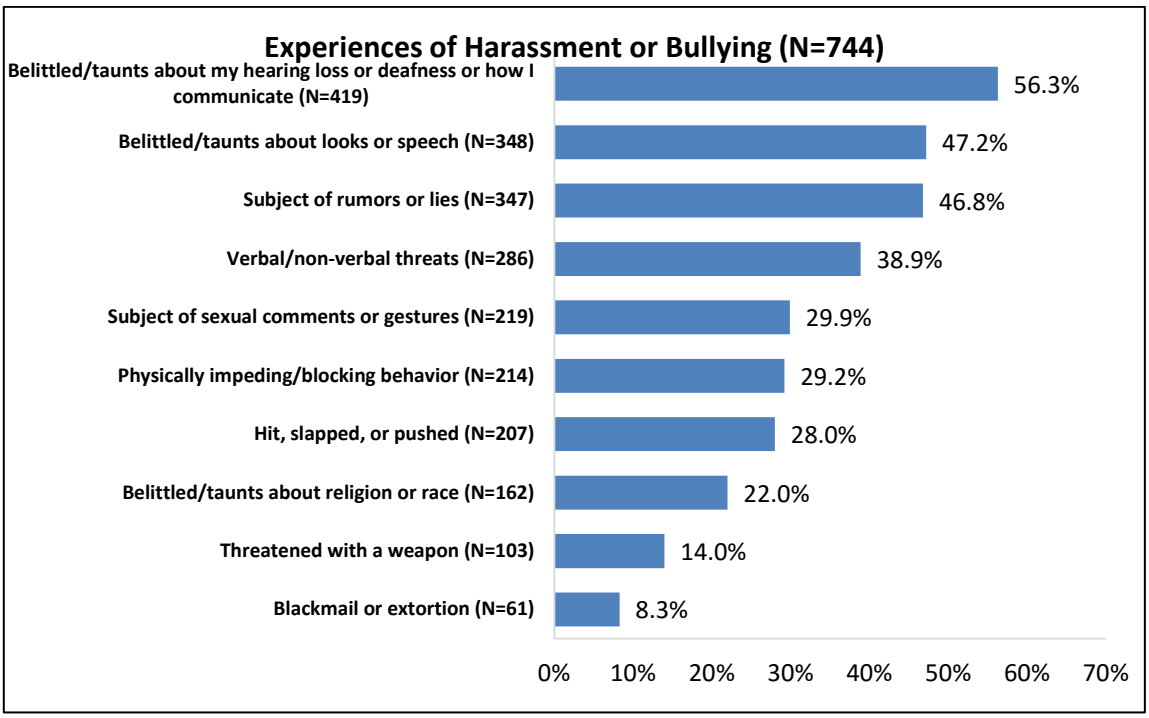
Harassment, Bullying, and Abuse

Participants were next asked a series of questions regarding harassment and bullying they had experienced, including where it had occurred, if they had contacted the police, and if they had

received mental health services after the experience. Ten different harassment and bullying situations were described. Thirty percent (N=224) of respondents (N=750) indicate that they have never experienced harassment or bullying, and 35.8% (N=316) have experienced it in the past year. Twenty-two (3.0%) indicated that they had experienced all 10 at some point in their lives.

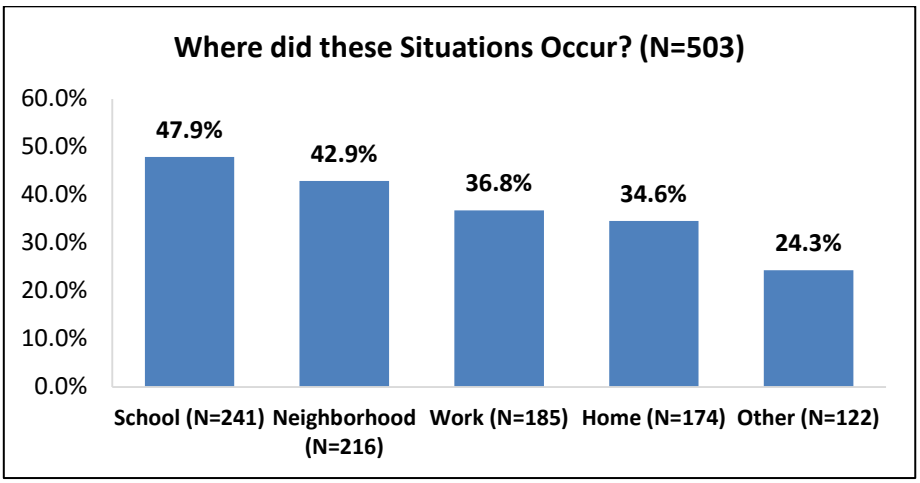
Over half (56.3%; N=419) of respondents have experienced taunts about their hearing loss or how they communicate during their lives. Nearly half (47.2%; N=348) have been belittled or taunted over their looks or speech. Another 46.8% (N=347) have been the subject of rumors or lies.

Figure 31. Experiences of Harassment or Bullying



Nearly half of 503 respondents (47.9%; N=241) have experienced situations involving harassment or taunts at school. Forty-three percent (N=216) also experienced such events in their own neighborhood.

Figure 32. Where Harassment/Bullying Occurred



Among respondents who have experienced harassment or bullying about their hearing loss or the way they communicate (N=419), 47.3% (N=198) said the harassment occurred at school, while 44.2% (N=185) stated it happened in their neighborhood.

Among those respondents who attended a mainstream school (with or without support) during K-6th grade and who have experienced harassment or bullying about their hearing loss or the way they communicate (N=243), 47.3% (N=115) said it occurred at school, while 43.6% (N=106) stated it happened in their neighborhood.

Respondents were also asked about their experiences of being harmed, threatened or abused. Forty-four respondents indicated they had contacted the police for assistance because of this. Thirty-seven people (84%) responded to the follow-up question asking if the communication experience with the police was positive or negative. Of these, 21 indicated positive experiences and 16 indicated negative experiences. The experiences tended to be described as positive when interpreters were provided, officers were understanding and made the effort to communicate, and were respectful. The negative experiences can be summed up by these three comments: *"I struggled to understand what they were saying." "They seemed irritated with the communication issues, and I was treated very dismissively." "They talked to the hearing people instead of me!"*

While 2.0% (N=15) say they have been physically forced to have sexual activity when they did not want to, 5.7% (N=43) responded they did not want to answer this question. Another 2.2% (N=17) were intentionally hit or physically hurt by their spouse/partner during the past 12 months; of these, only one person was encouraged to go to a shelter as a consequence. When these experiences are added to those that resulted in the respondent contacting the police, a total of 61 unduplicated responses related to harm, abuse, and threats were reported.

Among those who had been forced into sexual activity or who have been hit or physically hurt by their spouse/partner, just 48.4% (N=15) say they are able to receive services with a mental health provider to help them with violence, harassment, or abuse. Among these, 80.0% (N=12) say their mental health provider accommodates their communication preferences. Among those without access, a lack of insurance coverage or lack of interpreters are cited as reasons.

Limitations of the Study

While several excellent outcomes were a product of this research, the extremely short time frame impacted the project in several ways:

- In the development of the survey, the cognitive interview step was skipped. If time had allowed the inclusion of this step, some of the questions that caused people confusion could have been avoided. These were discussed in the report.
- The CAB had limited opportunity to review surveys and data. Many of them were also on vacations over the summer. This was mostly handled by requesting assistance from individual CAB members through email.
- Because it was summer, it was difficult to recruit individuals for focus groups, especially related to school programs. Even consumer organizations reduce the number of meetings they have over the summer.
- While social media was used heavily, which leaves out those without computers, large segments of the population were still reached through setting up community meetings.
- Building community trust takes time. For weeks after the survey had closed and focus groups were completed, people continued to request the opportunity to participate.
- The language level of the training program to educate researchers about protecting human rights (CITI) was challenging for most CAB members who do not use English as their first language. Although a graduate student was in the process of translating the materials into ASL, the project was not completed in time for this study.
- Because of the scope of the project and the timelines, there was insufficient time to compare data with secondary data sets, which would be helpful to the interpretation.

Findings and Recommendations

The Regional Resource Center on Deafness has appreciated the opportunity to conduct this important needs assessment for the State of Oregon. After reviewing the data, the research staff summarized a number of findings that led to recommendations for the State's consideration to improve services to Oregon's Deaf and Hard of Hearing Communities.

1. **Newborn infant hearing screening has made a huge impact on the lives of children with hearing loss.**
    a. Information for parents about services is not consistently provided.
    b. Language input from birth is vital. Oral and ASL methods used together will help the child develop Theory of Mind, agency, and understanding consequences, among others.
    c. Oregon requires insurance companies to cover bilateral cochlear implants for children if they qualify for them.
    d. Insurance companies do not cover hearing aids in the same way. As children grow, they need their hearing aids to grow with them. This is extremely expensive for parents, at a time when language input to children will have the most impact on the trajectory of their lives.
2. **Education of Deaf and hard of hearing children is complicated by both historical issues and state policy and law.**
    a. Until recently, there was no law on the books requiring teachers of the Deaf to be fluent in ASL.
    b. Oregon has just one program training teachers of the Deaf, and there is a severe shortage of qualified teachers in the state.
    c. Oregon has numerous public high school programs to teach ASL, but no requirements for those teachers to demonstrate mastery as other world languages do. College ASL programs often find incoming students have learned individual signs to match with English, but not the grammatical features of ASL.
    d. Finding skilled educational interpreters is a challenge for mainstream programs, especially in rural areas.
    e. Deaf and hard of hearing role models are vital to the child's identity development.
    f. The Oregon School for the Deaf is prevented by law from holding a preschool program there, something that is vital to Deaf and hard of hearing children's development.
    g. Although there is screening at birth, there may be complications to delivering early intervention services, sometimes because the services are not available, and sometimes because parents do not have the resources to follow through.
3. **Identity, critical mass, and access to community are challenges individuals and communities face.**
    a. Deaf, hard of hearing, deaf-blind, and deaf with additional disabilities adult role models can provide children a better understanding of how they might naturally approach the world with a visual or tactile mindset.
    b. Deaf, hard of hearing, deaf-blind, and deaf with additional disabilities adult role models can provide hearing teachers a better understanding of how to teach children taking advantage of their visual or tactile mindsets.

c. Because deafness, deaf-blindness, and hearing loss with additional conditions are low-incidence disabilities, it is a challenge for many families to find peer groups for their children.
d. Parents find it difficult to find ASL classes, to afford them when they are available, and to fit them into their schedules, especially if they have multiple children or jobs that don't allow flexible schedules.
e. Although mainstream programs are popular and a good fit for some children, they are not the best fit for all children. Notably, many children move from mainstream settings to residential settings between elementary and high school. Better systems need to be in place to either improve support for children in mainstream settings or to identify at the earliest point possible when the setting is not a good fit so the child does not lose valuable educational years.
f. Many children do not find their way to a Deaf community (referring to a culturally defined community) until after high school. This is often when they learn sign language and begin to develop a Deaf identity. This also applies to many children coming out of oral only programs.
g. As one teacher of the Deaf pointed out, *"Apparently teaching hearing babies ASL improves their cognitive development, but parents are warned against teaching their Deaf or hard of hearing babies ASL. It's obscene, really."* Reviews of research show that children are not less likely to learn to speak if they also use sign language.

4. **Hearing aids, cochlear implants, and assistive technology can be extremely helpful or extremely confusing and frustrating.**
    a. If there isn't audibility, there is not a good fit. If the audiologist hasn't tested audibility, there is no proof that it has been achieved through the hearing aids. This means the hearing aids are not providing the benefit they could, the individual is not hearing as well as they could, and that thousands of dollars have been wasted.
    b. Hearing aids and cochlear implants cannot overcome noisy environments alone. Other (additional) assistive technology can be extremely helpful in these situations.
    c. The general public, including those with hearing loss, often do not recognize the benefits and limitations of hearing aids and cochlear implants. There is a pervasive attitude of 'there's not much that can be done' to improve the individual's situation.
    d. Hearing aids, cochlear implants, and other assistive technology can be very expensive, especially recognizing the equipment may need to be replaced every five years. Individuals with hearing loss need assistance in locating support for purchasing this equipment.
    e. The vast majority of individuals with hearing loss are not aware of other types of assistive technology which can be used with or without hearing aids and cochlear implants. The one specialist that individuals with hearing loss may see (e.g., hearing aid dispenser; audiologist; ear, nose, and throat specialists) are typically not providing information about other assistive listening equipment. This information is found through consumer groups and internet searches.
    f. Video remote interpreting (VRI) can be a powerful tool, but it is not appropriate for all settings. It is often difficult to see the screen, the screen is smaller than having a live person there, and the image may freeze, causing communication interruptions. In legal settings, disrupting the flow of the courtroom causes some judges to pull the accommodation. In healthcare, even when it is working properly, it is a challenge for a patient laying in a bed to see or focus on the screen, much less hold the screen in a

position where it is viewable. Additionally, holding the screen would interfere with the Deaf patient responding. This is not necessarily as much of an issue if the patient is able to sit up and if the screen is on a stand.

5. **Access to higher education is often at risk because of early years of experimentation with educational settings and communication modes.**
    a. The early education merry-go-round of seeking the right educational environment for a child often means that they end up having challenges obtaining a regular diploma. English language skills may be below grade level and places students at risk of not completing.
    b. Entrance exams that have not been standardized on this population (or on any other minority population) can prevent capable students from entering bachelors and masters level program, thus limiting their ability to earn a living and become the role models for other Deaf, hard of hearing, deaf-blind, and individuals who have additional disabilities.
6. **Access to the labor market is often at risk as it is more difficult for Deaf and Hard of Hearing Communities members to get the education they need for some jobs, as well as employment training and on-the-job training.**
    a. Numerous transition programs have indicated the importance of work experience in high school as a gateway to early adult employment opportunities and later earning ability.
    b. Many members of the Deaf and Hard of Hearing Communities face the limiting stereotypes of the public and experience underemployment and unemployment.
    c. Hard of hearing individuals exit the labor force earlier than they would like because of challenges functioning in groups (e.g., staff meetings), using the phone, and social/interpersonal challenges. The labor market is losing talented, experienced people because of a lack of knowledge about assistive technology.
7. **Public services definitely play a major role in the lives of members of the Deaf and Hard of Hearing Communities, but they often face challenges with paperwork, legalese, complex rules, and workers who do not know how best to communicate with them.**
    a. Mental Health services are vital as isolation can cause depression. Coupled with the link between not using amplification and dementia, this sets up the population for challenges.
    b. Programs supporting substance abuse treatment, domestic violence and abuse, and mental illness are rarely accessible to members of the Deaf and Hard of Hearing Communities. Counselors who can provide treatment via direct communication or who understand the impact of disabilities on an individual are extremely rare.
8. **Impacting public attitudes is one of the most important issues that needs to be addressed.**
    a. While newborn hearing infant screening has produced impressive results for babies, hearing loss often occurs after birth, and often not until later adulthood. Adults tend to put off having their hearing tested for seven years before seeking assistance.
    b. Many participants referenced the challenges of communicating with the general public, which is especially problematic when seeking services or medical or emergency assistance.
    c. Myths the public holds regarding the ability of hearing aids or cochlear implants to restore normal hearing, that all people with hearing loss speech read, that people with

hearing loss are less intelligent or less able have a profoundly negative impact on the self-esteem, self-image, sense of agency, and the ability to successfully compete in higher education and employment.

d. Members of the general public become members with hearing loss, hearing and vision loss, and hearing, vision, and physical function loss. They also become family members of others with these losses. The better they understand the challenges and how to deal with them, the longer they can remain active in their lives and assist other family members to remain active and connected in theirs.
e. People who are at the front desks of many of the services members of the Deaf and Hard of Hearing Communities seek, are the gatekeepers to those services. They should be well trained to interact with members of the Deaf and Hard of Hearing Communities and ensure that their communication needs are being met.

9. **Communication access is vital to the success of individuals at home, work, school, or play.**
    a. Self-advocacy must be taught, along with what the law requires and what the responsibilities of the individual are.
    b. In order to have an educated populace, access must be provided to all.
    c. Communication access, such as open captioning and freely available assistive listening technology, benefits everyone (e.g., English language learners, people needing to search the text of a speech on video, people unfamiliar with the technology can easily try it out).
    d. Many, many focus group respondents, when asked what services could be provided to improve communication access responded: “Get them to enforce the ADA!”
10. **Individuals who are DeafBlind or deaf-blind or who have additional disabilities are in severe need of support service providers (SSPs).**
    a. Most of these individuals do not have the funding to pay for assistance to go to the grocery store or be driven to the doctor. Some states provide funding for a few hours each month, rarely enough for these individuals to lead anything close to a normal life.
    b. Being able to go for a walk, have mail read to you, or simply not be in fear that because you are by yourself you are vulnerable to a random accident or violence is something that most of us don’t face.
    c. Oregon does not currently provide funding for SSPs. SSPs help the individual both with communication and with what is happening in the environment…the kind of feedback the rest of us take in with our eyes.
11. **Deaf children in foster care need a way to be connected to families who have the language skills to help them grow to their full potential. Time is always of the essence with children.**

The research team believes that the most efficacious way to address these findings would be a Commission for the Deaf, Hard of Hearing, and Deaf-Blind. This center (or preferably a main center with satellite centers located around the state, or some other way to reach the rural parts of the state in person) would function with an advisory board of stakeholders to inform the staff and the State of the current events in the numerous areas that impact members of the Deaf and Hard of Hearing Communities’ lives. The employees would be individuals who, for the most part, experience hearing loss themselves and who can use the variety of communication modes they will face as the

State's citizens seek assistance. The Center should be able to advocate and lobby as needed for changes in Oregon's laws and standard practices. For example:

1. Early Childhood Intervention and Education: Develop a committee comprised of teachers of the Deaf, university faculty, parents, state agencies, and consumer organizations to evaluate the laws, policies, and standard operating procedures that are interfering with getting the best services to identified children at the earliest stage. This is one of the most important actions that can have an impact on children's futures to prevent them from becoming at risk of dropping out, not completing with a regular diploma, and their future earnings abilities. Explore the LEAD-K model for Oregon (e.g., https://www.facebook.com/LANGUAGEEQUALITY/), and explore changing the law so that Oregon School for the Deaf can house preschool and early intervention programs on campus.
2. Review policies in general that impact members of the Deaf and Hard of Hearing Communities: Another example worth studying is how Deaf and hard of hearing foster children are matched with families. Currently, there does not seem to be any way to connect Deaf children with families who sign. These kinds of policies stay on the books until someone is able to recognize that a change is needed.
3. Support Families and Children: The sooner both families and children have Deaf role models in their lives, the sooner they will learn how to learn visually along with amplification. Provide a center where families can learn from experts and from each other, and children can meet peers who have the same life experiences they have.
4. Assistive Technology: Provide an assistive technology center and satellite centers where people can check out assistive technology and see what will work for them. The impact of hearing loss is different for everyone, and some devices work better than others. Because of the expense of the equipment, and some people's difficulties in learning new technology, these centers should be staffed with people who experience hearing loss and vision loss to ensure functionally relevant equipment is recommended.
5. Ensure that the ADA is enforced: There are laws in place, but there is much confusion among consumers about what their rights and responsibilities are. Technical assistance should be provided to agencies, businesses, and consumers. This center can also provide technical assistance in the labor market to ensure that employers are aware of their responsibilities under the law.
6. Ensure access to higher education and thereby the labor market: Again, a committee of stakeholders should evaluate entrance requirements at universities and community colleges to determine if their policies unfairly prevent individuals who are Deaf or hard of hearing from obtaining an advanced degree when they are otherwise qualified.
7. Ensure availability of affordable hearing aids and assistive technology for all. The impact of hearing loss can be devastating: To children because of the impact on language learning and education, to adults because it can reduce their employability and upward mobility on the job, and to seniors because a recently worsening loss can further isolate them from family and loved ones unnecessarily. In addition, recent research has shown there to be a connection between untreated hearing loss and dementia. For those who do not identify with the Deaf community and use ASL, hearing loss is not just an inconvenience, it is a health hazard.

8. Ensure the affordability and availability of support services providers to people who are deaf and have additional disabilities. This is an area where the State is behind other states in providing these life-affirming services.
9. Provide outreach to positively impact public perceptions on living with hearing loss and to help people understand the options that are available.
10. Provide a community center where people can come to learn sign language, and other supports can be provided, such as reading mail to individuals with low vision. The community center can showcase Deaf adult role models, and in general, provide a gathering place where people can come to feel a part of a community of people who are like themselves.

Currently the state has a system of service providers who face a challenge providing services to this low incidence population. Because attitudes about hearing loss, especially in people who are gatekeepers to services, are a major problem for members of Oregon's Deaf and Hard of Hearing Communities, the State faces a challenge keeping everyone trained who will interface with a Deaf, hard of hearing, or deaf-blind person infrequently. And because of communication challenges, the State may not even know how many people have given up before they even try to obtain services.

The final recommendation is for the State to review The National Association of the State Agencies for the Deaf and Hard of Hearing's (NASADHH) most recent survey of state agencies for the Deaf and hard of hearing. Here it can find out how other states have funded such centers, how other states are combining services into these centers (e.g., telecommunications device access programs, grants for assistive technology libraries, interpreter referral and certification). This report is included here in Appendix B. There are a myriad of community partners, such as Western Oregon University, EHDI, Hands and Voices, RSPF, OVRS (to name just a few) who could help make this happen and who could assist in providing innovative services that would make Oregon a model for providing services and preventing its Deaf and Hard of Hearing Communities from falling into any of the possible at-risk outcomes they face.

Biographies

Cheryl D. Davis, Ph.D., Grant oversight: Dr. Cheryl Davis has been the Director of the Regional Resource Center on Deafness since 2003, and in 2004 received the Special Friend of Hard of Hearing People award from the Hearing Loss Association of America (then Self Help for the Hard of Hearing) for her work in educating consumers and service providers across the country on hearing assistance technology. She was the co-investigator in the development, standardization, and psychometric testing of the Transition Competence Battery for Deaf Adolescents and Young Adults, a project that explored Deaf adolescents' employment and independent living skills. She has published articles in both trade and consumer journals regarding access, accommodations, and self-advocacy. Dr. Davis was responsible for ensuring that the tasks were carried out on time and within budget, and served as a reviewer of the research methods as the study was carried out.

Denise Thew Hackett, Ph.D., MSCI, Principal Investigator: Dr. Denise Thew Hackett is bilingually fluent in American Sign Language (ASL) and written English. She identifies as Deaf and has worked as a psychologist and researcher in the marginalized community for most of her professional career to address mental health and health disparities faced among Deaf and hard of hearing individuals. She is currently an Assistant Professor at Western Oregon University in the Rehabilitation and Mental Health Counseling (RMHC) program in DSPS.

Dr. Thew Hackett is uniquely qualified to be conducting this project. Her previous hands-on experience in developing American Sign Language survey with the National Center on Deaf Health Research trained her in the crucial framework of incorporating necessary culturally sensitive components when working with marginalized communities who have historically been excluded from many traditional surveys. Dr. Thew Hackett experienced working with the Community Based Participatory Research (CBPR) model during her 7-year career at the University of Rochester Medical Center, which included her 3-year Postdoctoral Training in Preventive Cardiology. She co-authored peer-reviewed articles on CBPR and ethical issues.

Relevant to research experiences in mixed methods framework with marginalized communities, Dr. Thew Hackett was an assistant to the PI in a NIH-funded project "Informed Consent for the Deaf and Hard of Hearing Population" (quantitative method) and a CDC-funded project "Factors Influencing Partner Violence Perpetration Affecting Deaf Individuals" (mixed methods using KII, FG and survey). During her Postdoctoral training, Dr. Thew Hackett led the "Tailoring a Healthy Living Intervention to Deaf Adults: Sociocultural Data from the Target Group." She also conducted numerous KII and focus groups (FG) with her colleagues, and mentored interns on this framework. Additional experiences are outlined in the vita included in this proposal. Dr. Thew Hackett believes in incorporating diversity qualities among the Deaf and hard of hearing communities in every step of the project.

Evaluator, Sybille Guy, Ph.D. Team, The Research Institute: Dr. Guy is the Director of TRI's Center on Research, Evaluation & Analysis (CREA), and has an extensive background in team leadership and project management. Dr. Guy received her Ph.D. from the University of California at Los Angeles (UCLA) in Quantitative Psychology. As Data Analyst for the project she participated in quantitative and qualitative research instrument development and analysis.

Appendix A: Definitions

Note: Definitions with numbers in front of them are from RFP# DHS-4131-16: Community-based Needs Assessment (CNA).

2.2.2.1 “Assistive Communication Devices (ACD)” means technology that allows people experiencing communication barriers to communicate with the public at large.

2.2.2.2 “Assistive Listening Devices (ALD)” means a system of using amplifiers that bring sound directly into the ear via hearing aid telecoils or personal amplifying units.

2.2.2.3 “Computer Assisted Real-Time (CART)” means a form of instant translation of the spoken word into English text using a stenotype machine, computer, and real-time software which can be produced and delivered in-person or over the Internet.

2.2.2.4 “Culturally Competent” or “Cultural Competence” means the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, abilities, religions, genders, sexual orientations and other diverse backgrounds in a manner that recognizes, affirms and values the worth of individuals, families and communities, while protecting and preserving the dignity of each. Operationally defined, it is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes that create cultural settings in which quality of services produce better outcomes.

2.2.2.5 “Deaf Community”, for purposes of this RFP, means the entire diverse Deaf population, including people who are culturally D/deaf, DeafBlind, Deaf Plus, Hard of Hearing, Late-deafened, hearing aid or cochlear implant users and those experiencing hearing loss. This term may be used throughout the RFP for the purpose of brevity rather than restating each category and is not intended to exclude any group or population within the Deaf Community.

2.2.2.6 “Demographics” means age, county of residence, race, gender, education level completed, socioeconomic status, preferred identification within the Deaf Community, and primary or preferred means of communication.

2.2.2.7 “Focus Group” means a component of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs and attitudes towards a product, service, concept, advertisement or idea.

2.2.2.8 “Interpretive services” means services provided by a qualified individual or firm to provide communication access to individuals belonging to the Deaf Community via assistive technology including, but not limited to ALDs, CART, and qualified sign language interpreters.

2.2.2.9 “Qualified interpreter”, for purposes of this RFP, means “someone who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any specialized vocabulary.” (RID) will serve as documentation of qualification. Interpreters lacking NAD or RID certification may be deemed qualified if they have other certification (i.e., certification from another state or Educational Interpreter Performance Assessment (EIPA) for school settings).

American Sign Language (ASL): American Sign Language (ASL) is a visual language. With signing, the brain processes linguistic information through the eyes. The shape, placement, and movement of the hands, as well as facial expressions and body movements, all play important parts in conveying information. Like any spoken language, ASL is a language with its own unique rules of grammar and syntax. Source: https://nad.org/issues/american-sign-language/what-is-asl

ASL Interpreter: A sign language interpreter is a person trained in transferring meaning between a spoken and a signed language. This usually means someone who interprets what is being said and signs it for someone who can't hear, but understands sign.

Assistive listening device: a term applied to devices that transmit, process, and amplify sound. They may be used in conjunction with hearing aids, cochlear implants, or simply headphones or ear buds. The term is not used to refer to hearing aids or cochlear implants.

Braille: a form of written language for blind people, in which characters are represented by patterns of raised dots that are felt with the fingertips. Source: http://www.dictionary.com/browse/braille

Captel: CapTel is a captioned phone. It looks like a regular desk phone, but has a large digital readout so the individual can read what the other party says. A CapTel operator, automatically patched into the phone call on outgoing calls and (if you've got two phone lines) can be automatically patched into the call on incoming calls, too, creates the captions in real time. http://www.nchearingloss.org/captel.htm?fromncshhh.

Certified Deaf Interpreter: A Deaf Interpreter is a specialist who provides interpreting, translation, and transliteration services in American Sign Language and other visual and tactual communication forms used by individuals who are Deaf, hard-of-hearing, and Deaf-Blind. Source: http://www.interpretereducation.org/specialization/deaf-interpreter/

Close vision interpreter: used by deaf-blind individuals with low vision or tunnel vision. The interpreter works within the deaf-blind individual's range of vision, usually from a distance of about five feet or less.

Cochlear Implant: an electronic device that partially restores hearing in people who have severe hearing loss due to damage of the inner ear and who receive limited benefit from hearing aids. Source: http://www.mayoclinic.org/tests-procedures/cochlear-implants/basics/definition/prc-20021470

Cued Speech: a visual mode of communication that uses handshapes and placements in combination with the mouth movements of speech to make the phonemes of a spoken language look different from each other. Source: http://www.cuedspeech.org/cued-speech-definition.php

Culturally Deaf: refers to an individual with little or no functional hearing, who uses American Sign Language to communicate, and considers themselves to be members of the Deaf Culture. Source: https://www.deaftec.org/content/deaf-definitions.

Deaf and Hard of Hearing Communities: the term used in this report over Deaf Community (see 2.2.2.5 above) to refer the entire diverse population with hearing loss, including people who are culturally Deaf, deaf, deaf-blind, DeafBlind, Deaf Plus, Hard of Hearing, Late-deafened, hearing aid or cochlear implant users and those experiencing hearing loss.

deaf (not culturally): "small d" deaf do not tend to associate with members of the Deaf ccommunity, identify themselves more as hearing, and tend to regard their hearing loss in medical terms. Source: https://www.verywell.com/deaf-culture-big-d-small-d-1046233

Deaf-Blind (with hyphen): is a combination of vision and hearing loss.

DeafBlind (without hyphen): DeafBlind people identify themselves as culturally Deaf and blind, and have a strong Deaf identity.

DeafPlus: refers to the individual hearing status combined with additional conditions. (idea borrowed from http://www.handsandvoices.org/comcon/articles/deafplus.htm)

Haptics: developed in Norway during the early 90's in an effort to standardize a method of communication that was already evolving organically within the deaf-blind community. Haptic communication is a fixed set of signals performed in a specific way and in a defined order to provide visual and environmental information as well as social feedback to an individual who is deaf-blind. https://nationaldb.org/library/page/2588

Hard of Hearing: refers to an individual who has a hearing loss who may only use oral aural language and amplification, and may or may not use sign language. Source: https://www.deaftec.org/content/deaf-definitions

Hearing Impaired: used to describe an individual with any degree of hearing loss, is a term offensive to many Deaf and hard-of-hearing individuals. Source: https://www.deaftec.org/content/deaf-definitions

Late deafened: usually means deafness that happened postlingually, any time after the development of speech and language. Often it means after the age of adolescence (13 and above). Source: http://www.michdhh.org/deaf_hard_of_hearing/late_deafened.html

Oral deaf: a deaf individual utilizing the Oral method is a method for communication by using only the spoken language, lip reading, and voice training. Source: http://www.lifeprint.com/asl101/topics/communicatingwithdeaf.htm

Pidgin Signed English: a combination of American Sign Language (ASL) and English. ASL is a distinct language, and (like most other languages) it does not map perfectly to English. Source: http://www.nchearingloss.org/pse.htm

ProTactile this philosophy: supports the idea of providing social feedback through back channeling via touch. https://nationaldb.org/library/page/2588

Support Service Provider (SSP): A support service provider can be any person, volunteer or professional, trained to act as a link between persons who are deaf-blind and their environment. They typically work with a single individual, and act as a guide and

communication facilitator. The SSP serves as the eyes and ears of the person who is deaf-blind. Source: http://www.aadb.org/information/ssp/white_paper_ssp.html#history

Tactile ASL: a common means of communication used by people with both a sight and hearing impairment where the signer signs into the receiver's hands.

Total Communication or Sim-Com: is an approach to Deaf education that aims to make use of a number of modes of communication such as signed, oral, auditory, written and visual aids, depending on the particular needs and abilities of the child. Source: https://en.wikipedia.org/wiki/Total_Communication

VideoPhone: A videophone is a telephone with a video display, capable of simultaneous video and audio for communication between people in real-time. A Deaf individual might use this to sign directly with another person or with the relay service, a hard of hearing person may use it to assist with speech reading. Source: https://en.wikipedia.org/wiki/Videophone

Appendix B: NASADHH 2009 Survey of State Commissions, Divisions, and Councils Serving Deaf and Hard of Hearing People

2009 Survey of the State Commissions, Divisions, and Councils Serving Deaf and Hard of Hearing People

Prepared by Steven A. Florio, M.S., Executive Director
Rhode Island Commission on the Deaf and Hard of Hearing

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I. Purpose and Method

The purpose of this survey is to report the current functions, budget, staffing, demographic, and services of state agencies serving deaf and hard of hearing people in the United States. This will help agency administrators and their board members to gain understanding of how each commission, division, and council are structured as well as how their services and programs are delivered within their statutes and means in their respective states.

The Michigan Division on Deaf and Hard of Hearing volunteered to gather information and put it into a report back in 2002 and 2004. The last survey conducted was done in 2004. The Rhode Island Commission on the Deaf and Hard of Hearing stepped up and volunteered to gather information for this 2009 Survey Report. This report is developed primarily for the agency administrators and board members only.

A questionnaire was copied from the 2004 Survey Report with revisions including a section on demographics and a question on agency's change added. The 2009 Survey was created online through www.surveymonkey.com so everyone would be able to participate and respond more quickly and conveniently. The e-mail with url links to surveymoney.com was sent to 39 known states (including 2 in Minnesota) that have a commission, division, council, or office serving Deaf and Hard of Hearing persons. The respondents were asked to fill the questionnaire if they meet the definition below.

> *Definition of State Agency: A state government agency established and funded by the state legislature to serve deaf and hard of hearing people exclusively. Staff members are employees of the state civil service. This agency provides statewide services including but not limited to, information and referral, interpreter referral, interpreter classification or qualification or licensing, advocacy, and technical assistance. This state agency may have a commission, council, or board of appointees to give guidance to the agency.*

The questionnaire asked for at least 85 informational items. Microsoft Excel 2003 was used to tabulate the responses. The tables were created to give the readers a clear picture of selected topics and a clear comparison eliminating the need for a lengthy written report. These responses were put together into a Microsoft Publisher 2003 format to create a final 2009 Survey Report. Frequent reminders were sent to the respondents after the deadline through e-mails and videophones (direct or via video relay service).

This 2009 Survey Report is distributed only to the agency administrators and/or board chairpersons of known states that are listed in the report electronically.

I. Purpose and Method (continued)

I am truly pleased to report that 100% participation in the 2009 survey has occurred and I want to thank all respondents for taking their time to participate in the survey. I am confident that anyone who reads this report will find the 2009 Survey Report informative and useful.

Please do not hesitate to contact me if you have questions or concerns about the 2009 Survey Report, I can be reached at 401-354-7651 either via point-to-point or video relay service or by e-mailing to me at SFlorio@cdhh.ri.gov.

Steven A. Florio, M.S., Executive Director
Rhode Island Commission on the Deaf and Hard of Hearing
One Capitol Hill, Ground Floor
Providence, RI 02908

II. Executive Summary

The findings of the survey are summarized as follows:

1) **Number of Respondents:** All 39 state agencies including 2 in Minnesota responded to the questionnaire. This represents 100% participation of known state agencies or 76% of the states in United States of America.

2) **Deaf and Hard of Hearing Terms:** 85% of the agency names including the theme, "Deaf and Hard of Hearing".

3) **Communication:** 100% of the agencies who participated have a website on the internet. (Only 88% in 2004). 79% of the agencies now have videophone access. (No source back in 2004 but we can safely assume it was under 50% in 2004.)

4) **Administrator:** 39% of the administrator positions are state civil service classified and 26% of the positions are Governor-appointed. 59% of the administrators are either deaf or hard of hearing.

5) **Administrator Salary:** The salaries of the agency administrators in the survey range from $35,000 to $85,000 per year. 59% of the administrators are in the vicinity of $45,000 to $85,000, and 26% are $85,000 and up.

6) **Department:** 28% (11) of the agencies are independent, followed by 23% (9) under Rehabilitative Services, Two 13% (5 each of two) fall under Human Rights/Services and Social/Health Services.

7) **Board Composition:** The size of respondents' boards range from 7 to 27 members. Four (4) respondents do not have a board. The board members in 28 (72%) states are appointed by the Governor. Board terms vary from 2 to 4 years. An overwhelming majority of the boards meet at least 4 times a year. 19 (49%) state commissions have a law requiring a majority of deaf and hard of hearing persons on the board. 100% of the state boards reimburse their members travel expenses, only one with a certain criteria (reimbursed if more than 50 miles travelled.).

8) **Fiscal Year:** All but five (5) states follow the July 1 through June 30 fiscal year.

9) **Authorized Budget:** Virginia has the largest budget (2004: North Carolina) and New Mexico has the highest dollar amount per capita (2004: North Carolina). Total of all 39 state agencies' budgets is **$86,992,065.00.**

10) **Staff Size:** The number of employees on staff range from 1 to 72. (2004: 55) The average number of agency employees is 13 (2004: 12)

II. Executive Summary (Continued)

11) **Services:** The most common services that the agencies provide are Information and Referral (95%), Advocacy (90%), Deaf Awareness/Orientation (79%), Technical Assistance (77%), and Interpreter Referral (72%). Over half (1/2) of the agencies provide Assistive Technology, Interpreter Directory, CART Referral, Services to Hard of Hearing, Client Assistance, and Adult/Community Education. 13% (N = 5) of the state commissions provide or manage the telecommunication relay services.

12) **Interpreter Services:** 72% of the state agencies provide the Interpreter Referral service. 41% (N = 16) of the state commissions qualify or license interpreters within their state. The data sources used to compute the figures of Deaf and Hard of Hearing population among the state agencies are varied.

13) **Demographic:** California has a large general and deaf/hard of hearing population. The average percentage used to compute the Deaf and Hard of Hearing figures against the data source is 10%.

14) **Agencies Affected since 2004:** The most significant changes or impacts on the state agencies occurred in Texas (2004) and Washington (2009). Two newly established state agencies since 2004 are Florida (2004) and New York (2008). And since the 2004 survey, Vermont has been eliminated (2009).

1.0 AGENCY

1.1 Survey Participation

Thirty nine (39) state commissions, divisions, councils, and offices serving Deaf and Hard of Hearing persons from thirty eight (38) states responded to the questionnaire. That is fantastic because this is 100% participation. This is the first time that the report includes all state commissions, divisions, councils, and offices. There are a few states that do not have state agencies including commission, divisions, councils, and offices that can be founded under 1.2 List of States that do not have an agency serving Deaf and Hard of Hearing persons. (Table 1.1)

	State	Agency Name
1	Arizona	Arizona Commission for the Deaf and Hard of Hearing
2	California*	California Office of Deaf Access
3	Colorado	Colorado Commission for the Deaf and Hard of Hearing
4	Connecticut	Connecticut Commission on the Deaf and Hearing Impaired
5	Delaware	Delaware Office for the Deaf and Hard of Hearing
6	Florida	Florida Coordinating Council for the Deaf and Hard of Hearing
7	Hawaii	Hawaii Disability and Communication Access Board
8	Idaho	Idaho Council for the Deaf and Hard of Hearing
9	Illinois	Illinois Deaf and Hard of Hearing Commission
10	Indiana	State of Indiana, Deaf and Hard of Hearing, Employment and Innovations
11	Iowa	Deaf Services Commission of Iowa
12	Kansas	Kansas Commission for the Deaf and Hard of Hearing
13	Kentucky	Kentucky Commission on the Deaf and Hard of Hearing
14	Louisiana	Louisiana Commission for the Deaf
15	Maine	Maine Division for the Deaf, Hard of Hearing, and Late Deafened
16	Maryland	Maryland Governor's Office of the Deaf and Hard of Hearing
17	Massachusetts	Massachusetts Commission for the Deaf and Hard of Hearing
18	Michigan	Michigan Division on Deaf and Hard of Hearing
19	Minnesota (Commission)	Commission of Deaf, DeafBlind, and Hard of Hearing Minnesotans
20	Minnesota (DHHSD)	Minnesota Deaf and Hard of Hearing Services Division
21	Mississippi	Mississippi Office on Deaf and Hard of Hearing
22	Missouri	Missouri Commission for the Deaf and Hard of Hearing
23	Nebraska	Nebraska Commission for the Deaf and Hard of Hearing
24	Nevada*	Nevada, Aging & Disability Services Division - Disabilities Unit
25	New Hampshire	New Hampshire Office of the Deaf and Hard of Hearing
26	New Mexico	New Mexico Commission for the Deaf and Hard of Hearing Persons
27	New Jersey	New Jersey Division of the Deaf and Hard of Hearing
28	New York	New York State Interagency Coordinating Council for Services to Persons who are Deaf, Deaf-Blind, or Hard of Hearing
29	North Carolina	North Carolina Division of Services for the Deaf and Hard of Hearing
30	Oregon	Oregon Department of Human Services - Deaf and Hard of Hearing Services Program
31	Pennsylvania	Pennsylvania Office for the Deaf and Hard of Hearing
32	Rhode Island	Rhode Island Commission on the Deaf and Hard of Hearing
33	Tennessee	Tennessee Council for the Deaf and Hard of Hearing
34	Texas	Texas, Office for Deaf and Hard of Hearing Services
35	Utah	Utah Division of Services for the Deaf and Hard of Hearing
36	Virginia	Virginia Department for the Deaf and Hard of Hearing
37	Washington	Washington Office of the Deaf and Hard of Hearing
38	West Virginia	West Virginia Commission for the Deaf and Hard of Hearing
39	Wisconsin	Wisconsin Office for the Deaf and Hard of Hearing

* = Agency overseeing grants that are awarded to the organizations serving the Deaf and Hard of Hearing persons.

1.2 List of States that do not have a state agency serving Deaf and Hard of Hearing persons.

Table 1.2

	State	Comments
1	Arkansas	
2	Alabama	
3	Alaska	
4	Georgia	a nonprofit organization receiving state contract in providing statewide services for deaf and hard of hearing.
5	Montana	
6	North Dakota	
7	Ohio	
8	Oklahoma	
9	South Carolina	
10	South Dakota	
11	Vermont	Position eliminated effective June 2009.
12	Wyoming	

1.3 Communication and Technology

This section indicates how the public to contact representatives at the agency for any reason on any questions they may have. TTY was eliminated because it is clearly on the decline. However, the videophone has dramatically increased since 2004. As you can see, seventy-nine percent (79%) of all agencies have videophone available for the public to use to reach the agency. Also, in 2004, only 88% (n=26) of agencies have their websites available for the public. Today, 100% of state agencies have websites.

Table 1.3

N	Website	Toll Free	Videophone	Agency Email	Administrator Email
39	39	21	31	20	39
100%	100%	54%	79%	51%	100%

1.4 State Commissions, Councils, Divisions, and Offices Established

Michigan was the 1st state to pass legislation to create a state program or a state service for the Deaf and Hard of Hearing on October 29, 1937. The only time they were inactive was 1975 to 1979. Virginia was the first state to establish an independent state department (commission, council, division, and office) serving the Deaf and Hard of Hearing.

As of January 2010

State	Year	Anniversary
Michigan	29-Oct-1937	72
Virginia	1-Jul-1972	37
Texas	1973	37
Connecticut	1974	36
Iowa	1975	35
New Jersey	31-Jul-1977	32
Rhode Island	1977	32
Arizona	1978	32
Tennessee	1-Jul-1978	31
Minnesota (DHHSD)	1979	31
Washington	1979	31
Nebraska	Spring 1979	30
California	1980	30
Louisiana	1980	30
Wisconsin	1981	29
Kentucky	1982	28
New Hampshire	1-May-1981	28
Kansas	1-Jul-1982	27
Utah	1983	27
Oregon	1983	27
Maine	1-Jul-1983	26
Minnesota (Comm.)	1985	25
Pennsylvania	1986	24
Massachusetts	1-Jul-1986	23
Indiana	1988	22
Missouri	1988	22
North Carolina	1989	21
West Virginia	1989	21
Nevada	1990	20
Idaho	1-Jul-1991	18
New Mexico	26-Jul-1991	18
Delaware	1-Mar-1993	16
Illinois	1-Jan-1997	13
Mississippi	1-Jul-1998	11
Hawaii	1-Jan-2000	10
Maryland	2001	9
Colorado	1-Jul-2001	8
Florida	1-Jul-2004	5
New York	2007	3

1.4 State Commissions, Councils, Divisions, and Offices Established (Continued)

Additional comments about their establishments

Indiana - Legislation was passed in 1988. The office opened in 1989.

Nevada - Relay and equipment distribution started in 1990. The advocacy component was added in 2002.

New York - Legislation was passed in July 2007. New York State Interagency Coordinating Council for Services to Persons who are Deaf, Deaf-Blind, or Hard of Hearing was officially established on January 1, 2008.

Pennsylvania - Legislation was passed in 1986. The office opened in 1988.

Rhode Island - Legislation was passed in 1977. The office opened on May 9, 1978. It was restructured on July 13, 1992 with its current name, RI CDHH.

Wisconsin - Legislation was passed in 1939 to set a state appropriation for Wisconsin Association of the Deaf (WAD)'s Service Bureau of the Deaf. According to the March 1979 final report of the Governor's Committee on Problems of Deaf & Hard of Hearing People, the Service Bureau initially was a private non-profit agency (unconfirmed) operated by the WAD. Apparently as a result of the final report, which had a list of recommendations, the Bureau became a state entity---by 1981, under the auspices of the then-named Department of Health and Social Services. The agency was formerly called, the Bureau of the Hearing Impaired.

1.5 History of the First State Agency Established in the United States of America.

Michigan's Act 72 of 1937 was passed to establish the Division on Deafness on October 29, 1937. The original language of the bill is below:

DIVISION ON DEAFNESS ACT

Act 72 of 1937

AN ACT to establish the division on deafness and the advisory council on deafness within the department of labor; to prescribe the powers and duties of the department, the division, the council, and certain state officers; to establish a fund and provide for expenditures from that fund; and to provide for an appropriation.

History: 1937, ACT 72, Eff. Oct. 29, 1937.

Additional history milestones of the Division on Deaf and Hard of Hearing (Current name of the State Agency in Michigan) are as follows:

HISTORY/MILESTONES

- 1921 - Michigan Association of the Deaf (MAD) began first effort to establish the Division of Deaf and Deafened (DDD).
- 1937 - The legislature passed P.A. 72 that established the DDD in the Department of Labor and Industry to assist deaf persons with employment.
- 1938 - First deaf person was hired as the first director.
- 1958 - DDD was transferred to Michigan Employment Security Commission.
- 1975 - DDD ceased activity after the director resigned.
- 1979 - DDD was revitalized by Governor William Milliken and transferred to Michigan Department of Labor, Bureau of Commission on Handicapper Concerns.
- 1980 - DDD reopened its doors with Christopher Hunter as its director. It has new services: advocacy, information and referral, interpreter referral, and technical assistance. It has staff of 4 persons: State Interpreter Coordinator, Rights Representative and Secretary.
- 1988 - The legislature amended the law (P.A. 434), changing name to Division on Deafness and revising responsibilities to protect and assist all hearing impaired persons, with special emphasis on deaf persons", forming 13 member Governor appointed Advisory Council.
- 1993 - Hard of Hearing Specialist position was added to serve hard of hearing Michigan citizens.
- 1996 - DDD and Michigan Commission on Disability Concerns were eventually transferred to the Michigan Independence Agency after the Department of Labor was abolished.
- 1997 - Hard of Hearing Specialist position was eliminated through the department downsizing affected by the early retirement program.
- 1998 - Hard of Hearing Specialist position was restored through public contacts to the legislature and department. Today DOD has four staff members: Director, State Interpreter Coordinator, Hard of Hearing Specialist, and Secretary.
- 2002 - Executive Order #2002-10 DOD renamed Division on Deaf and Hard of Hearing (DODHH)

1.6 Has Your Agency Changed Since 2004?

California - Our Deaf Access Program has undergone budget cuts since 2004.

Colorado - 3.3 FTEs added in February 2010.

Connecticut - In 2005, the agency's Business/Human Resources Department was transferred to the Department of Administrative Services. This was done through legislation, 23 agency's Business/HR Departments were merged. This has been positive for the agency, more resources are available especially with the tight fiscal constraints. It has not increased restrictions or had an effect on the challenges that confront the agency.

Indiana - Yes, we are more connected to Vocational Rehabilitation Services and Bureau of Blind and Visually Impaired. Some ways, it has helped working closer with the Rehabilitation Counselors for the Deaf but it has become more challenging too as not everyone understands the challenges faced by deafness.

Kansas - Downsized by losing one part-time support staff. Our agency is now 100% State General Funds.

Maryland - No - there were legislative attempts to merge us with the Department of Disabilities but they did not pass.

Massachusetts - Through interagency agreements, we administer, coordinate, and provide communication access to other agencies; funding for providing these services increased from $300K to over $900K. Budget reductions have reduced funding for both administrative support and direct services. We shared Information Technology, Human Services, and Legal Counsel staff with other agencies within EOHHS in effort to stretch resources.

Minnesota (Comm.) - No, in fact, our budget has gone from $95,000 in 2004 to $600,000 this year.

Minnesota (DHHSD) - The agency has gradually reduced level of services over the past few years due to budget reduction/ unallotment decisions.

Missouri - In FY2010, the commission received an 18% budget reduction in Personnel money. This resulted in the loss of 1 full-time position, and reduced a second position to part-time.

Nebraska - Downsized one staff due to budget cuts. Minimal impact.

Nevada - Under DHHS, we were an offshoot of the Departments' Director's. Last year, the Legislature decided to merge us with Aging Services changing the name. Our prior agency was The Office of Disability Services.

Has your agency changed since 2004? (Continued)

New York - Legislation was passed in July 2007. New York State Interagency Coordinating Council for Services to Persons who are Deaf, Deaf-Blind, or Hard of Hearing was officially established on January 1, 2008. This is part of New York State Commission on Quality of Care and Advocacy for Persons with Disabilities. NYS Commission on Quality of Care and Advocacy for Persons with Disabilities was originally established on January 1, 1978 under different name and is with its current name starting on April 15, 2005. In 2005, the Commission on Quality Care of the Mentally Disabled and the Office of Advocate for Persons with Disabilities merged by statute to avoid duplication and to improve service delivery and advocacy for persons with disabilities.

North Carolina - In SFY2008-2009, the Governor and the NC General Assembly, in two separate actions, transferred a total of $9.5M from the Telecommunications Trust Fund into the General Fund to address NC's budgetary shortfall. Legislative action mandated that DSDHH's Community Resources Program (seven regional centers) be funded by the Telecommunications Relay Service receipts instead of general appropriations, giving the State of NC $2M per year. Due to the large cash balance in the Telecommunications Trust Fund, these actions did not significantly impact DSDHH's programs and services. However, DSDHH must comply with certain restrictions on travel and expenditures in order to ensure a balanced budget at the end of SFY2010.

Oregon - In 2005, our program was moved from the Oregon Disabilities Commission and placed within the Department of Human Services. The effect was to downsize this program while we are under a hiring freeze.

Rhode Island - In 2007, the Legislature attempted to consolidate RICDHH into a Department of Advocacy with 4 of the small agencies but failed. In 2008, Governor attempted to consolidate RICDHH into the Department of Elderly Affairs with two other small agencies in response to the legislature's request but failed.

Texas - In 2004 the state legislature undertook a major reorganization by consolidating 3 agencies into 4 new departments. The former Texas Commission for the Deaf and Hard of Hearing is now the Office for Deaf and Hard of Hearing Services (DHHS) under the Dept of Assistive and Rehabilitative Services. All staff and programs have remained intact and services remain unchanged but with increased funds. In the organization DHHS is under the Division of Vocational Rehabilitation and thus able to use agency funds for matching purposes to draw down federal funds. This has resulted in roughly $1.2 million increase in service funds which has a very positive impact. A troublesome restriction is that we cannot be involved with the legislature. Much more policy and paperwork are involved with the new structure and we have not gotten additional staff to handle the paperwork. Overall the changes have been helpful.

Has your agency changed since 2004? (Continued)

Utah - No but we have had to lay off a few employees that has affected the services we provide.

Washington - The previous and current Secretary has reorganized and retained ODHH reporting to the Office of the Secretary. This reorganization is at the discretion of Secretary, not law or executive order. This is positive as ODHH visibility is heightened, opportunities to access executive management is available, etc..

West Virginia - In 2004 the positions of Staff Interpreter and Deputy Director were consolidated into one position - Deputy Director (who is also an interpreter). This has not had a significant impact other than in amount of manpower to complete projects.

2.0 Administration

2.1 Position Title and Type

Of 39 state agencies, 38% (N = 15) of positions is called, Director and 36% (N = 14) of positions is called, Executive Director. 38% (N = 15) of positions are identified as state civil service classified and 25% (N = 10) of positions are identified as Governor Appointee.

Table 2.1 Title

Title	N
Director	15
Executive Director	14
Administrator	2
Deputy Director	1
Office Public Information Officer	1
Program Assistant	1
Manager	1
Commissioner	1
Social Services Program Specialist II	1
State Coordinator	1
Public Policy and Government Relations Director	1
Total	39

Table 2.2 Type

Type	N
Civil Service Class	15
Governor Appointee	10
Report to the governing board	5
Appointed by the Department	4
Report directly to Governor	3
State Administrative, exempt	1
Report directly to OVR Director	1
Total	39

2.2 Hearing Status of Administrators

Of 39 State Agencies, 59% (N = 23) of state agency administrators identified themselves deaf or hard of hearing. Only 1% increase since 2004. The majority, if not all, of administrators who identified themselves as hearing know Sign Language. (Based on conversations between the administrators and Steven Florio of Rhode Island while conducting the 2009 Survey.)

Table 2.3 Hearing Status

	2009		2004	
Hearing Status	States	%	States	%
Deaf	17	44%	13	50%
Hard of Hearing	6	15%	2	8%
Hearing	16	41%	7	27%
No response	0	0%	4	15%
Total	39	100%	26	100%

2.3 Salary Range of Administrators

Of 39 State Agencies, 26% of salary ranges is $85,000 and over. The rest of salary ranges are pretty even. The possible factors are the size of agency's annual budget, administrators' longevity among the administrators, base salary range, college education, and other incentives.

Table 2.4 Salary Range of Administrators

	2009		2004	
Salary Range	**N**	**%**	**N**	**%**
$0 - $25,000	0	0%	0	0%
$25,001 - $35,000	0	0%	0	0%
$35,001 - $45,000	4	10%	2	8%
$45,001 - $55,000	5	13%	7	28%
$55,001 - $65,000	7	18%	3	12%
$65,001 - $75,000	5	13%	7	28%
$75,001 - $85,000	6	15%	5	20%
$85,001 and higher	10	26%	1	4%
No Response	2	5%	0	0%
Total	39	100%	25	100%

2.4 List of Administrators

Table 2.4 - Administrators

State	Administrator	Title
Arizona	Sherri Collins	Executive Director
California	Tom Lee	Deputy Director
Colorado	Cliff Moers	Administrator
Connecticut	Stacie J. Mawson	Executive Director
Delaware	Loretta Sarro	Public Information Officer
Florida	Mary Grace Tavel	Program Assistant
Hawaii	Francine Wai	Executive Director
Idaho	Steven Snow	Executive Director
Illinois	John Miller	Director
Indiana	Rhonda Marcum	Manager
Iowa	Kathryn Baumann-Reese	Administrator
Kansas	Rebecca J. Rosenthal	Executive Director
Kentucky	Virginia L. Moore	Executive Director
Louisiana	Naomi DeDual	Executive Director
Maine	John G. Shattuck	Division Director
Maryland	Lisa H. Kornberg	Director
Massachusetts	Heidi L. Reed	Commissioner
Michigan	Sheryl Emery	Director
Minnesota (Comm.)	Mary Hartnett	Executive Director
Minnesota (DHHSD)	Bruce Hodek	Division Director
Mississippi	Benjamin Wagenknecht	Director
Missouri	Barry Critchfield	Executive Director
Nebraska	Peter J. Seiler, Ed.D.	Executive Director
Nevada	Betty Hammond	Social Svcs Pgm Specialist II
New Hampshire	H. Dee Clanton	State Coordinator
New Mexico	Barbara "BJ" Wood	Executive Director
New Jersey	David Alexander	Director
New York	Rosemary Lamb	Director
North Carolina	Jan Withers	Director
Oregon	Patricia O'Sullivan	Public Policy/Gov't Rel. Director
Pennsylvania	Sharon Behun	Director
Rhode Island	Steven A. Florio	Executive Director
Tennessee	Thom Roberts	Executive Director
Texas	David W. Myers	Director
Utah	Marilyn Call	Division Director
Virginia	Ronald L. Lanier	Director
Washington	Eric Raff	Director
West Virginia	Marissa Johnson	Executive Director
Wisconsin	Linda Huffer	Director

3.0 Location of the Agency

Department	N	State
Independent or Executive Office	**11**	Arizona, Connecticut, Idaho, Illinois, Maryland, Minnesota (Commission), Nebraska, New Mexico, New York, Rhode Island, and Virginia
Social and/or Health Services	**5**	
Department of Social Services		California
Department of Health		Florida
Department of Social and Health Services		Washington
Department of Health Services		Wisconsin
Department of Health		Hawaii
Human Rights or Services	**5**	
Within the Division of Boards and Commissions under the Dept. of Human Services		Colorado
Department of Human Rights		Iowa
Department of Human Services		Minnesota (DHHSD)
Department of Human Services		New Jersey
Department of Human Services		Oregon
Health and Human Services	**4**	
Executive Office of Health and Human Services		Massachusetts
Department of Health and Human Services, Aging and Disability Services Division		Nevada
Department of Health and Human Resources		West Virginia
Department of Health and Human Services		North Carolina
Rehabilitation Services	**9**	
Division of Vocational Rehab under Dept of Labor		Delaware
Bureau of Rehabilitative Services under Dept of Family and Social Service		Indiana
Social Rehabilitation Service within the Kansas Rehabilitation Services		Kansas
Department of Social Service within the LA Rehabilitation Services		Louisiana
Bureau of Rehabilitation under Department of Labor		Maine
Department of Rehabilitation Services		Mississippi
Division of Vocational Rehab under Dept of Human Services		Tennessee
Department of Assistive and Rehabilitative Services		Texas
Department of Rehabilitation under Dept of Education		Utah
Labor	**2**	
Department of Labor, Energy and Economic Growth		Michigan
Department of Labor and Industry		Pennsylvania
Education	**3**	
Education and Workforce Development Cabinet		Kentucky
Department of Elementary and Secondary Education		Missouri
Department of Education, Division of Career Technology and Adult Learning		New Hampshire

4.0 Board Composition

4.1 Size

For the purpose of this section, the term, "board" is defined as a board, commission, or advisory council. Only 4 state agencies (California, Delaware, Texas, and Washington) do not have a board/advisory function. Washington's Advisory Committee was abolished by the Governor's Executive Order this year (2009).

The largest number of seats is 27 in North Carolina and the smallest number of seats is 7 in 4 states (Colorado, Indiana, Iowa, and New Mexico).

49% (N = 19) of State Agencies have a law requiring a majority of deaf and hard of hearing persons on the board.

Table 4.1—Size of Board Composition

State	N	Majority D/HH Required
North Carolina	27	No
Maine	26	No
Connecticut	21	No
Massachusetts	12-20	Yes
Florida	17	No
Hawaii	17	No
Kansas	17	No
Louisiana	17	No
New Hampshire	17	No
Pennsylvania	17	No
West Virginia	17	No
Maryland	16	Yes
Minnesota (Comm.)	15	Yes
Utah	15	Yes
New York	15	Yes
Arizona	14	Yes
New Jersey	14	Yes
Kentucky	13	Yes
Michigan	13	Yes
Rhode Island	13	Yes

State	N	Majority D/HH Required
Oregon	12	Yes
Illinois	11	Yes
Nevada	11	No
Tennessee	11	No
Idaho	9	No
Mississippi	9	No
Missouri	9	Yes
Nebraska	9	Yes
Virginia	9	No
Wisconsin	9	Yes
Minnesota (DHHSD)	8	Yes
Colorado	7	No
Indiana	7	Yes
Iowa	7	Yes
New Mexico	7	Yes
California	N/A	N/A
Delaware	N/A	N/A
Texas	N/A	N/A
Washington	N/A	N/A

4.2 Seats of the Board

72% (N = 28) of State Agencies' board members are appointed by the Governor.

Table 4.2—Seats of the Board

State	One Term equals to a number of	Appointed by:	The Travel Expense reimbursed?
New Mexico	6	Governor	Yes
Missouri	4	Governor	Yes
Virginia	4	Governor	Yes
Wisconsin	4	Governor	Yes
Florida	4	Governor	Yes
Pennsylvania	4	Governor	Yes
North Carolina	4	Mixed of Governor, Department Administrator, and selected by membership	Yes
Kentucky	2 to 4	Governor and selected by the membership for some slots	Yes
Hawaii	2 to 4	Governor	Yes
Iowa	3	Governor	Yes
Minnesota (DHHSD)	3	Department Administrator	Yes
Illinois	3	Governor	Yes
Nevada	3	Department Administrator	Yes
Tennessee	3	Governor	Yes
Michigan	3	Governor	Yes
New Jersey	3	Governor	Yes
Minnesota (Comm.)	3	Governor	Yes
Maryland	3	Governor	Yes if they requested.
Kansas	3	Governor	Yes
Louisiana	3	Governor	Yes
New Hampshire	3	Department Administrator	Yes
West Virginia	3	Governor	Yes
Indiana	2 to 3	Department Administrator	Yes
Colorado	2	Governor	Yes
Mississippi	2	Department of Rehab Services' Executive Director	Yes
Nebraska	2	Governor	Yes
Oregon	2	Department Administrator	Yes
Rhode Island	2	Governor	Yes if they requested.
Arizona	2	Governor	Yes
Utah	2	Board of Education	Yes if they live more than 50 miles away.
Maine	2	Governor	Yes
Massachusetts	2	Governor	Yes
Connecticut	Coterminous with Governor	Governor	Yes
Idaho	Vary depending on each seat	Governor	Yes
New York	Staggered	4 by Governor and 4 by legislative leaders	Yes
California	N/A	N/A	N/A
Delaware	N/A	N/A	N/A
Texas	N/A	N/A	N/A
Washington	N/A	N/A	N/A

4.3 Representatives on the Board

Almost all state agencies have a law requiring both Deaf and Hard of Hearing to serve on the board. Parents are second after Deaf and Hard of Hearing.

Table 4.3 Representatives

Representative	N
Deaf	31
Hard of Hearing	30
Parent	20
State Government Official	16
Deaf Organization	15
Educator	12
Interpreter Organization	11
General Public	9
Audiologist	8
Hard of Hearing Organization	7
Local Rep. (each island county incl'd)	7
Late Deafened Organization	5
Physician including otolaryngolsist	4
Hearing	3
Early Intervention Provider	3
Not Required	3
Psychologist	2
No Response	2

Table 4.4 Other Representatives

Other Representatives	N
Professionals	7
State Agency Representatives	4
Community Representative (D/HH)	3
Late-Deafened	2
Interpreter	2
Hearing Aid Specialist/Dispenser	2
Supt of School for the Deaf/School Rep	2
Deaf-Blind organization	2
Government Representatives-ex officers	1
Elders	1
Children and Families	1
Business Community	1
Local Public School	1
Speech Disabled	1
Director of Vocational Rehabilitation	1
Black-Deaf organization	1
Persons with Disabilities	1
Service Providers	1

4.4 Meeting

74% (N = 29) of the state boards are required to meet at least 4 times a year. Utah is required to meet at least 10 times a year. Massachusetts is required to meet at least 8 times a year. Only two states (Mississippi and New York) are required to meet at least 3 times. Also, only two states (Oregon and Nevada) do not have any law requiring a certain number of meetings a year. Utah allows the members to participate in the meeting by video conferencing.

4.5 Communication Access at the Meeting.

All State Agencies' boards arranged various communication access services for their meetings without requiring a request of communication access in advance.

Interpreters - - - 100%
CART - - - 90%
Assistive Listening Devices - 28%
Assistive Listening System - 14%
Oral Interpreter - - - 5%
Tactile Interpreters for Deaf-Blind - 5%

5.0 Funding

5.1 Fiscal Year

Only 5 states have different fiscal years than the rest of state agencies. 33 states follow the July 1st through June 30th fiscal year. 3 of 5 states (Michigan, New Hampshire, and Wisconsin) start their fiscal year on October 1st and end on September 30th, similar to the Federal Government's fiscal year. One of 5 states, Texas, starts on September 1st and ends on August 31st. And one of 5 states, New York, starts on April 1st and ends on March 31st.

5.2 Authorized Budget

The respondents were asked for their total authorized annual budget for their agencies. It is difficult to compare state budgets when no two state agencies providing the same services and programs. Some states manage or provide telecommunications relay service (TRS) and/or Telecommunication Distribution and others do not. TRS and Telecommunication Distribution services account for a large portion of the budgets.

For your own assessment needs, various data formats are provided as follows:

1) Budget by Per Capita
2) Annual Gross Amount
3) Rank by State Funds
4) Rank by "Surcharge" Funds
5) Rank by General Population including Gross Amount and State Funds

By per capita, New Mexico is leading in per capita, $2.07 per person, to provide services for the Deaf and Hard of Hearing. Florida is the lowest with $0.01 per capita based on 18,881,445 people living in Florida and are used to services provided for Deaf and Hard of Hearing people by the Florida government. New York is the 2nd lowest with $0.02 per capita. Please see Table 5.1 for per capita of all states next page.

Table 5.1 Budget by Per Capita

	State	Per Capita	Gross	Population
1	New Mexico	$ 2.07	$ 4,100,000.00	1,984,356.00
2	Virginia	$ 2.04	$ 15,859,138.00	7,769,089.00
3	North Carolina	$ 1.44	$ 13,000,000.00	9,000,000.00
4	Minnesota (DHHSD)	$ 1.36	$ 6,800,000.00	5,000,000.00
5	Hawaii	$ 1.09	$ 1,400,000.00	1,288,198.00
6	Utah	$ 0.91	$ 2,021,891.00	2,233,169.00
7	Washington	$ 0.89	$ 5,624,971.00	6,287,759.00
8	Massachusetts	$ 0.87	$ 5,500,000.00	6,349,097.00
9	Arizona	$ 0.84	$ 5,441,100.00	6,500,000.00
10	Nevada	$ 0.68	$ 1,646,018.00	2,414,807.00
11	Louisiana	$ 0.64	$ 2,800,000.00	4,400,000.00
12	Nebraska	$ 0.48	$ 858,400.00	1,783,432.00
13	Connecticut	$ 0.44	$ 1,529,248.00	3,501,252.00
14	Maine	$ 0.43	$ 560,508.00	1,300,000.00
15	Rhode Island	$ 0.37	$ 370,146.00	1,011,960.00
16	Colorado	$ 0.21	$ 954,040.00	4,550,688.00
17	Tennessee	$ 0.19	$ 1,020,000.00	5,464,458.00
18	Texas	$ 0.19	$ 3,900,500.00	21,000,000.00
19	New Hampshire	$ 0.18	$ 313,721.00	1,700,000.00
20	Delaware	$ 0.15	$ 133,900.00	873,092.00
21	West Virginia	$ 0.15	$ 268,000.00	1,800,000.00
22	Kentucky	$ 0.14	$ 860,000.00	6,000,000.00
23	California	$ 0.14	$ 5,200,000.00	36,700,000.00
24	Iowa	$ 0.13	$ 378,792.00	2,926,324.00
25	Kansas	$ 0.11	$ 290,000.00	2,700,000.00
26	Wisconsin	$ 0.10	$ 500,000.00	5,000,000.00
27	Michigan	$ 0.10	$ 1,000,000.00	10,003,422.00
28	Minnesota (Comm.)	$ 0.10	$ 495,000.00	5,000,000.00
29	Idaho	$ 0.09	$ 150,600.00	1,600,000.00
30	New Jersey	$ 0.09	$ 807,000.00	8,682,661.00
31	Missouri	$ 0.07	$ 403,792.00	5,800,310.00
32	Illinois	$ 0.07	$ 808,800.00	12,419,293.00
33	Oregon	$ 0.06	$ 240,000.00	3,790,060.00
34	Maryland	$ 0.05	$ 301,000.00	5,633,597.00
35	Indiana	$ 0.05	$ 325,000.00	6,195,643.00
36	Pennsylvania	$ 0.04	$ 460,000.00	12,448,279.00
37	Mississippi	$ 0.04	$ 104,500.00	2,921,088.00
38	New York*	$ 0.02	$ 316,000.00	19,460,297.00
39	Florida	$ 0.01	$ 250,000.00	18,881,445.00

** = $316,000 was appropriated by the General Assembly when the Interagency Coordinating Council for the Deaf and Hard of Hearing was first established. $316,000 and additional adjustments annually are now part of the overall agency's budget, NYS Commission on Quality of Care and Advocacy for Persons with Disabilities, ($17.6m)*

Table 5.2 Rank by Annual Gross Amount

	State	Gross
1	Virginia	$ 15,859,138.00
2	North Carolina	$ 13,000,000.00
3	Minnesota (DHHSD)	$ 6,800,000.00
4	Washington	$ 5,624,971.00
5	Massachusetts	$ 5,500,000.00
6	Arizona	$ 5,441,100.00
7	California	$ 5,200,000.00
8	New Mexico	$ 4,100,000.00
9	Texas	$ 3,900,500.00
10	Louisiana	$ 2,800,000.00
11	Utah	$ 2,021,891.00
12	Nevada	$ 1,646,018.00
13	Connecticut	$ 1,529,248.00
14	Hawaii	$ 1,400,000.00
15	Tennessee	$ 1,020,000.00
16	Michigan	$ 1,000,000.00
17	Colorado	$ 954,040.00
18	Kentucky	$ 860,000.00
19	Nebraska	$ 858,400.00
20	Illinois	$ 808,800.00
21	New Jersey	$ 807,000.00
22	Maine	$ 560,508.00
23	Wisconsin	$ 500,000.00
24	Minnesota (Comm.)	$ 495,000.00
25	Pennsylvania	$ 460,000.00
26	Missouri	$ 403,792.00
27	Iowa	$ 378,792.00
28	Rhode Island	$ 370,146.00
29	Indiana	$ 325,000.00
30	New York*	$ 316,000.00
31	New Hampshire	$ 313,721.00
32	Maryland	$ 301,000.00
33	Kansas	$ 290,000.00
34	West Virginia	$ 268,000.00
35	Florida	$ 250,000.00
36	Oregon	$ 240,000.00
37	Idaho	$ 150,600.00
38	Delaware	$ 133,900.00
39	Mississippi	$ 104,500.00

** = $316,000 was appropriated by the General Assembly when the Interagency Coordinating Council for the Deaf and Hard of Hearing was first established. $316,000 and additional adjustments annually are now part of the overall agency's budget, NYS Commission on Quality of Care and Advocacy for Persons with Disabilities.($17.6m)*

Table 5.3 Rank by State Funds

The funding source of the state agencies varies. State agencies that received at least 85% from the surcharge fund (excise tax or other names) are excluded from this list. To be included, state agencies receive state funds appropriated by the state legislature and/or Memo of Understanding (MOU)/Grants through other state agencies/departments.

	State	State Funds
1	Massachusetts	$ 5,280,000.00
2	Minnesota (DHHSD)	$ 5,168,000.00
3	California	$ 2,860,000.00
4	Louisiana	$ 2,800,000.00
5	Utah	$ 2,021,891.00
6	Connecticut	$ 1,529,248.00
7	Hawaii	$ 1,400,000.00
8	Texas	$ 1,189,652.50
9	Tennessee	$ 1,020,000.00
10	Michigan	$ 1,000,000.00
11	Kentucky	$ 860,000.00
12	Nebraska	$ 858,400.00
13	Illinois	$ 808,800.00
14	New Jersey	$ 807,000.00
15	Wisconsin	$ 500,000.00
16	Minnesota (Comm.)	$ 495,000.00
17	Pennsylvania	$ 460,000.00
18	Missouri	$ 403,792.00
19	Iowa	$ 378,792.00
20	Rhode Island	$ 370,146.00
21	Indiana	$ 325,000.00
22	Maine	$ 319,489.56
23	New York*	$ 316,000.00
24	Maryland	$ 301,000.00
25	Kansas	$ 290,000.00
26	West Virginia	$ 268,000.00
27	Florida	$ 250,000.00
28	Oregon	$ 240,000.00
29	Idaho	$ 150,600.00
30	Delaware	$ 133,900.00
31	Mississippi	$ 104,500.00
32	New Hampshire	$ -

* = Please check the footnotes in the previous page of Annual Gross Amount for information on NY.

Table 5.4 Rank by "Surcharge" Funds

The definition, "Surcharge", refers to a charge against the telephone on landlines, wireless, and internet known as VOIP paid by the consumers in these respective states to cover various services and programs provided. Some states have different names for it such as Disabled Telephone Users Fund, Excise Tax, Universal Service Fund, and TRS fund. Most of them are set up by the State Public Utilities Commission or the similar.

	State	Funding	From other sources
1	Virginia	$ 14,431,815.58	99% from Communications Tax for Relay
2	North Carolina	$ 12,900,000.00	99% from surcharge on landlines and wireless.
3	Washington	$ 5,624,971.00	100% from Excise Tax from Telephone subscribers TRS surcharges.
4	Arizona	$ 5,441,100.00	100% - Excise Tax (telephone landline only)
5	New Mexico	$ 4,100,000.00	100% from Telephone Relay service surcharges
6	Nevada	$ 1,646,018.00	100% from PUC's telecommunication fund
7	Minnesota (DHHSD)	$ 1,632,000.00	24% from telephone surcharge for TEDP
8	Colorado	$ 820,474.40	86% from Disabled Telephone Users Fund
9	Maine	$ 140,127.00	25% from Universal Service Fund.

Table 5.5 Rank by General Population including Gross Amount and State levels.

	State	Population	Gross Amount	State Fund	Other sources
1	California	36,700,000.00	$ 5,200,000.00	$ 2,860,000.00	$ 2,340,000.00
2	Texas	21,000,000.00	$ 3,900,500.00	$ 1,189,652.50	$ 2,710,847.50
3	New York*	19,490,297.00	$ 316,000.00	$ 316,000.00	$ -
4	Florida	18,881,445.00	$ 250,000.00	$ 250,000.00	$ -
5	Pennsylvania	12,448,279.00	$ 460,000.00	$ 460,000.00	$ -
6	Illinois	12,419,293.00	$ 808,800.00	$ 808,800.00	$ -
7	Michigan	10,003,422.00	$ 1,000,000.00	$ 1,000,000.00	
8	North Carolina	9,000,000.00	$ 13,000,000.00	$ 13,000,000.00	$ -
9	New Jersey	8,682,661.00	$ 807,000.00	$ 807,000.00	$ -
10	Virginia	7,769,089.00	$ 15,859,138.00	$ 1,427,322.42	$14,431,815.58
11	Arizona	6,500,000.00	$ 5,441,100.00	$ 5,441,100.00	$ -
12	Massachusetts	6,349,097.00	$ 5,500,000.00	$ 5,280,000.00	$ 220,000.00
13	Washington	6,287,759.00	$ 5,624,971.00	$ 5,624,971.00	$ -
14	Indiana	6,195,643.00	$ 325,000.00	$ 325,000.00	$ -
15	Kentucky	6,000,000.00	$ 860,000.00	$ 860,000.00	$ -
16	Missouri	5,800,310.00	$ 403,792.00	$ 234,692.00	$ 169,100.00
17	Maryland	5,633,597.00	$ 301,000.00	$ 301,000.00	$ -
18	Tennessee	5,464,458.00	$ 1,020,000.00	$ 1,020,000.00	$ -
19	Minnesota (Comm.)	5,000,000.00	$ 495,000.00	$ 495,000.00	$ -
20	Minnesota (DHHSD)	5,000,000.00	$ 6,800,000.00	$ 6,800,000.00	$ -
21	Wisconsin	5,000,000.00	$ 500,000.00	$ 500,000.00	$ -
22	Colorado	4,550,688.00	$ 954,040.00	$ 954,040.00	$ -
23	Louisiana	4,400,000.00	$ 2,800,000.00	$ 2,800,000.00	$ -
24	Oregon	3,790,060.00	$ 240,000.00	$ 240,000.00	$ -
25	Connecticut	3,501,252.00	$ 1,529,248.00	$ 1,092,320.00	$ 436,928.00
26	Iowa	2,926,324.00	$ 378,792.00	$ 378,792.00	$ -
27	Mississippi	2,921,088.00	$ 104,500.00	$ 104,500.00	$ -
28	Kansas	2,700,000.00	$ 290,000.00	$ 290,000.00	$ -
29	Nevada	2,414,807.00	$ 1,646,018.00	$ 1,646,018.00	$ -
30	Utah	2,233,169.00	$ 2,021,891.00	$ 1,821,891.00	$ 200,000.00
31	New Mexico	1,984,356.00	$ 4,100,000.00	$ 4,100,000.00	$ -
32	West Virginia	1,800,000.00	$ 268,000.00	$ 268,000.00	$ -
33	Nebraska	1,783,432.00	$ 858,400.00	$ 832,648.00	$ 25,752.00
34	New Hampshire	1,700,000.00	$ 313,721.00	$ -	$ 313,721.00
35	Idaho	1,600,000.00	$ 150,600.00	$ 143,070.00	$ 7,530.00
36	Maine	1,300,000.00	$ 560,508.00	$ 462,399.00	$ 98,109.00
37	Hawaii	1,288,198.00	$ 1,400,000.00	$ 1,400,000.00	$ -
38	Rhode Island	1,011,960.00	$ 370,146.00	$ 370,146.00	$ -
39	Delaware	873,092.00	$ 133,900.00	$ 133,900.00	$ -

** = $316,000 was appropriated by the General Assembly when the Interagency Coordinating Council for the Deaf and Hard of Hearing was first established. $316,000 and additional adjustments annually are now part of the overall agency's budget, NYS Commission on Quality of Care and Advocacy for Persons with Disabilities.($17.6m)*

6.0 Staffing

6.1 Full-time and Part-time Count

3 States, North Carolina, Minnesota, and Massachusetts, have the largest number of full-time employees on their staff. Connecticut has a large number of part-time employees on their staff. The average of full-time employees among 39 state agencies is 11 employees. For part-time employees, the average is 2 employees.

Table 6.1 Rank by Total Staff

	State	FTE	Part-Time	Total
1	North Carolina	71	1	72
2	Massachusetts	51.66	13	64.66
3	Minnesota (DHHSD)	53	0	53
4	Connecticut	9	40	49
5	Indiana *	3	21	24
6	Utah	20	2	22
7	Texas	18	0	18
8	Washington	17	0	17
9	Hawaii	16	0.5	16.5
10	New Mexico	16	0	16
11	Arizona	15	0	15
12	Kentucky	13	0	13
13	Nebraska	12	1	13
14	Virginia	9	2	11
15	Nevada	9.56	0	9.56
16	New Jersey	9	0	9
17	Wisconsin	8	1	9
18	Illinois	8	0	8
19	Colorado**	6.1	0	6.1
20	Minnesota (Comm.)	5	0	5
21	Pennsylvania	5	0	5
22	Iowa	4	1	5
23	Missouri	4	1	5
24	New York***	5	0	5
25	California	4	0	4
26	Louisiana	4	0	4
27	Michigan	4	0	4
28	Maryland	3	0	3
29	Mississippi	3	0	3
30	Rhode Island	3	0	3
31	West Virginia	3	0	3
32	Kansas	2	1	3
33	Maine	2	1	3
34	Oregon	1	2	3
35	Delaware	2	0	2
36	Idaho	2	0	2
37	New Hampshire	2	0	2
38	Tennessee	2	0	2
39	Florida	1	0.6	1.6

* 21 RCDs as part-time included.
** effective on February 2010
*** NYS CQCAPD - Overall 103 FTEs. For D/HH Council, 5 FTEs sharing responsibilities with other councils.

6.2 Staff Hearing Status

Top five (5) state agencies that have best percentage of Deaf and Hard of Hearing employees hired are Tennessee, Mississippi, Rhode Island, Nevada, and Colorado. The majority of employees have normal hearing.

Table 6.2 Rank by percentage of all Deaf, Hard of Hearing, Late Deafened, DeafBlind, and D/HH plus Disabilities.

	State	Deaf	%	HoH	%	Late-Deafened	%	HL + DA	%	ALL D/ HH/LD/ HD	%	Hear-ing	%
1	Tennessee	1	50%	1	50%	0	0%	0	0%	2	100%	0	0%
2	Rhode Island	2	67%	0	0%	0	0%	0	0%	2	67%	1	33%
3	Mississippi	1	33%	0	0%	0	0%	1	33%	2	67%	1	33%
4	Nevada	5	47%	1	9%	1	9%	0	0%	7	66%	3.56	34%
5	Colorado*	2	33%	0	0%	0	0%	2	33%	4	66%	2	33%
6	Pennsylvania	3	60%	0	0%	0	0%	0	0%	3	60%	2	40%
7	Minnesota (Comm.)	2	40%	0	0%	0	0%	1	20%	3	60%	2	40%
8	Utah	9	41%	2	9%	1	5%	1	5%	13	59%	9	41%
9	New Mexico	5	36%	3	21%	0	0%	0	0%	8	57%	6	43%
10	Indiana**	7	29%	6	25%	0	0%	0	0%	13	54%	11	46%
11	Kentucky	5	38%	1	8%	1	8%	0	0%	7	54%	6	46%
12	New Hampshire	1	50%	0	0%	0	0%	0	0%	1	50%	1	50%
13	Kansas	1	50%	0	0%	0	0%	0	0%	1	50%	1	50%
14	Idaho	1	50%	0	0%	0	0%	0	0%	1	50%	1	50%
15	Delaware	1	50%	0	0%	0	0%	0	0%	1	50%	1	50%
16	Michigan	1	25%	1	25%	0	0%	0	0%	2	50%	2	50%
17	Iowa	2	44%	0	0%	0	0%	0	0%	2	44%	2.5	56%
18	Wisconsin	2	22%	0	0%	2	22%	0	0%	4	44%	5	56%
19	Illinois	3	43%	0	0%	0	0%	0	0%	3	43%	4	57%
20	Arizona	4	33%	1	8%	0	0%	0	0%	5	42%	7	58%
21	Washington	6	35%	0	0%	0	0%	1	6%	7	41%	10	59%
22	Missouri	1	20%	1	20%	0	0%	0	0%	2	40%	3	60%
23	Massachusetts	14	24%	7	12%	2	3%	0	0%	23	39%	36	61%
24	Texas	6	33%	1	6%	0	0%	0	0%	7	39%	11	61%
25	North Carolina	19	30%	4	6%	0	0%	1	2%	24	38%	39	62%
26	Florida	0	0%	0	0%	0.6	38%	0	0%	0.6	38%	1	63%
27	Nebraska	3	27%	1	9%	0	0%	0	0%	4	36%	7	64%
28	Maryland	0	0%	1	33%	0	0%	0	0%	1	33%	2	67%
29	Minnesota (DHHSD)	17	32%	0	0%	0	0%	0	0%	17	32%	36	68%
30	New York ***	0	0%	1	25%	0	0%	0	0%	1	25%	4	100%
31	California	1	25%	0	0%	0	0%	0	0%	1	25%	3	75%
32	New Jersey	2	22%	0	0%	0	0%	0	0%	2	22%	7	78%
33	Virginia	1	9%	1	9%	1	9%	0	0%	3	17%	8	73%
34	Hawaii	1	6%	1	6%	0	0%	0	0%	2	13%	14.5	91%
35	West Virginia	0	0%	0	0%	0	0%	0	0%	0	0%	3	100%
36	Oregon	0	0%	0	0%	0	0%	0	0%	0	0%	3	100%
37	Maine	0	0%	0	0%	0	0%	0	0%	0	0%	3	100%
38	Louisiana	0	0%	0	0%	0	0%	0	0%	0	0%	4	100%
39	Connecticut	0	0%	0	0%	0	0%	0	0%	0	0%	49	100%
								Total		178.6	37%	311.56	63%

* effective on February 2010
** 21 RCDs as part-time included.
*** NYS CQCAPD - Overall 103 FTEs. For D/HH Council, 5 FTEs sharing responsibilities with other councils

6.3 Staff Position Titles Other Than Administrator

State	Staff Position Titles Other Than Administrator
Arizona	Deputy Director, Assistant to the Executive Director, Business Manager, Special Project Specialist, Administrative Assistant, Deaf Specialist, Hard of Hearing Specialist, Licensing/ Certificate Coordinator, Account Payable, Information Assessment Coordinator, AZTEDP Program Planner, and Public Relations Coordinator.
California	Deputy Director, Staff Services Manager, Staff Services Analyst, and Associate Governmental Program Analyst
Colorado	Legal Auxiliary Services Manager, Telecommunications Equipment Distribution Program Coordinator, Sign Language Interpreter, Technical Assistance Specialists (2), and Legal Auxiliary Services Coordinator
Delaware	Public Information Officer and Administrative Support Specialist
Florida	Program Assistant and Outreach and Education Coordinator.
Hawaii	Program and Policy Development Coordinator, Program Specialists (3), Communication Access Specialist, Communication Access Technician, Facility Access Specialists (4.5), Planner, Secretary, Clerk, Coordinator, and Assistant Coordinator
Idaho	Administrative Assistant
Illinois	Assistant Director, Personnel Manager, Legal Counsel, Program Coordinator, Project Coordinator, Interpreter Coordinator, and Executive Secretary.
Indiana	Program Director, Program Consultants, Counselors and Secretaries
Iowa	Secretary, Disability Consultants (3)
Kansas	Interpreter QA Coordinator, and Information Referral Specialist
Kentucky	Executive Staff Assistant, Internal Policy Analyst, Interpreter Referral Specialist, Information Coordinators (2), Executive Secretary, Executive Interpreter, Interpreter II, Network Analyst, Document Processing Specialist, Administrative Specialist, and Information Office Supervisor.
Louisiana	Program Coordinator, Program Specialist, and Administrative Program Specialist
Maine	Administrative Assistant and Central Office Consultant
Maryland	Assistant Director, and Special Assistant
Massachusetts	Deputy Commissioner of Program and Policy, Deputy Commissioner of Administration and Finance, Administrative Assistant, Case Manager, Staff Interpreter, Interpreter/CART Specialist, Department Supervisor, Director of Interpreting Services, Director of Case Management, Project Coordinator, Program Coordinator, Human Resources Liaison, Accountant, Accounting Clerk, Business Manager, Contract Manager, Communication Access Outreach Training Specialist, and Screening and Evaluation Coordinator
Michigan	Interpreter, Interpreter Coordinator, and Hard of Hearing Specialist
Minnesota (Comm.)	Public Policy Coordinator, Education Outreach Director, Technology Access Specialist, and Office Coordinator
Minnesota (DHHSD)	Assistant Director, Regional Managers, Mental Health Director, Program Development Supervisor, Telephone Equipment Administrator, Program Planner, Staff Interpreters, Administrative Assistants, Program Consultants, TED Specialists, Deaf-Blind Specialist, Office Liaison, and Mental Health Specialists.
Mississippi	Assistant Administrative II and full-time interpreter
Missouri	Interpreter Certification Coordinator, Workshop/Training Specialist, Information Specialist/Staff Interpreter, and Executive Secretary
Nebraska	Field Representatives, Mental Health Specialist, Business Manager, Staff Assistants, and Administrative Assistant
Nevada	Management Staff (.24 FTE), Support Staff (.32 FTE), Program Administration, Office Manager, Regional Supervisor, Case Manager Specialists, and Communication Support Staff
New Hampshire	Secretary

6.3 Staff Position Titles Other Than Administrator (continued)

State	Staff Position Titles Other Than Administrator
New Mexico	Chief Financial Officer, Service Coordinator, Las Cruces Office Coordinator, Service Coordinators (2), Director of Special Projects, Director of Public Policy and Advocacy, Director of Telecommunication and Technical Assistance, Director of Communication Access and Development, Office Administrative Assistant, Telephone Distribution Program Specialist, Information and Referral Specialist, Public Education and Outreach Specialist, Financial Coordinator, and Business Operations Specialist.
New Jersey	Executive Assistant, Secretarial, Deaf and Hard of Hearing Specialists
New York	Attorneys, social workers, policy analysts, nurses, fiscal analysts, division directors, administrative officer, personnel administrator, mail clerks, administrative assistants, and agency director.
North Carolina	Office Assistant, Program Assistant, Technology Resource Coordinator, Emergency Preparedness Coordinator, Planner/Evaluator, Business Manager, Communication Access Manager, Human Resources Manager, Information Technology Specialist, Hard of Hearing Services Manager, Community Resource Program Manager, Telecommunication Resources Program Manager, Equipment Distribution Service Coordinator, Staff Interpreter, Director's Interpreter, Regional Center Manager, Deaf Services Specialist, Hard of Hearing Services Specialists, Deaf-Blind Services Specialist, Interpreter Services Specialist, Telecommunication Consultant, and Community Accessibility Consultant.
Oregon	Program Coordinator, part-time back-up/support for coordinator, manager, and trainer.
Pennsylvania	Administrative Assistant, Representatives (3)
Rhode Island	Program Manager and Interpreter/CART Referral Specialist
Tennessee	Secretary
Texas	Financial Services Liaison, Interpreter, BEI Program Administrator, Interpreter Certification Administrative Technicians (2), Communication Access Administrative Technician, Communication Access Specialist, Direct Services Program Specialist, Hard of Hearing Specialist, Outreach Development Specialist, STAP.Office Administrator, STAP Program Specialists (2), and STAP Administrative Technicians (5)
Utah	Secretaries, deaf facilities supervisor, interpreters, interpreter certification manager, counselors, case managers, outreach position, deaf program specialists, hard of hearing program specialists, certified deaf interpreter, language mentors for interpreter, and Training Technology specialist.
Virginia	Administration & Policy Manager, Relay & Technology Manager, Business Manager, Outreach Manager, Technology Programs Specialist, VQAS Programs Specialist, Outreach Specialist, Program Support Technician, ISP Coordinator, and CapTel Specialist.
Washington	Assistant Director, Fiscal Officer, Executive Assistants (6), Program Managers (2), Program Support, Information Technology (IT) Manager, IT Network Specialist, IT Database Specialist, Office Assistant, and Customer Service Representative.
West Virginia	Deputy Director and Secretary
Wisconsin	Human Services Program Coordinator, Regional Coordinator, Administrative Assistant, and Interpreter.

7.0 Services

7.1 General Services

The top five (5) services provided by among 39 state agencies are Information and Referral (95%), Advocacy (90%), Deaf Awareness/Orientation/Training (79%), Technical Assistance (77%), and Interpreter Referral (77%).

Table 7.1 - General Services

	Services	N	%
1	Information and Referral	37	95%
2	Advocacy	35	90%
3	Deaf Awareness/Orientation/Training	31	79%
4	Technical Assistance	30	77%
5	Interpreter Referral	28	72%
6	Assistive Technology	27	69%
7	Interpreter Directory	25	64%
8	CART Referral	25	64%
9	Services to Hard of Hearing	24	62%
10	Client Assistance	24	62%
11	Adult/Community Education	20	51%
12	Lending Library	19	49%
14	Interpreter Training and Workshop	18	46%
15	Newsletter	18	46%
16	Equipment Loan	18	46%
17	Interpreter Qualifying and Licensing	16	41%
18	Telecommunication Distribution Program	16	41%
19	Senior Citizens Services	15	38%
20	Emergency needs	14	36%
21	Deaf-Blind Services	13	33%
22	Interpreter Services (direct)	12	31%
23	Research	12	31%
24	Deaf Festival	10	26%
25	Sign Language Instructions/Classes	8	21%
26	Counseling	7	18%
27	Relay Service	5	13%
28	Job Development and Placement	5	13%
29	Video Remote Interpreting Service	4	10%
30	Legislation affecting community- direct lobbing	3	8%
31	Community Outreach	3	8%
32	Remote CART Service	2	5%
33	Accessibility to State Agencies	2	5%
34	Equipment Program contracted by Division	1	3%
35	Case Management Services for Adults	1	3%
36	Children's Specialists	1	3%
37	Communication Access Technology and Training Services	1	3%
38	Deaf and Hard of Hearing Independent Living Services	1	3%
39	Communication Services	1	3%
40	Quality Assurance Screening	1	3%

7.2 Relay Services

The State Agencies identified are responsible to oversee the State Relay Service in various forms.

Table 7.2 - Overseeing State Relay Services

Relay Services
Arizona
New Mexico
North Carolina
Virginia
Washington

7.3 State Telecommunication Distribution Program

The State Agencies identified are in charge of Telecommunication Distribution Program.

Table 7.3 - Telecommunication Distribution

Telecommunication Distribution Program
Arizona
Colorado
Kentucky
Louisiana
Maine
Minnesota (DHHSD)
Nebraska
Nevada
New Mexico
New Jersey
North Carolina
Tennessee
Texas
Virginia
Washington
Wisconsin

7.4 Legislative Actions by the State Agencies

The State Agencies identified are allowed by the statutes to initiate, create, and lobby the legislation at the General Assembly.

Table 7.4 - State Agencies Allowed to lobby the legislations

Legislative Actions
Kentucky
Minnesota (Commission)
Rhode Island

7.5 Interpreter Referral

The State Agencies identified provide the interpreter referral services in various ways. Some provide regular interpreter referral services. Some provide interpreter referrals to State departments/agencies only, some provide for state courts only, some maintain a list of interpreters for distribution purposes, some are responsible to handle registrations of interpreters who work in the state.

Table 7.5 - Interpreter Referral

Interpreter Referral
Arizona
California
Colorado
Connecticut
Idaho
Illinois
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota (DHHSD)
Mississippi
Nebraska
Nevada
New Hampshire
New Mexico
New Jersey
North Carolina
Pennsylvania
Rhode Island
Tennessee
Texas
Utah
Virginia

7.6 Interpret Qualifying and Licensing

The State Agencies identified have programs that issue certificates, licenses, and/or qualify interpreters in their respective states.

Table 7.6 - Interpreter Qualifying and Licensing

Interpreter Qualifying and Licensing
Arizona
Colorado
Illinois
Kansas
Kentucky
Louisiana
Massachusetts
Michigan
Missouri
Nebraska
New Hampshire
New Mexico
Pennsylvania
Texas
Utah
West Virginia

8.0 Demographic Information

81 Demographic—Deaf and Hard of Hearing Population

The information below with both percentages and data sources varies from state to state. All 39 state agencies need to agree on percentage for each category (Deaf, Hard of Hearing, and Deaf Blind) and which source they will use to compute the figure in their respective states. They need consistency as to how to compute the figures.

Table 9.1 - Rank by Deaf and Hard of Hearing Population

	State	General Population	Deaf and Hard of Hearing	Percentage of Deaf/HoH	Percentage of Deaf Only	Percentage of HoH Only	Percentage of Deaf-Blind
1	California	36,700,000.00	3,800,000.00	2.0%	N/A	N/A	N/A
2	Texas	21,000,000.00	3,800,000.00	8.8%	2.3%	6.5%	N/A
3	Florida	18,881,445.00	3,021,031.00	16.0%	N/A	N/A	N/A
4	New York	19,490,297.00	1,500,000.00	N/A	N/A	N/A	N/A
5	Michigan	10,003,422.00	1,400,000.00	10.0%	N/A	N/A	N/A
6	Illinois	12,419,293.00	1,068,059.00	8.6%	N/A	N/A	N/A
7	North Carolina	9,000,000.00	1,000,000.00	15.3%	N/A	N/A	N/A
8	Maryland	5,633,597.00	957,711.00	17.0%	N/A	N/A	N/A
9	Washington	6,287,759.00	880,286.00	N/A	N/A	N/A	N/A
10	New Jersey	8,682,661.00	800,000.00	8.6%	N/A	N/A	N/A
11	Tennessee	5,464,458.00	780,373.00	7.0%	18%	N/A	N/A
12	Arizona	6,500,000.00	704,000.00	11.0%	N/A	N/A	N/A
13	Virginia	7,769,089.00	675,910.00	8.7%	1%	N/A	N/A
14	Kentucky	6,000,000.00	645,000.00	11.0%	N/A	N/A	N/A
15	Pennsylvania	12,448,279.00	624,061.00	N/A	N/A	N/A	N/A
16	Missouri	5,800,310.00	580,000.00	10.0%	1%	9%	N/A
17	Massachusetts	6,349,097.00	546,022.00	8.6%	0.23%	N/A	N/A
18	Minnesota (Comm.)	5,000,000.00	500,000.00	10.0%	N/A	N/A	N/A
19	Wisconsin	5,000,000.00	500,000.00	10.0%	N/A	N/A	N/A
20	Minnesota (DHHSD)	5,000,000.00	497,229.00	10.0%	1%	9%	N/A
21	Indiana	6,195,643.00	495,651.00	N/A	N/A	N/A	N/A
22	Colorado	4,550,688.00	418,000.00	8.6%	0.9%	7.7%	N/A
23	Louisiana	4,400,000.00	400,000.00	10.0%	1%	N/A	N/A
24	New Mexico	1,984,356.00	337,340.00	16.0%	2%	14%	N/A
25	Kansas	2,700,000.00	270,000.00	12.0%	10%	N/A	N/A
26	Iowa	2,926,324.00	229,131.00	8.0%	0.9%	7.1%	N/A
27	Connecticut	3,501,252.00	208,000.00	8.0%	6%	2%	N/A
28	Utah	2,233,169.00	199,822.00	10.0%	1.7%	8.8%	N/A
29	Nevada	2,414,807.00	193,184.56	8.0%	N/A	N/A	N/A
30	Oregon	3,790,060.00	179,000.00	N/A	N/A	N/A	N/A
31	Idaho	1,600,000.00	137,000.00	8.6%	1.6%	7%	N/A
32	Maine	1,300,000.00	105,000.00	10.0%	N/A	N/A	N/A
33	New Hampshire	1,700,000.00	101,000.00	10.0%	N/A	N/A	N/A
34	Rhode Island	1,011,960.00	87,028.00	8.6%	N/A	N/A	N/A
35	Hawaii	1,288,198.00	47,817.00	N/A	N/A	N/A	N/A
36	Delaware	873,092.00	31,000.00	N/A	N/A	N/A	N/A
37	Mississippi	2,921,088.00	20,000.00	N/A	N/A	N/A	N/A
38	Nebraska	1,783,432.00	11,630.00	N/A	N/A	N/A	N/A
39	West Virginia	1,800,000.00	Unknown	N/A	N/A	N/A	N/A
			Average:	**10.0%**	**3%**	**8%**	**0%**

8.2 Demographic— Data Sources to be Used for Deaf and Hard of Hearing Population

Table 9.2 - Data Sources Used by States

State	Data Sources
Arizona	U.S. Census Bureau
California	State Department of Finance Estimates - 1990 and U.S. Census - 2008
Colorado	U.S. Department of Health and Human Services - July 2007
Connecticut	General Population from CT Dept of Health - 2008
Delaware	US Census Sensory Data - 2006 and US Census Bureau - July 2008
Florida	Florida Legislature Economic and Development Resource.
Hawaii	D/HH population from Gallaudet University Library FAQ - June 2004
Idaho	Formula set-forth by Gallaudet Research Institute (GRI)
Illinois	United States Department of Health and Human Services at 8.6%, Gallaudet University Research Institute, the Centers for Disease Control and Prevention, and National Center for Health Statistics.
Indiana	2003 US Census Bureau
Iowa	US Census
Kansas	Gallaudet Research Institute
Kentucky	US Census, University Research as of 2007
Louisiana	US Census - 07/08
Maine	National Institute on Deafness and Communication Disorder 2002
Maryland	US Census estimates for 2008
Massachusetts	US Department of Commerce, Bureau of the Census, 2000 Census- March 2001, National Center for Health Statistics
Michigan	Contracted State Survey
Minnesota (Comm.)	National Center for Health Statistics - 2006
Minnesota (DHHSD)	Gallaudet Research Institute
Mississippi	US Census Bureau & Gallaudet University Research Institute
Missouri	US Census Bureau - 2007, 10% inaccurate, CDC indicates better % is 14% including institutionalized persons
Nebraska	General Population from US Census 2008. D/HH population based on a number of registrations for various programs that Nebraska Commission offered in the past.
Nevada	
New Hampshire	US Census Bureau - 2000
New Mexico	
New Jersey	US Center for Health Statistics - 1994
New York	US Census - 2008 and NYSCQCAPD's website
North Carolina	15.32% for age 18 and up only. US Census Bureau and 2008 Series 10 report data from www.cdc.gov/nchs/nhis.htm
Oregon	US Census
Pennsylvania	US Census - 2000 and US Census 1990

8.2 Demographic— Data Sources to be Used for Deaf and Hard of Hearing Population (Continued)

Table 9.2 - Data Sources Used by States (continued)

State	Data Sources
Rhode Island	US Census 2001, Nat'l Center for Health Statistics- Nat'l Health Interview Survey-1994
Tennessee	1990 Census (figures were taken from the Tennessee Statistical Abstract 1994/1995)
Texas	2005 Census and 2005 National Health Interview Survey
Utah	US Census Bureau 2000
Virginia	National Center for Health Statistics - 2005
Washington	US Census - general population, Gallaudet Research Institute 2005 on D/HH
West Virginia	US Census Bureau
Wisconsin	US Census

9.0 Agency Website and E-Mail Addresses

9.1 Agency Website Addresses

Table 8.1 - Agency Website Addresses

State	Website
Arizona	www.acdhh.org
California	www.cdss.ca.gov/cdssweb/PG145.htm
Colorado	www.coloradodeafcommission.com
Connecticut	www.ct.gov/cdhi
Delaware	www.delawareworks.com/dvr/services/dodhh.shtml
Florida	www.fccdhh.org
Hawaii	www.hawaii.gov/health/dcab
Idaho	www.cdhh.idaho.gov
Illinois	www.idhhc.state.il.us
Indiana	www.dhhs.in.gov
Iowa	www.dsci.iowa.gov
Kansas	www.srskansas.org/kcdhh
Kentucky	www.kcdhh.org
Louisiana	www.dss.state.la.us
Maine	www.maine.gov/rehab/dod
Maryland	www.odhh.maryland.gov
Massachusetts	www.state.ma.us/MCDHH
Michigan	www.mcdc-dodhh.org
Minnesota (Comm.)	www.mncdhh.org
Minnesota (DHHSD)	www.dhhsd.org
Mississippi	www.odhh.org
Missouri	www.mcdhh.mo.gov
Nebraska	www.ncdhh.ne.gov
Nevada	www.dhhs.nv.gov
New Hampshire	www.ed.state.nh.us
New Mexico	www.cdhh.state.nm.us
New Jersey	www.state.nj.us/humanservices/ddhh/
New York	www.cqcapd.state.ny.us
North Carolina	www.ncdhhs.gov/dsdhh/
Oregon	www.oregon.gov/DHS/odhhs/index.shtml
Pennsylvania	www.dli.state.pa.us….Keyword: ODHH
Rhode Island	www.cdhh.ri.gov
Tennessee	www.tennessee.gov/humanserv/rehab/cc6.html
Texas	www.dars.state.tx.us/dhhs
Utah	www.deafservices.utah.gov
Virginia	www.vddhh.org
Washington	http://odhh.dshs.wa.gov
West Virginia	www.wvdhhr.org/wvcdhh
Wisconsin	http://dhs.wisconsin.gov/sensory/

9.2 Agency E-mail Addresses

These email addresses are used by the public to contact the agency. Specific individual's email address is not included.

Table 8.2 - Agency E-mail Addresses

State	Agency E-Mail Addresses
Arizona	info@acdhh.state.az.gov
California	deaf.access@dss.ca.gov
Colorado	email.ccdhh@state.co.us
Connecticut	cdhi@ct.gov
Hawaii	dcab@doh.hawaii.gov
Illinois	dhh.webmaster@illinois.gov
Iowa	dhr.dsci@iowa.gov
Kentucky	info_svcs@ky.gov
Maryland	odhh@gov.state.md.us
Massachusetts	See website for link to submit msgs
Michigan	DODHH@Michigan.gov
Minnesota (Comm.)	mncdhh.info@state.mn.us
Missouri	mcdhh@mcdhh.mo.gov
New York	webmaster@cqcapd.state.ny.us
North Carolina	DSDHH.Information@ncmail.net
Oregon	info.odhhs@state.or.us
Pennsylvania	ra-li-ovr-odhh@state.pa.us
Rhode Island	cdhh@cdhh.ri.gov
Tennessee	TCDHH.Council.DHS@tn.gov
Virginia	frontdsk@vddhh.virginia.gov
Washington	odhh@dshs.wa.gov
West Virginia	wvcdhh@wvdhhr.org

10.0 Agency Contact List

Arizona

Arizona Commission f/t D/HH
1400 W. Washington Street, Room 126
Phoenix, AZ 85007
800-352-8161 TOLL - V/TTY
602-542-3323 V/TTY
866-948-7035 VP
602-542-3380 FAX
info@acdhh.state.az.gov

California

Office of Deaf Access
744 P Street, M.S. 8-16-91
Sacramento, CA 95814
916-653-7651 TTY
916-653-8320 VOICE
916-653-4001 FAX
deaf.access@dss.ca.gov

Colorado

Colorado Commission f/t D/HH
1575 Sherman Street, 2nd Floor
Denver, Colorado 80203
303-866-4734 TTY
720-457-3679 VP
303-866-3824 VOICE
303-866-4831 FAX
email.ccdhh@state.co.us

Connecticut

Commission on the D/HI
P.O. Box 330730
67 Prospect Avenue
Hartford, CT 06133
800-708-6796 TOLL
860-231-8169 TTY
860-231-8756 VOICE
860-231-8746 FAX
cdhi@ct.gov

Delaware

Delaware Office f/t D/HH
Division of Vocational Rehabilitation
4425 North Market Street
Wilmington, DE 19802-1307
302-761-8275 TTY
302-504-4741 VP
302-761-8275 VOICE
302-761-6611 FAX
Loretta.Sarro@state.de.us

Florida

Florida Coordinating Council f/t D/HH
4052 Bald Cypress Way, Bin A06
4025 Esplanade Way, Room 235.10
Tallahassee, FL 32399-1707
866-602-3275 TOLL
850-245-4914 TTY
850-245-4913 VOICE
850-921-8138 FAX
MaryGrace_Tavel@doh.state.fl.us

Hawaii

Disability and Communication Access Board
919 Ala Moana Blvd. Room 101
Honolulu, Hawaii 96814
808-586-8121 TTY/Voice
866-552-3572 VP
808-586-8129 FAX
dcab@doh.hawaii.gov

Idaho

Idaho Council f/t D/HH
1720 Westgate Drive, Suite A
Boise, ID 83704
800-433-1323 TOLL/VOICE
800-433-1361 TTY
208-473-2122 VP
208-334-0952 FAX
snows2@dhw.idaho.gov

Illinois

Illinois D/HH Commission
1630 S. 6th Street
Springfield, IL 62703
877-455-3323 TOLL
217-557-4495 TTY
217-303-8010 VP
217-557-4495 VOICE
217-557-4492 FAX
dhh.webmaster@illinois.gov

Indiana

Indiana, D/HH, Employment and Innovation
402 W. Washington Street
IGCS – W453
Indianapolis, IN 46204
800-545-7763 TOLL
866-800-4634 VP
317-542-3325 FAX
Rhonda.Marcum@fssa.in.gov

10.0 Agency Contact List (continued)

Iowa

Deaf Services Commission of Iowa
Iowa Department of Human Rights
321 E 12th Street
Des Moines, IA 50319
888-221-3724 TOLL
515-281-3164 TTY
515-598-7327 VP
515-281-3164 VOICE
515-242-6119 FAX
dhr.dsci@iowa.gov

Kansas

Kansas Commission f/t D/HH
915 SW Harrison Street
Docking State Office Building, 9 N
Topeka, Kansas 66612
800-432-0698 TOLL
785-368-8046 TTY
785-246-5077 VP
785-368-8034 VOICE
785-368-7467 FAX

Kentucky

Kentucky Commission on the D/HH
632 Versailles Road
Frankfort, KY 40601
800-372-2907 TOLL
502-573-2604 TTY/VOICE
502-385-0544 VP
502-573-3594 FAX
Info_svcs@ky.gov

Louisiana

Louisiana Commission for the Deaf
627 North Fourth Street, 2nd Floor
P.O. Box 91297
Baton Rouge, LA 70821-9297
800-256-1523 TOLL – TTY/V
866-515-9928 VP
225-219-2949 FAX
ndedual@dss.state.la.us

Maine

Division f/t D, HH, and Late Deafened
42 Commerce Drive
Augusta, Maine 04333
888-755-0023 TTY
866-760-8430 VP
207-623-7957 VOICE
john.g.shattuck@maine.gov

Maryland

Maryland Governor's Office of the D/HH
217 E. Redwood Street
Suite 1300
Baltimore, MD 21202
410-767-7756 TTY
443-453-5954 VP
410-767-6290 VOICE
410-333-1016 FAX
odhh@gov.state.md.us

Massachusetts

Massachusetts Commission f/t D/HH
150 Mount Vernon Street, Suite 550
Dorchester, MA 02125
800-530-7570 TTY
800-882-1155 VOICE
617-740-1700 TTY
866-970-7177 VP
617-740-1600 VOICE
617-740-1810 FAX

Michigan

Division on Deaf and Hard of Hearing
201 N Washington Sq. Suite 150
Lansing, MI 48913
877-499-6232 TOLL – TTY/VOICE
517-507-5223 VP
517-335-7773 FAX
DODHH@Michigan.gov

Minnesota I

Commission of D/D-Blind/HH Minnesotans
444 Lafayette Road North
St. Paul, MN 55155-3814
888-206-2001 TTY
651-964-2060 VP
651-431-5961 VOICE
651-431-7588 FAX
mncdhh.info@state.mn.us

Minnesota II

Deaf and Hard of Hearing Services Division
Elmer Andersen Human Services Building
540 Cedar Street
St. Paul, MN 55155
888-206-6506 TTY
651-964-1452 VP
651-431-2355 VOICE
651-431-7417 FAX

10.0 Agency Contact List (continued)

Mississippi
Office on Deaf and Hard of Hearing
3895 Beasley Road
Jackson, MS 39213
601-898-7056 TTY
601-206-0228 VP
601-898-7057 VOICE
601-898-7098 FAX
benjamin.wagenknecht@mdrs.state.ms.us

Missouri
Missouri Commission f/t D/HH
1500 Southridge Drive
Suite 201
Jefferson City, MO 65109
573-526-5205 TTY/VOICE
573-526-5209 FAX
mcdhh@mcdhh.mo.gov

Nebraska
Nebraska Commission f/t D/HH
4600 Valley Road
Lincoln, NE 68510
800-545-6244 TOLL
402-471-3593 TTY/VOICE
402-471-3067 FAX

Nevada
Aging & Disability Svcs Div.– Disabilities Unit
3656 Research Way
Suite 32
Carson City, NV 89706
888-337-3839 TOLL
775-687-3388 TTY
775-687-4452 VOICE
775-687-3292 FAX
bahammond@adsd.nv.gov

New Hampshire
Office of the Deaf and Hard of Hearing
21 South Fruit Street, Suite 200
Concord, NH 03301
603-271-1483 TTY
646-863-7075 VP
603-271-3471 VOICE
603-271-7095 FAX
hdclanton@ed.state.nh.us

New Mexico
New Mexico Commission f/t D/HH Persons
2500 Louisiana Blvd.
Suite 400
Albuquerque, NM 87110
866-755-0242 TOLL
505-881-8824 TTY/VP/VOICE
505-881-8831 FAX

New Jersey
New Jersey Division of the D/HH
222 South Warren Street
Trenton, NJ 08625
609-984-7281 TTY/VOICE
609-498-7019 VP
609-633-3625 FAX

New York
NYS Interagency Coordinating Council for Services to Persons who are Deaf, Deaf-Blind, or Hard of Hearing
NYS Commission on Quality of Care and Advocacy for Persons with Disabilities
401 State Street
Schenectady, NY 12305-2397
800-624-4143 TOLL – TTY/VOICE
518-388-0691 VOICE
518-388-3375 FAX
webmaster@cqcapd.state.ny.us

North Carolina
NC Division of Services f/t D/HH
2301 Mail Service Center
Raleigh, NC 27699-2301
800-851-6099 TOLL
919-874-2212 TTY/VP/VOICE
919-855-6872 FAX
DSDHH.Information@ncmail.net

Oregon
Dept of Human Svcs D/HH Services Pgm
500 Summer Street NE
Salem, OR 97301
800-521-9615 TOLL
503-947-5183 TTY/VOICE
503-947-5184 FAX
Info.odhhs@state.or.us

10.0 Agency Contact List (continued)

Pennsylvania
Pennsylvania Office f/t D/HH
1521 North 6th Street
Harrisburg, PA 17102
800-233-3088 TOLL – TTY/VOICE
717-783-4912 TTY/VOICE
866-572-2628 VP
717-783-4913 FAX
ra-li-ovr-odhh@state.pa.us

Rhode Island
Rhode Island Commission on the D/HH
One Capitol Hill, Ground Level
Providence, RI 02908
401-222-1205 TTY
401-256-5511 VP
401-222-1204 VOICE
401-222-5736 FAX
cdhh@cdhh.ri.gov

Tennessee
Tennessee Council f/t D/HH
Citizens Plaza Building, 14th Floor
400 Deaderick Street
Nashville, TN 37243
800-270-1349 TTY
615-313-4918 VOICE
615-532-4685 FAX
TCDHH.Council.DHS@tn.gov

Texas
Office for D/HH Services
P.O. Box 12904
Austin, TX 78711
512-407-3251 TTY
512-410-6556 VP
512-407-3250 VOICE
512-407-3299 FAX
david.myers@dars.state.tx.us

Utah
Division of Services f/t D/HH
Sanderson Community Center of the D/HH
5709 South 1500 West
Taylorsville, UT 84123
801-313-6815 TTY
801-657-5200 VP
801-263-4861 VOICE
801-263-4865 FAX
mcall@utah.gov

Virginia
Virginia Department f/t D/HH
1602 Rolling Hills Drive
Suite 203
Richmond, VA 23229-5012
800-552-7917 TOLL
804-662-9502 TTY
804-325-1290 VP
804-662-9502 VOICE
804-662-9718 FAX
frontdsk@vddhh.virginia.gov

Washington
Office of the Deaf and Hard of Hearing
P.O. Box 45301
Olympia, WA 98503-5300
800-422-7930 TOLL
360-902-8000 TTY/VOICE
360-339-7382 VP
360-902-0855 FAX
odhh@dshs.wa.gov

West Virginia
West Virginia Commission f/t D/HH
Capitol Complex
Building 6, Room 863
Charleston, WV 25305
866-461-3578 TOLL
304-558-1675 TTY/VOICE
304-205-0330 VP
304-558-0937 FAX
wvcdhh@wvdhhr.org

Wisconsin
Office for the Deaf and Hard of Hearing
1 West Wilson Street #451
Madison, WI 53703
888-701-1251 TTY
608-266-1865 VOICE

2009 Survey Questionnaire

WWW.MONKEYSURVEY.COM

Data Collection Process
October 2009-December 2009

GENERAL INFORMATION

Please fill in your State Agency contact information:

Name of Agency: _____
Address: _____
Address2: _____
City: _____ State: _____Zip Code: _____

Toll-free number: ( ) _____-_____
Main phone number - TTY: ( ) _____-_____
Main phone number - VP: ( ) _____-_____
Main phone number - Voice: ( ) _____-_____
Fax number: ( ) _____-_____
Agency E-mail address: _____
Website address: _____
Agency founded (MM/DD/YYYY):_____/_____/_____

What is location of your agency? Under what agency or department?

_____

Since 2004, has your agency merged with any other agencies, expanded, downsized, or reorganized as required by law or executive order? If yes, please explain the impact on your agency in general. Positive? Increase restrictions? Challenges?

_____
_____
_____
_____

GENERAL ADMINISTRATION INFORMATION

Name of Administrator: _____

What is the title of administrator's position? (Examples: Executive Director, Commissioner, Director, etc.)

Hearing Status?

- □ Deaf
- □ Hard of Hearing
- □ Late-Deafened
- □ Hearing

Which one of the following listed below best matches your Administrator's position?

- □ Civil Service Classified Position
- □ Governor appointed position
- □ Report directly to Governor
- □ Other (please specific): _____

What is Annual Salary of the Administrator? Please check one. (confidential)

- □ $0 to $25,000
- □ $25,001 to $35,000
- □ $35,001 to $45,000
- □ $45,001 to $55,000
- □ $55,001 to $65,000
- □ $65,001 to $75,000
- □ $75,001 to $85,000
- □ $85,001 and higher

Administrator's contact information:

E-mail address: _____
Videophone: _____
Phone - Voice:_____
Fax number: _____

COMPOSITION OF COMMISSION, COUNCIL, OR BOARD

Number of Members serving on commission, council, or board?

_____

One Term = how many year?

_____

Appointed by:

- □ Governor
- □ Department Administrator
- □ Legislature
- □ Other (please specify): _____

Does your law requires a majority number of deaf and hard of hearing representatives?

- □ Yes
- □ No

What representations on your commission, council, or board does your law require? (Please check all that apply.)

- □ not required
- □ hard of hearing
- □ psychologist
- □ physician, otolaryngolsist
- □ state government official
- □ deaf organization representative
- □ hard of hearing organization representative
- □ late deafened organization representative
- □ general public
- □ deaf
- □ audiologist
- □ educator
- □ parent
- □ early intervention provider
- □ interpreter organization

- □ hearing
- □ local(regional) representative
- □ Other (please specify): _____

Minimum number of regular meetings in a year as required by the law.

_____

What communication access accommodation(s) is automatically and routinely arranged for the regular meeting? Any accommodation that would not require a special request in advance? (Please check all that apply.)

- □ Interpreter
- □ CART
- □ Assistive Listening System (ALS)
- □ Assistive Listening Device (ALD)
- □ Video Remote Interpreter (VRI)
- □ Remote CART
- □ Other (please specify): _____

Are the members reimbursed for travel expenses?

- □ Yes
- □ No
- □ Other (please specify): _____

FUNDING (Fiscal Year 2010)

What is your fiscal year cycle?

- □ October 1 to September 30
- □ January 1 to December 31
- □ July 1 to June 30
- □ Other (please specify): _____

Total authorized (enacted) budget for Fiscal Year 2010? (e.g.: $560,000)

_____

Is your authorized (enacted) budget good for …..

- □ One year (annual)?
- □ Two years (biennial)?
- □ Other (please specify): _____

Funding Source(s) (Please check all that apply.):

- □ State appropriation (What % is state funded? _____%)
- □ Federal
- □ Third party contract (MOU, Agreements, etc.)
- □ Grants (state and/or federal)
- □ Fees
- □ Donations/gifts
- □ Other (please specify):
  _____

STAFF AT YOUR AGENCY

Please fill in:

- ✦ Number of full-time equivalent (FTE) staff positions (administrator included.):

_____

- ✦ Number of part-time positions Number of staff members who are deaf: _____
- ✦ Number of staff members who are hard of hearing: _____
- ✦ Number of staff members who are late-deafened: _____
- ✦ Number of staff members who are hearing: _____
- ✦ Number of staff members who are deaf, HoH, or LateD **PLUS** other disability:

_____

Please list staff positions that are part of your agency (please attached if you have many positions that might not fit in this section.):

_____

_____

Please check all that apply closely and list other services that are not on this list.

- □ Adult/Community Education
- □ Advocacy
- □ Assistive Technology
- □ Counseling
- □ Client Assistance
- □ Deaf Awareness/Orientation/Training
- □ Deaf Festival
- □ Equipment Loan
- □ Emergency Needs
- □ Information and Referral
- □ Interpreter Directory
- □ Interpreter Referral
- □ CART Referral
- □ Interpreter Services (direct)
- □ Interpreter Qualifying and Licensing
- □ Interpreter Training and Workshop
- □ Video Remote Interpreting Service
- □ Remote CART Service
- □ Job Development and Placement
- □ Lending Library
- □ Newsletter
- □ Research
- □ Senior Citizens Services
- □ Deaf Blind Services
- □ Services to Hard of Hearing
- □ Sign Language Instruction/Classes
- □ Technical Assistance
- □ Relay Service
- □ Telecommunication Distribution program
- □ Other (please specify): _____

DEMOGRAPHICS

Questions about your population in your State

✦ What is the combined deaf and hard of hearing population estimate of your state? _____

✦ What is the total general population in your state?:_____

✦ What data source do you use to compute the estimates? U.S. Census Bureau? U.S. Department of Health? As of WHEN? Please be specific.:

_____

✦ What percentage do you use to compute the population of Deaf and Hard of Hearing?: _____

✦ Please put 'N/A' if you do not have it, what percentage do you use to compute the population of DEAF only?: _____

✦ Please put 'N/A' if you do not have it, what percentage do you use to compute the population of Hard of Hearing only?: _____

Please put 'N/A' if you do not have it, what percentage do you use to compute the population of Deaf-blind? : _____

Any general comments?

_____

_____

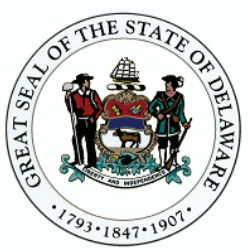
_____


GREAT SEAL OF THE STATE OF ARIZONA
DITAT DEUS
1912

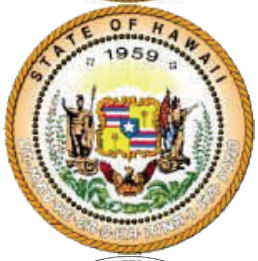

THE GREAT SEAL OF THE STATE OF CALIFORNIA
EUREKA


STATE OF COLORADO
NIL SINE NUMINE
1876


SIGILLUM REIPUBLICÆ CONNECTICUTENSIS


GREAT SEAL OF THE STATE OF DELAWARE
1793 1847 1907


GREAT SEAL OF THE STATE OF FLORIDA
IN GOD WE TRUST


STATE OF HAWAII
1959


GREAT SEAL OF THE STATE OF IDAHO
ESTO PERPETUA


SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818


SEAL OF THE STATE OF INDIANA
1816

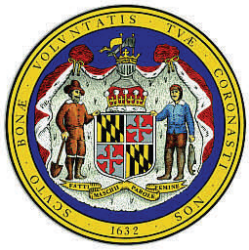

THE GREAT SEAL OF THE STATE OF IOWA


GREAT SEAL OF THE STATE OF KANSAS
AD ASTRA PER ASPERA
JANUARY 29, 1861


COMMONWEALTH OF KENTUCKY
UNITED WE STAND
DIVIDED WE FALL

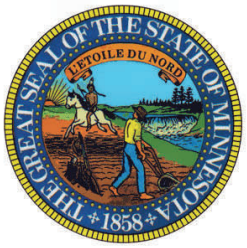

STATE OF LOUISIANA
UNION · JUSTICE
CONFIDENCE


MAINE


BONÆ VOLVNTATIS TVÆ CORONASTI NOS
SCVTO
1632

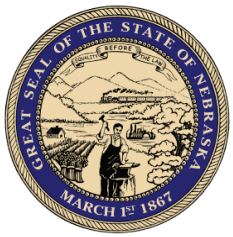

SIGILLUM REIPUBLICÆ MASSACHUSETTENSIS.


THE GREAT SEAL OF THE STATE OF MICHIGAN
TUEBOR
CIRCUMSPICE


THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

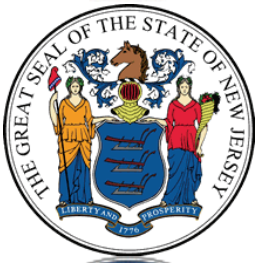

THE GREAT SEAL OF THE STATE OF MISSISSIPPI


THE GREAT SEAL OF THE STATE OF MISSOURI

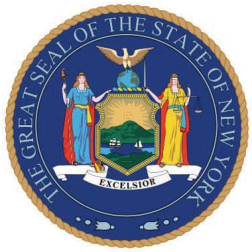

GREAT SEAL OF THE STATE OF NEBRASKA
MARCH 1ST 1867

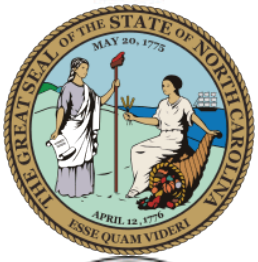

THE GREAT SEAL OF THE STATE OF NEVADA


SEAL OF THE STATE OF NEW HAMPSHIRE
1776


THE GREAT SEAL OF THE STATE OF NEW JERSEY
LIBERTY AND PROSPERITY
1776


GREAT SEAL OF THE STATE OF NEW MEXICO
1912


THE GREAT SEAL OF THE STATE OF NEW YORK
EXCELSIOR


THE GREAT SEAL OF THE STATE OF NORTH CAROLINA
MAY 20, 1775
APRIL 12, 1776
ESSE QUAM VIDERI


STATE OF OREGON
THE UNION
1859


SEAL OF THE STATE OF PENNSYLVANIA


SEAL OF THE STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
HOPE
1693


THE GREAT SEAL OF THE STATE OF TENNESSEE
XVI
AGRICULTURE
COMMERCE
1796


THE STATE OF TEXAS


THE GREAT SEAL OF THE STATE OF UTAH
1847
1896


VIRGINIA
SIC SEMPER TYRANNIS


THE SEAL OF THE STATE OF WASHINGTON
1889


STATE OF WEST VIRGINIA
MONTANI SEMPER LIBERI


GREAT SEAL OF THE STATE OF WISCONSIN

PROGRAM PRIORITIZATION FOR 2017-19

Agency Name: Department of Human Services

2017-19 Biennium **Agency Number: 10000**

Agency-Wide Priorities for 2017-19 Biennium

1	2	3	4a	4b	4c	4d	6	7	8	9	10	12	13	14	15	16	17	18	19	20	21	22
Priority (ranked with highest priority first)		**Agency Initials**	**Program or Activity Initials**	**SCR**	**Program Unit/Activity Description (DCR)**	**Sub-DCR**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**New or Enhanced Program (Y/N)**	**Included as Reduction Option (Y/N)**	**Legal Req. Code (C, D, FM, FO, S)**	**Legal Citation**	**Explain What is Mandatory (for C, FM, and FO Only)**	**Comments on Proposed Changes to CSL included in Agency Request**
Agcy	**Prgm/ Div**																					
DHS	APD	DHS	APD	060-08	APD Program	Nursing Facilities	Seniors living outside of institutions	12	142,173,590	0	155,133,449	512,074,291	0	$ 809,381,330	0	0.00	N	Y	FM	42 CFR 483	Under Title XIX of the Social Security Act, institutional long term care is provided to low income seniors.	
DHS	CW	DHS	CW	060-02	Community Based Domestic Violence Services		Absence of repeat maltreatment	12	448,251	0	3,268,895	2,568,342	0	$ 6,285,488	0	0.00	N	Y	S	ORS 418	Federal opportunity to contract for community based domestic violence services.	
DHS	APD	DHS	APD	060-08	APD Program	Community-Based Care Facilities	People with disabilities in community settings	12	253,611,174	0	14,091,754	580,559,997	0	$ 848,262,925	0	0.00	N	N	FO	42 CFR 440.180		
DHS	I/DD	DHS	I/DD	060-09	I/DD Program	K Plan Services (Includes Day Hab)	People with disabilities in community settings	12	673,245,775	0	7,164,734	1,487,944,637	0	$ 2,168,355,146	0	0.00	N	N	FO	OR 427		POP 105 Stable and Competent Workforce for I/DD Services
DHS	I/DD	DHS	I/DD	060-09	I/DD Program	Waiver Services - Employment First (DD 54-No Day Hab)	People with disabilities in community settings	12	40,501,628	0	0	69,670,644	0	$ 110,172,272	0	0.00	N	N	FM	OR 427		POP 105 Stable and Competent Workforce for I/DD Services
DHS	I/DD	DHS	I/DD	060-09	I/DD Program	Waiver Services - No Employment DD 54	People with disabilities in community settings	12	8,930,693	0	8,424,000	9,382,906	0	$ 26,737,599	0	0.00	N	N	FM	OR 427		Nothing
DHS	I/DD	DHS	I/DD	060-09	I/DD Program	Stabilization and Crisis Unit (group homes)	People with disabilities in community settings	12	49,259,506	0	2,017,778	79,029,432	0	$ 130,306,716	745	745.00	N	N	S	ORS 427		Nothing
DHS	CW	DHS	CW	060-02	Community Based Sexual Assault Victims Fund			12	78,965	0	518,399	0	0	$ 597,364	0	0.00	N	Y	S	ORS 418.005	Federal opportunity to contract for community based sexual assault services.	
DHS	CW	DHS	CW	060-02	Foster Care	Foster Care Prevention	Timeliness and permanency of child reunification	12	780,303	0	87,603	2,510,135	0	$ 3,378,041	0	0.00	N		FM	ORS 418.005-.036	Federal opportunity to utilize federal funds to support foster care prevention services.	
DHS	CW	DHS	CW	060-03	Foster Care	Foster Family Shelter Care		12	3,201,863	0	365,442	920,113	0	$ 4,487,418	0	0.00	N	Y	FM	ORS 418.005, 418.470, 418-495, 418.647	Federal regulations for State to operate a Foster Care System - and claim Title IV-E for shelter placements.	POP 108 Family Foster Care Rate Reimbursement
DHS	CW	DHS	CW	060-03	Other Tribal Programs			12	765,030	0	31,501	1,683,551	0	$ 2,480,082	0	0.00	N		FO	ORS 418	Allows the State to provide Title IV-E payments for children in Tribal child welfare programs.	
DHS	CW	DHS	CW	060-03	Foster Care	Regular Foster Care	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	69,893,823	0	8,822,556	37,380,677	0	$ 116,097,056	0	0.00	N		FM	ORS 418.005 - .036, 418-495, 418.647	Federal regulations for State to operate a Foster Care System - and claim Title IV-E to support foster care services.	POP 108 Family Foster Care Rate Reimbursement
DHS	CW	DHS	CW	060-03	Foster Care	Enhanced Supervision	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	7,005,338	0	927,185	3,859,500	0	$ 11,792,023	0	0.00	N		FO	ORS 418.005 - .036 , 418-495, 418.647	Federal regulations State to operate a Foster Care System - and claim Title IV-E for enhanced supervision to keep children safe.	POP 108 Family Foster Care Rate Reimbursement
DHS	CW	DHS	CW	060-03	Foster Care	Personal Care	Teen suicide, Absence of repeat maltreatment	12	2,391,651	0	195,293	2,326,766	0	$ 4,913,710	0	0.00	N	Y	S	ORS 418.005 - .036, 418-495	Federal opportunity to utilize federal funds to support children's extraordinary medical needs in their foster care setting.	POP 108 Family Foster Care Rate Reimbursement

Agency-Wide Priorities for 2017-19 Biennium																							
1	2	3	4a	4b	4c	4d	6	7	8	9	10	12	13	14	15	16	17	18	19	20	21	22	
Priority (ranked with highest priority first)		Agency Initials	Program or Activity Initials	SCR	Program Unit/Activity Description (DCR)	Sub-DCR	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or Enhanced Program (Y/N)	Included as Reduction Option (Y/N)	Legal Req. Code (C, D, FM, FO, S)	Legal Citation	Explain What is Mandatory (for C, FM, and FO Only)	Comments on Proposed Changes to CSL included in Agency Request	
Agcy	Prgm/ Div																						
DHS	CW	DHS	CW	060-03	Foster Care	Independent Living Services	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	1,607,670	0	126,336	7,979,164	0	$ 9,713,170	0	0.00	N		FM	ORS 418.005 - .036	Federal opportunity to utilize federal funds/GRANT to support youth in developing skills and support higher education and housing needs as they transition out of care.		
DHS	CW	DHS	CW	060-03	Foster Care	Nursing Assessments	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	29,631	0	6,602	(684)	0	$ 35,549	0	0.00	N		FO	ORS 418.005 - .036, 418-495	Federal opportunity to utilize federal funds to assure children's medical needs are met when they are in out of home care.		
DHS	CW	DHS	CW	060-03	Foster Care	Other Medical	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	5,044,802	0	23,710	0	0	$ 5,068,512	0	0.00	N	Y	S	ORS 418.005 - .036	General Fund program that allows the Department to obtain necessary evaluations on family members to facilitate timely services and reunification.		
DHS	CW	DHS	CW	060-03	Foster Care	Client Transportation	Timeliness and permanency of child reunification	12	4,739,060	0	936,111	722,516	0	$ 6,397,687	0	0.00	N	Y	S	ORS 418.005 - .036 418	Federal opportunity to utilize federal funds to provide necessary transportation for visitation and other necessary case related purposes, includes education related transportation.		
DHS	CW	DHS	CW	060-03	Foster Care	IV-E Waiver Care	Timeliness and permanency of child reunification	12	2,264,340	0	35,788	3,821,248	0	$ 6,121,376	0	0.00	N		FO	ORS 418.590	Federal opportunity to utilize federal funds to test alternative theories to improve child welfare services and achieve timely, safe reunification.		
DHS	CW	DHS	CW	060-03	Foster Care	Contracted Foster Care Svc	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	599,609	0	23,835	403,788	0	$ 1,027,232	0	0.00	N		FO	ORS 418.005 - .036, 418-495	Federal regulations for State to operate a Foster Care System and contract for services as appropriate to meet the needs of children.		
DHS	CW	DHS	CW	060-03	Foster Care	Interstate Compacts	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	484,062	0	16,427	308,974	0	$ 809,463	0	0.00	N		FM	ORS 418.005 - .036 , 418-495, 418.647	Federal opportunity to utilize federal funds to assure safe and stable placements for children placed with a relative in another state.		
DHS	CW	DHS	CW	060-03	Residential Care	Residential Treatment	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	30,395,910	0	4,275,508	42,465,750	0	$ 77,137,168	0	0.00	N		FO	ORS 418, 005-.036, 418-495	Federal regulations for State to operate a Foster Care System including residential services for children who qualify and will benefit from such services.	POP 109 Behavioral Rehabilitation Services - Daily Rate Increase	
DHS	CW	DHS	CW	060-03	Residential Care	Target Children	Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	4,922,774	0	417,379	5,696,523	0	$ 11,036,676	0	0.00	N		FO	ORS 418-.005 -.036, 418-495	Federal regulations for State to operate a Foster Care System and contract for child specific services to meet children's extraordinary needs.		
DHS	CW	DHS	CW	060-02	In-Home Safety and Reunification Services			12	7,506,060	0	196,102	10,708,825	0	$ 18,410,987	0	0.00	N	Y	S	ORS 418	Enables the State to write contracts to support keeping children safely at home or returning them home with continuing services.		

Agency-Wide Priorities for 2017-19 Biennium																							
1	2	3	4a	4b	4c	4d	6	7	8	9	10	12	13	14	15	16	17	18	19	20	21	22	
Priority (ranked with highest priority first)		Agency Initials	Program or Activity Initials	SCR	Program Unit/Activity Description (DCR)	Sub-DCR	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or Enhanced Program (Y/N)	Included as Reduction Option (Y/N)	Legal Req. Code (C, D, FM, FO, S)	Legal Citation	Explain What is Mandatory (for C, FM, and FO Only)	Comments on Proposed Changes to CSL included in Agency Request	
Agcy	Prgm/ Div																						
DHS	CW	DHS	CW	060-02	Recovering Families Mutual Homes		Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	429,880	0	152	342,440	0	$ 772,472	0	0.00	N	Y	FO	ORS 418	Federal opportunity to contract with Alcohol and Drug free housing.		
DHS	CW	DHS	CW	060-02	Family Support Teams		Absence of repeat maltreatment	12	2,092,557	0	288,397	3,689,560	0	$ 6,070,514	0	0.00	N		FO	ORS 418	Federal opportunity to contract with Alcohol and Drug counseling and intervention services.		
DHS	CW	DHS	CW	060-03	System of Care		Absence of repeat maltreatment	12	3,934,032	0	331,328	8,504,050	0	$ 12,769,410	0	0.00	N	Y		ORS 418	Program that allows the Department to provide services to support children and families obtain necessary evaluations on family members to facilitate timely services and reunification.		
DHS	CW	DHS	CW	060-02	Strengtheng, Presrvg & Reunfg Families (SPRF)			12	12,436,097	0	0	18,375,433	0	$ 30,811,530	0	0.00	N	Y	S	ORS 418	Program that allows the Department to provide services to support children and families to maintain children safely at home and facilitate timely reunification.		
DHS	CW	DHS	CW	060-04	Guardianship Assistance		Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	6,903,999	0	760,342	13,631,255	0	$ 21,295,596	0	0.00	N		FO &S	ORS 418.330-340	Federal opportunity to provide GA to IV-E eligible children.		
DHS	CW	DHS	CW	060-04	Adoption Assistance		Timely adoption, Timeliness and permanency of child reunification	12	68,116,665	0	196,953	67,405,753	0	$ 135,719,371	0	0.00	N		FM	ORS 418.330-340	Federal requirement to provide AA to IV-E eligible children.		
DHS	CW	DHS	CW	060-04	Post Adoption-Services		Timely adoption, Timeliness and permanency of child reunification	12	190,604	0	57	1,037,830	0	$ 1,228,491	0	0.00	N	Y	FM	ORS 418	Federal requirement to spend applicable child GF on post adoption services.		
DHS	SS	DHS	SS	060-01	Supplemental Nutrition Asst. Program	EBT SNAP	Food stamp utilization, Food stamp accuracy	12	0	0	0	0	2,122,011,827	$ 2,122,011,827	0	0.00		N	FM	SNAP is guided by federal legislation found in the "Farm Bill" authorized by the Agricultural Act of 2014 (P.L. 113-79, Feb. 7,2014). Program policy is reauthorized every five years through the Farm Bill.			
DHS	SS	DHS	SS	060-01	Supplemental Nutrition Asst. Program	SNAP Cashout	Food stamp utilization, Food stamp accuracy	12	0	0	0	0	92,333,504	$ 92,333,504	0	0.00		N	FM	SNAP is guided by federal legislation found in the "Farm Bill" authorized by the Agricultural Act of 2014 (P.L. 113-79, Feb. 7,2014). Program policy is reauthorized every five years through the Farm Bill.			
DHS	APD	DHS	APD	060-08	Disability Determination Services Program		Seniors living outside of institutions	12	0	0	0	17,950,845	0	$ 17,950,845	0	0.00	N	N					
DHS	SS	DHS	SS	060-01	Supplemental Nutrition Asst. Program	SNAP Employment and Training	Food stamp utilization, Food stamp accuracy	12	727,896	0	0	4,987,216	0	$ 5,715,112	0	0.00		N	FM	This program is mandated by federal legislation found in the Food and Nutrition Act of 2008, authorized by the 2008 Farm Bill.			
DHS	APD	DHS	APD	060-08	APD Program	In-home Program	Seniors living outside of institutions	12	346,018,375	0	4,589,092	784,422,127	0	$ 1,135,029,594	0	0.00	N	N	FO	42 CFR 440.180			
S+A46	SS	DHS	SS	060-01	Food Assistance		Food stamp utilization, Food stamp accuracy	12	4,637,833	0	0	2,381,769	0	$ 7,019,602				N	FO	7 CFR Part 247 and 250; Emergency Food Assistance Act of 1983;FNS Instructions 716-3, 410-1, and 113-1; Oregon Revised Statutes 458.530; Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.)			

Agency-Wide Priorities for 2017-19 Biennium																							
1	2	3	4a	4b	4c	4d	6	7	8	9	10	12	13	14	15	16	17	18	19	20	21	22
Priority (ranked with highest priority first)		Agency Initials	Program or Activity Initials	SCR	Program Unit/Activity Description (DCR)	Sub-DCR	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or Enhanced Program (Y/N)	Included as Reduction Option (Y/N)	Legal Req. Code (C, D, FM, FO, S)	Legal Citation	Explain What is Mandatory (for C, FM, and FO Only)	Comments on Proposed Changes to CSL included in Agency Request
Agcy	Prgm/ Div																					
DHS	SS	DHS	SS	060-01	Family Support and Connections		TANF re-entry, TANF family stability	12	275,719	0	0	3,943,763	0	$ 4,219,482	0	0.00		N	FO	Title II of the Child Abuse Prevention and Treatment Act (CAPTA), as amended by P.L. 111-320, authorizes grant funds to be released to the states and names the program Community-Based Grants for the Prevention of Child Abuse and Neglect (CBCAP).		
DHS	SS	DHS	SS	060-01	TA Domestic Violence Survivors		TANF re-entry, TANF family stability, Absence of repeat maltreatment	12	0	0	0	8,693,857	0	$ 8,693,857	0	0.00		N	FO	ORS 411.117 (1) (e)		
DHS	SS	DHS	SS	060-01	Cash Assistance	TANF Basic	TANF re-entry, TANF family stability	12	62,715,999	0	358,400	165,348,240	0	$ 228,422,639	0	0.00		Y	FO	The TANF program is authorized under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Act, as amended by the Work Opportunity Reconciliation Act of 199 (PRWORA), and the Deficit Reduction Act of 2005. State Statue chapters are 411 and 412.		
DHS	SS	DHS	SS	060-01	Cash Assistance	TANF UN	TANF re-entry, TANF family stability	12	47,987,214	0	640	0	0	$ 47,987,854	0	0.00		N	FO	State Statutes Chapters 411 and 412.		
DHS	SS	DHS	SS	060-01	Cash Assistance	State Family Pre SSI/SSDI	TANF re-entry, TANF family stability	12	3,794,181	0	1,688,072	0	0	$ 5,482,253	0	0.00		N	FO	State Statutes Chapters 411 and 412.		
DHS	I/DD	DHS	I/DD	060-09	I/DD Program	Other Services (Includes Housing)	People with disabilities in community settings	12	2,805,330	0	3,868,196	3,071	0	$ 6,676,597	0	0.00	N	Y	S	OR 427		Nothing
DHS	SS	DHS	SS	060-01	JOBS Contracts/Support Services Activities	TANF Programs	TANF re-entry, TANF family stability	12	44,747,215	0	184,320	36,958,972	0	$ 81,890,507	0	0.00		N	FO	State Statutes Chapters 411 and 412.		
DHS	VR	DHS	VR	060-07	VR - Basic Rehabilitative Services		Vocational rehabilitation services employment	12	9,263,851	0	1,930,972	42,334,173	0	$ 53,528,996	0	0.00	N	N	FM	34 CFR 361, 34 CFR 363, 34 CFR 397	Provision of services to individuals with disabilities to assist them to obtain, maintain, regain and advance in employment.	Youth Transition and Career Technical Education - This POP will provide equitable access for students with disabilities into CTE programs and other pre-employment training opportunities like career pathways at community colleges as well as non-traditional education entry points such as apprentices and trades programs.
DHS	VR	DHS	VR	060-07	State Independent Living Council (SILC)		Vocational rehabilitation services employment	12	1,838,647	0	0	534,362	0	$ 2,373,009	0	0.00	N	N	FM	45 CFR 1329	Support of the Centers for Independent Living to provide services to individuals with disabilities to give them the capability of living as independently as possible	Nothing was submitted.
DHS	APD	DHS	APD	060-08	APD Program	Other Services		12	3,945,755	0	1,955,077	11,554,647	0	$ 17,455,479	0	0.00	N	Y				
DHS	APD	DHS	APD	060-08	APD Program	Older Americans Act	Access to I&R and I&A	12	2,153,981	0	0	32,204,050	0	$ 34,358,031	0	0.00	N	N	FM	42 CFR Chapter 35		
DHS	APD	DHS	APD	060-08	APD Program	Oregon Project Independence	Seniors living outside of institutions	12	5,077,755	0	0	(1)	0	$ 5,077,754	0	0.00	N	Y		ORS 410.422		
DHS	SS	DHS	SS	060-01	Employment Related Daycare		Enhanced child care	12	84,773,581	0	87,854,185	0	0	$ 172,627,766	0	0.00		Y	FO	ORS 409.010(2)©, 411.141 and 418.485		
DHS	SS	DHS	SS	060-01	Refugee Program			12	0	0	0	13,740,633	0	$ 13,740,633	0	0.00		N	FO	ORS 411.060, 409.010(2) ©, 409.010(2) (h)		
DHS	APD	DHS	APD	060-08	APD Program	Oregon Supplemental Income Program (OSIP)		12	12,516,590	0	0	0	0	$ 12,516,590	0	0.00	N	N	FO	ORS 411.706		
DHS	SS	DHS	SS	060-01	Cash Assistance	TANF Transition	TANF re-entry, TANF family stability	12	3,230,385	0	0	0	0	$ 3,230,385	0	0.00		N	FO	State Statutes Chapters 411 and 412.		
DHS	SS	DHS	SS	060-01	Youth Services			12	0	0	0	910,829	0	$ 910,829	0	0.00		N	FO	The Title V Federal Abstinence Education Program Grant		
DHS	CW	DHS	CW	060-04	Private Adoption Services		Timely adoption, Timeliness and permanency of child reunification	12	539,803	0	0	663,719	0	$ 1,203,522	0	0.00	N	Y	S	ORS 418 and ORS 109.304-410		
DHS	CW	DHS	CW	060-04	Contracted Adoption Services		Timely adoption, Timeliness and permanency of child reunification	12	2,223,678	0	0	2,067,254	0	$ 4,290,932	0	0.00	N	Y	S	ORS 418 and ORS 109.304-410		

Agency-Wide Priorities for 2017-19 Biennium																							
1	2	3	4a	4b	4c	4d	6	7	8	9	10	12	13	14	15	16	17	18	19	20	21	22	
Priority (ranked with highest priority first)		**Agency Initials**	**Program or Activity Initials**	**SCR**	**Program Unit/Activity Description (DCR)**	**Sub-DCR**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**New or Enhanced Program (Y/N)**	**Included as Reduction Option (Y/N)**	**Legal Req. Code (C, D, FM, FO, S)**	**Legal Citation**	**Explain What is Mandatory (for C, FM, and FO Only)**	**Comments on Proposed Changes to CSL included in Agency Request**	
Agcy	**Prgm/ Div**																						
DHS	CW	DHS	CW	060-04	Independent Adoption Services		Timely adoption, Timeliness and permanency of child reunification	12	0	0	246,106	0	0	$ 246,106	0	0.00	N		S	ORS 109.315			
DHS	CW	DHS	CW	060-04	Assisted Search Services		Timely adoption, Timeliness and permanency of child reunification	12	0	0	89,557	0	0	$ 89,557	0	0.00	N		S	ORS 109.425-507			
DHS	CW	DHS	CW	060-03	Youth Investment Programs		Timely adoption, Absence of repeat maltreatment, Timeliness and permanency of child reunification	12	2,922,243	0	0	8,970,317	0	$ 11,892,560	0	0.00	N		FM	ORS 418			
														$ -									
														$ -									
									2,046,181,373	-	311,448,233	4,112,673,259	2,214,345,331	$ 8,684,648,196	745	745.00							

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
D Debt Service
FM Federal - Mandatory
FO Federal - Optional (once you choose to participate, certain requirements exist)
S Statutory

Prioritize each program activity for the Agency as a whole

Document criteria used to prioritize activities:

Oregon
Kate Brown, Governor

Department of Human Services
Office of the Director
500 Summer St. NE, E-15
Salem, OR 97301
Voice: 503-945-5600
Fax: 503-581-6198

January 20, 2017

The Legislative Fiscal Office Required the Department of Human Services to Produce a 15% reduction list for the 2017-19 ways and means process

The reduction options presented in this document are not intended to reflect the policy or program recommendations of the agency. The Oregon Department of Human Services (DHS) is acutely aware that the reduction options on this list have significant consequences for Oregonians and the communities in which they live. The agency is -- and has been -- engaged in ongoing search for efficiencies that allow us to reduce costs and maximize resources with minimal impact to clients. We also work to ensure that as services to clients are reduced because of reductions, that we also reduce our infrastructure and administrative overhead concurrently.

Guiding Principles
In approaching these reductions, DHS was guided by a set of priorities in making proposed reductions. However, to reach the targeted reduction levels for the Department – which totals more than $486 million in General Fund – it was not possible to reflect all of the following principles and priorities in the reduction list:

- For all programs, the agency looked closely at client safety and stability, preserving the infrastructure of programs and the provider-systems that serve clients, maintenance of effort (MOE) issues, legal risk, cross-program impact, cost shifting, and what the reduction would mean in terms of the loss of federal matching funds.

- DHS looked closely at whether repeated reductions to programs no longer made sense, and whether it was time to consider the elimination of some programs in order to preserve others.

- In Child Welfare programs, DHS prioritized prevention activities and services to keep children safe at home and out of foster care over those further into the child welfare system, such as adoption and guardianship.

- In Intellectual and Developmental Disabilities programs, DHS prioritized continuing programs and services for those clients in long-term care. DHS also made every effort to consider reductions that would not move people into higher cost settings but could keep them at home and in their communities.

- In Self Sufficiency, Intellectual and Developmental Disability and Vocational Rehabilitation programs, DHS prioritized services and programs that helped support and preserve family stability and to maintain employment outcomes for Oregonians.

- In Aging and People with Disabilities programs, DHS prioritized keeping as much of Oregon's high-quality system in place as possible – that is, prioritizing home and community-based services.

Agency Name (Acronym)				*DHS*										
2017 - 2019 Biennium														
				modified CSL	$ 3,239,728,566		$ 545,577,869		$ 5,252,837,422	$ 2,214,345,331	$ 11,252,489,188	8238	8164.88	
				Detail of Reductions to 2017-19 Current Service Level Budget										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Priority (ranked with highest priority first)		**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Impact of Reduction on Services and Outcomes**
1		dhs	VR	Use one time ReAllotment revenues to backfill CSL GF **In GB**	(7,400,000)		-		(7,400,000)		$ (14,800,000)	0	0.00	OVRS has successfully been awarded one time ReAllotment funding allowing a partial one time backfill of GF. If possible this reduction should replace the program and position reduction so VR does not enter an order of selection.
2		dhs	DHS	1% Additional Vacancy Savings **in GB**	(6,440,675)		(1,233,888)		(6,154,258)		$ (13,828,821)			This action reduces the funding for personal services in DHS by taking a 1% reduction in personal services funding. This action reduces personal services funding lowering the overall capacity of DHS to complete it's mission.
3		dhs	DHS	Remove inflation from S&S **In GB**	(3,045,922)		(1,198,069)		(3,842,276)		$ (8,086,267)			This action reduces the funding for general inflation in most services and supply line items in DHS. This reduces service and supply funding lowering the overall capacity of DHS to complete it's mission.
4		dhs	DHS	Disallowed Backfill for Federal Grants **In GB**	(13,774,780)						$ (13,774,780)			This action assumes that there will be sufficient federal funding to cover assumed shortfall in capped grants. The agency will be reviewing it's federal grant balances to determine the impact of this reduction closer to the close of the 15-17 budget when ending balances are more clear.
5		dhs	DHS	Statewide Reduction to S&S **In GB**	(3,099,387)		(594,899)		(3,212,489)		$ (6,906,775)			This action reduces the funding for services and supplies in DHS by taking a 3% reduction in services and supplies funding. This reduces service and supply funding lowering the overall capacity of DHS to complete it's mission.
6		dhs	CW Delivery	Staffing Workload Reduction **In GB**	(920,440)				(917,676)		$ (1,838,116)		(9.00)	This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in Child Welfare to ensuring the safety of Oregon Children.
8		dhs	APD	Reduce the complex medical add-on for nursing facilities by 50%. **IN GB**	(6,590,581)		(1,339,048)		(14,387,840)		$ (22,317,469)	0	0.00	This reduction would eliminate half of the 40% premium paid to nursing facilities that serve individuals with certain complex medical conditions. Taking this reduction will require a statutory change to implement.
9		dhs	APD	Eliminate Live-in Program as of July 1 2017 - move consumers to Hourly program. **IN GB**	(20,823,405)		(501,776)		(57,995,710)		$ (79,320,892)	0	0.00	At the time of this report, there are approximately 350 individuals remaining in the Live-in care program.
10		dhs	APD Delivery	Equity Model Reduction **In GB**	(9,680,044)				(6,581,512)		$ (16,261,556)			This reduction is to CSL earned positions for AAA's at 24 months. Positions were "earned" that are then priced for the contract amount to the providers. This reduced the number of earned positions back to 12 months in this reduction. Staffing levels are critical in Aging and People with Disabilities to ensuring the safety of Oregon Seniors.
11		dhs	APD Delivery	State Staffing Workload Reduction **In GB**	(5,480,377)				(3,475,794)		$ (8,956,171)		(58.00)	This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in APD to ensuring the safety of Oregon's aging and people with disabilities.
12		dhs	CW Delivery	Screening Positions **In GB**	(6,846,675)				(1,706,686)		$ (8,553,361)		(45.50)	This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in Child Welfare to ensuring the safety of Oregon Children.

Priority (ranked with highest priority first)		Agency	SCR or Activity Initials	Program Unit/Activity Description	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	Impact of Reduction on Services and Outcomes	Effective Date
1		dhs	VR	Use one time ReAllotment revenues to backfill CSL GF **In GB**	(7,400,000)		-		(7,400,000)		$ (14,800,000)	0	0.00	OVRS has successfully been awarded one time ReAllotment funding allowing a partial one time backfill of GF. If possible this reduction should replace the program and position reduction so VR does not enter an order of selection.	**7/1/2017**
2		dhs	DHS	1% Additional Vacancy Savings **in GB**	(6,440,675)		(1,233,888)		(6,154,258)		$ (13,828,821)			This action reduces the funding for personal services in DHS by taking a 1% reduction in personal services funding. This action reduces personal services funding lowering the overall capacity of DHS to complete it's mission.	**7/1/2017**
3		dhs	DHS	Remove inflation from S&S **In GB**	(3,045,922)		(1,198,069)		(3,842,276)		$ (8,086,267)			This action reduces the funding for general inflation in most services and supply line items in DHS. This reduces service and supply funding lowering the overall capacity of DHS to complete it's mission.	**7/1/2017**
4		dhs	DHS	Disallowed Backfill for Federal Grants **In GB**	(13,774,780)						$ (13,774,780)			This action assumes that there will be sufficient federal funding to cover assumed shortfall in capped grants. The agency will be reviewing it's federal grant balances to determine the impact of this reduction closer to the close of the 15-17 budget when ending balances are more clear.	**7/1/2017**
5		dhs	DHS	Statewide Reduction to S&S **In GB**	(3,099,387)		(594,899)		(3,212,489)		$ (6,906,775)			This action reduces the funding for services and supplies in DHS by taking a 3% reduction in services and supplies funding. This reduces service and supply funding lowering the overall capacity of DHS to complete it's mission.	**7/1/2017**
6		dhs	CW Delivery	Staffing Workload Reduction **In GB**	(920,440)				(917,676)		$ (1,838,116)		(9.00)	This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in Child Welfare to ensuring the safety of Oregon Children.	**7/1/2017**
8		dhs	APD	Reduce the complex medical add-on for nursing facilities by 50%. **IN GB**	(6,590,581)		(1,339,048)		(14,387,840)		$ (22,317,469)	0	0.00	This reduction would eliminate half of the 40% premium paid to nursing facilities that serve individuals with certain complex medical conditions. Taking this reduction will require a statutory change to implement.	**1/1/2018**
9		dhs	APD	Eliminate Live-in Program as of July 1 2017 - move consumers to Hourly program. **IN GB**	(20,823,405)		(501,776)		(57,995,710)		$ (79,320,892)	0	0.00	At the time of this report, there are approximately 350 individuals remaining in the Live-in care program.	**7/1/2017**
10		dhs	APD Delivery	Equity Model Reduction **In GB**	(9,680,044)				(6,581,512)		$ (16,261,556)			This reduction is to CSL earned positions for AAA's at 24 months. Positions were "earned" that are then priced for the contract amount to the providers. This reduced the number of earned positions back to 12 months in this reduction. Staffing levels are critical in Aging and People with Disabilities to ensuring the safety of Oregon Seniors.	**7/1/18**
11		dhs	APD Delivery	State Staffing Workload Reduction **In GB**	(5,480,377)				(3,475,794)		$ (8,956,171)		(58.00)	This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in APD to ensuring the safety of Oregon's aging and people with disabilities.	**7/1/2018**
12		dhs	CW Delivery	Screening Positions **In GB**	(6,846,675)				(1,706,686)		$ (8,553,361)		(45.50)	This reduction is to CSL earned positions. The positions were earned at 24 months but was cut back to 12 months in this reduction. Staffing levels are critical in Child Welfare to ensuring the safety of Oregon Children.	**7/1/2017**

Agency Name (Acronym)				*DHS*											
2017 - 2019 Biennium															
				modified CSL	$ 3,239,728,566		$ 545,577,869		$ 5,252,837,422	$ 2,214,345,331	$ 11,252,489,188	8238	8164.88		
				Detail of Reductions to 2017-19 Current Service Level Budget											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Priority (ranked with highest priority first)		**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Impact of Reduction on Services and Outcomes**	**Effective Date**
13		dhs	SS	ERDC - Provider Incentive Payments (100% Reduction)	(3,617,587)		-		-		$ (3,617,587)	0	0.00	Eliminating the provider incentive payment for 3, 4, 5 star providers would limit the number of providers who chose to become star rated. Children benefit from quality child care situations, especially during the critical years of brain development, birth to 5 years old. Star rated providers must meet additional training requirements in several areas including child development to reach a star rating. Data through Western Oregon Teaching institute showed an increase in provider interested in achieving a star rating due the incentive payments available when providing child care to a subsidy child full time.	**10/1/2017**
14		dhs	SS	TANF - Time Limit 60 Months -Full Family Sanction (No Hardship Exemptions)	(11,092,844)						$ (11,092,844)			This action establishes a 60 month time limit for TANF receipt for the entire family allowing no exemptions. The current Oregon time limit is 60 months and state statute allows for only the adults needs to be removed from TANF once the 60 month limitation has been reached and the family has no hardship exemption. Oregon's policy provides for the children in the home to continue to receive TANF. For families who have reached the new time-limit, the entire case would close. Some families may see an increase in SNAP benefits as cash benefits end. Ending TANF cash benefits for the entire family may result in family instability and homelessness. Families would have to rely on other community based safety net programs which have already experienced increased demand. During the biennium an average of 1,679 families per month are expected to be impacted. Based on their accrued time, the majority of these family's (970 families) will reach their time limitation in April 2016. Families will also be impacted if they come from another state and the accrued time (alone or in combination with Oregon accrued time) equals to or exceeds 60 months. This action requires an amendment to ORS 412.079.	**10/1/17**
15		dhs	SS	TANF - Time Limit 48 Months - Removing Adult Only	(7,931,297)		-		-		$ (7,931,297)	0	0.00	This action would remove the Adult only on the case which would put the child in a TANF no-adult pay standard table, which would lower their grant. This would impact approximately 3,952 Cases.	**10/1/2017**
16		dhs	SS	NNCR Families: Counting their income towards eligibility	(3,993,135)		-		-		$ (3,993,135)	0	0.00	By counting the Non-Needy Caretaker Relative Income, this will affect 95% of current NNCR cases, in that they would be over income, and the case would close. The remaining 5% would result in a lower payment amount, as the income they count would be counted dollar for dollar, and reduce their TANF payment by that amount, which also results in a savings.	**10/1/2017**
17		dhs	SS	Adult Count 50% of SSI Income for TANF Eligibility (Adults Only)	(19,913,411)		-		-		$ (19,913,411)	0	0.00	This action establishes counting 50% of the SSI Adult's SSI Payment as income towards the TANF grant, which could make them ineligible due to the TANF income limit. 50% of the standard payment for SSI recipients is $367 which is more than the TANF payment standard for most SSI adult situations with two or fewer children. There could be a small percentage (5%) or so that would be eligible due to special circumstances. Estimated cases closed due to being over the income limit would be 2,151, and approximately 131 cases would be reduced to a lower TANF grant amount.	**10/1/2017**
18		dhs	I-DD	Eliminate GF only Bedhold payments for 50, 51, and 142	(4,481,850)		-		-		$ (4,481,850)	0	0.00	Effective 7/1/2017 This reduction proposes to eliminate bedhold payments to residential providers when an individual is temporarily not in care. This impacts service elements 50 (Adult Group Homes), 51 (Adult Supported Living services and 142 (Children's residential services)	**7/1/2017**

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				Detail of Reductions to 2017-19 Current Service Level Budget										
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19		dhs	I-DD	Eliminate GF only Bedhold payments for 58 (Foster Care Services)	(1,181,021)		-		-		$ (1,181,021)	0	0.00	Effective 10/1/17 This reduction proposes to eliminate bedhold payments to residential providers when an individual is temporarily not in care.	**10/1/2017**
20		dhs	I-DD	One time use of Fairview Housing Trust Fund of $6.0 million. **In GB**	(6,000,000)		-		-		$ (6,000,000)	0	0.00	Effective 7/1/17 significantly reduces options to help families and individuals with I/DD remove housing barriers by funding things such as ramps, accessible bathing options, and other housing modifications. Requires a statute change. Balance of account will be about $100k after this action.	**7/1/2017**
21		dhs	Shared Services	Remove General Assistance from financial services (HB4042). **In GB**			(125,194)				$ (125,194)		(0.87)	House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded.	**7/1/2017**
22		dhs	SAEC	Remove General Assistance from financial services (HB4042). **In GB**	(62,597)						$ (62,597)			House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded.	**7/1/2017**
23		dhs	APD Delivery	Remove General Assistance (HB4042). **In GB**	(225,590)						$ (225,590)		(2.00)	House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded.	**7/1/2017**
24		dhs	APD	Remove General Assistance (HB4042). **In GB**	(1,597,705)		(1,869,511)				$ (3,467,216)			House Bill 4042 funded the General Assistance Project, beginning July 1, 2016. It serves individuals enrolled in the medical assistance program, who have disabilities that meet Presumptive Medicaid disability criteria, and who are experiencing homelessness. The program provides clients up to $545 per month for housing, up to $90 per month for utilities, and $60 per month for personal incidental funds (PIF). Pursuit of Social Security benefits is a condition of eligibility. Housing payments, utility payments, and PIF expenditures would be recovered from clients' Supplemental Security Income (SSI) lump sum payments when and if benefits are awarded.	**7/1/2017**

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25		dhs	CW Child Safety	Sexual Assault Victims Fund	(78,965)		(518,399)		-		$ (597,364)	0	0.00	Sexual Assault Victims Services is funding that is specifically designed to assist adult sexual assault survivors with shelter and support services. These services are provided to the community at large, not just Child Welfare involved families. In 2015, Oregon domestic and sexual violence programs answered 134,888 calls for help, a 3 percent increase over 2014. This included calls about domestic violence, sexual assault, stalking and other issues with 1,484 adult sexual assault survivors receiving services. An elimination of these services would leave many adult victims of sexual assault unable to find safety and support.	**7/1/2017**
26		dhs	CW Child Safety	Domestic Violence Services	(448,251)		(3,316,892)		(2,568,342)		$ (6,333,485)	0	0.00	Domestic Violence Services is funding that is specifically designed to assist victims of domestic violence and their children in accessing safe shelter, community based services such as hospital accompaniment and support groups, and in an effort to end violence before it begins, programs provide education and awareness events. In 2015, Oregon domestic and sexual violence programs answered 134,888 calls for help, a 3 percent increase over 2014. This included calls about domestic violence, sexual assault, stalking and other issues. These services are provided to the community at large, not just Child Welfare involved families. In 2015 there were 10,196 requests for shelter unmet with no reduction. An elimination of these services would leave many adult victims of domestic violence and their children unable to find safety and support.	**7/1/2017**
27		dhs	CW Child Safety	Recovering Family Mutual Homes – 30% reduction	(128,964)		(46)		(102,732)		$ (231,742)	0	0.00	A cut of 30% is larger than appears as these budgets have a Federal match. These services currently provide payment directly to housing for child welfare parents, with their children, coming out of residential A&D treatment settings in three counties. Any cut in these services leads directly to the elimination of housing for individual parents with small children. This reduction will create immediate instability for families whose parent has recently completed A&D treatment. Cutting these services will result in increased barrier to children remaining with their parents which means increases in foster care. Additionally, it will increase length of stay in foster care.	**7/1/2017**
28		dhs	CW Child Safety	Recovering Family Mutual Homes – additional 15% reduction	(45,137)		(16)		(35,956)		$ (81,109)	0	0.00	A cut of 15% is larger than appears as these budgets have a Federal match. These services currently provide payment directly to housing for child welfare parents, with their children, coming out of residential A&D treatment settings in three counties. Any cut in these services leads directly to the elimination of housing for individual parents with small children. This reduction will create immediate instability for families whose parent has recently completed A&D treatment. Cutting these services will result in increased barrier to children remaining with their parents which means increases in foster care. Additionally, it will increase length of stay in foster care.	**7/1/2017**
29		dhs	CW Permanency	Private Adoptions: 25% Cut Description of Services: Fee for services, budgeted at $1,202,890 per biennium. Payment for placement and supervision services for DHS foster children in in-state and out-of-state adoptive families studied and supervised by private agencies.	(134,951)		-		(165,930)		$ (300,881)	0	0.00	25% Cut Reduce the number of in-state private agency placements but keep out-of-state private placements at the current level. General applicant Oregon families can get home studies through their local DHS offices (although waiting times will increase), but out-of-state general applicants (non-relatives) would have no means to get a study through their local child welfare office for Oregon children, as ICPC covers home studies with relatives only. Reductions impact the number of adoptive families overall and reduces the overall number of adoptive placements being made.	**7/1/2017**

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30		dhs	VR	Reduce Client Service by 5%	(1,626,324)		(117,329)		(3,901,178)		$ (5,644,831)	0	0.00	The proposed reduction would result in an 5% decrease in case services forcing the creation of a waitlist. 1,839 individuals would not get services including youth served under third-party agreements with local school districts. This would jeopardize the match dollars that these agreements provide thus further reducing the program budget. Small specialized vendors who rely on the program for revenue would experience a sharp drop in income. Additionally this will impact the ability of the program to meet the required Maintenance of Effort resulting in a reduction in federal funds available, and resulting in the program reinstituting the Order of Selection. OVRS with out an investment above the Current Service level is at risk of reinstituting the Order of Selection, and is at risk for failure to meet the level of services set forth in Executive Order 15-04 and in the settlement agreement for Lane V Brown regarding employment for persons with Intellectual and Developmental Disabilities.
31		dhs	VR	Reduce VR Personal Service Expense by 2.5%	(813,162)		(58,664)		(1,950,589)		$ (2,822,415)	(21)	(21.00)	The proposed reduction would result in an additional 2.5% decrease in personal service expense, through lay offs reducing the VR workforce by 8.4% and forcing the creation of a waitlist. 2,880 individuals would not get services including youth served under third-party agreements with local school districts. This would jeopardize the match dollars that these agreements provide thus further reducing the program budget. Small specialized vendors who rely on the program for revenue would experience a sharp drop in income. Additionally this will impact the ability of the program to meet the required Maintenance of Effort resulting in a reduction in federal funds available, and resulting in the program reinstituting the Order of Selection. OVRS with out an investment above the Current Service level is at risk of reinstituting the Order of Selection, and is at risk for failure to meet the level of services set forth in Executive Order 15-04 and in the settlement agreement for Lane V Brown regarding employment for persons with Intellectual and Developmental Disabilities.
32		dhs	APD	Eliminate OPI for people with disabilities. **IN GB**	(6,000,000)		-		-		$ (6,000,000)	0	0.00	Approximately 300 individuals per month will lose access to the OPI people with disabilities program if funding is eliminated.
33		dhs	APD	Reduce OPI by $10M. **IN GB**	(10,000,000)		-		-		$ (10,000,000)	0	0.00	We estimate that approximately 1,000 of the over 2,100 individuals currently being served per month by the traditional OPI program will no longer have access to these services if OPI is reduced by this amount.
				5% SUBTOTAL	**(163,475,078)**	**-**	**(10,873,731)**	**-**	**(114,398,968)**	**-**	**(288,747,778)**	**(21)**	**(136.37)**	
34		dhs	APD	Reduce OPI by another $6M. **IN GB**	(6,000,000)		-		-		$ (6,000,000)	0	0.00	We estimate that approximately 1,000 of the over 2,100 individuals currently being served per month by the traditional OPI program will no longer have access to these services if OPI is reduced by this amount. This is an additional $6 M, leaving $5 M to cover the Maintenance of effort requirements for the OAA Federal Grants.
35		dhs	APD	Eliminate the second half of complex medical add-on for nursing facilities.	(6,590,581)		(1,339,048)		(14,387,840)		$ (22,317,469)	0	0.00	This reduction would eliminate the 40% premium paid to nursing facilities that serve individuals with certain complex medical conditions. Taking this reduction will require a statutory change to implement.

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36		dhs	SS	ERDC - Reduce caseload cap from 7,762 to an average of 7,262 (500 Cases)	(8,137,500)		-		-		$ (8,137,500)	0	0.00	Caseload cap is currently 7,762: this would reduce to an average of 7,262. Increase in TANF cases may make it very difficult to get at desired level. This reduction continues the elimination of child care supports for all parents with incomes under 185% of poverty, limiting those supports to only TANF families transitioning to employment; families reapplying for ERDC benefits after a break of less than two calendar months; families with a child in the filing group that is eligible for a current opening in a contracted child care slot or Early Head Start – Child Care Partnership; families that are currently eligible or have been determined eligible for TA-DVS in any preceding three months; or families currently working with Child Welfare (as part of an assessment, open case or transition) and there is an ongoing safety plan in place that states child care is required to keep the child in their home, place the child with a relative or other known adult or when transitioning the child back into the home or out of stranger foster care. This reduction will further impact the ability of parents to maintain employment, the ability of child care providers to provide care and be employed, and the quality of child care children receive. This reduction will impact family child care providers, child care centers, Early Head Start/Head Start and after-school programs and may increase the number of children left home without an appropriate provider. This would affect 1,590 providers. This reduction will reduce the amount of state expenditures that count toward its MOE obligations. ERDC is mainly funded by CCDF federal dollars through an Interagency Agreement with DHS and The Oregon Department of Education (ODE). ODE has a stake in this reduction and has expressed their concern to DHS.	**10/1/2017**
37		dhs	I-DD	Reduce the Family to Family Network Program **In GB**	(642,940)		-		-		$ (642,940)	0	0.00	Effective 7/1/17 Reduce funding to Family to Family Networks by 50%. This program began in 2012 after 2011 made significant reductions in the Family Support Program. The funding ($1.3M) supports up to eight networks. The work already accomplished by these groups includes family training, identification of local resources, and general support from one family to another. The networks leverage parent time and local resources in an effort to provide support at no cost to DHS/DD.	**7/1/2017**
38		dhs	I-DD	Eliminate the Family to Family Network Program **In GB**	(642,940)		-		-		$ (642,940)	0	0.00	Effective 7/1/17 reduce another 50% which would eliminate Family to Family Networks. This program began in 2012 after 2011 made significant reductions in the Family Support Program. The funding ($1.3M) supports up to eight networks. The work already accomplished by these groups includes family training, identification of local resources, and general support from one family to another. The networks leverage parent time and local resources in an effort to provide support at no cost to DHS/DD.	**7/1/2017**
39		dhs	I-DD	Eliminate the Family Support Program	(2,357,887)		-		-		$ (2,357,887)	0	0.00	Effective 7/1/2017 This program provides a small amount of support that goes a long way to helping family with care of child with developmental disability. Approximately 1,000 children and their families will lose service as a result of this program elimination.	**7/1/2017**
40		dhs	I-DD	Eliminate the funded FTE via Workload models for Family Support Program	(276,818)		-		(337,245)		$ (614,063)	0	0.00	Effective 7/1/2017 The CDDP workload models are funded at 3.47 FTE for the work of Family Support program. If Family Support program is eliminated than the corresponding FTE would be removed.	**7/1/2017**

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41		dhs	I-DD	Eliminate Regional Staff **In GB**	(4,788,406)		-		(3,315,737)		$ (8,104,143)	0	0.00	Effective 7/1/17 This reduction proposes to eliminate the Regional Staff that support CDDPs with crisis situations.
42		dhs	I-DD	Eliminate Eliott homes at SACU, staff and expenses	(1,510,672)		(130,457)		(2,393,128)		$ (4,034,257)	0	(21.12)	Effective 10/1/17 This reduction proposes to close all three Eliott homes. 21.12 FTE are eliminated 10.1.2017. The corresponding 24 positions will be abolished fully in the 19-21 biennium.
43		dhs	CW Permanency	Contracted Adoption Services - 25% Reduction	(555,920)		-		(516,814)		$ (1,072,734)	0	0.00	25% Reduction The Multnomah County District Attorney contract, Whitney Investigations contract, and Black Helterline Attorney contract are all essential legal services that will be deferred to the Department of Justice if these contracts are cut or eliminated (see explanation below in the 100% elimination section), so cuts to these contracts in contracted adoption services would result in a cost shift to the DOJ budget. Of the remaining contracted adoption services, leave Oregon Adoption Resource Exchange and Northwest Adoption Resource Exchange intact
44		dhs	CW Permanency	Permanency: 25% Reduction Post Adoption Services program, impacting supports for over 400 adoptive and guardianship families each year. (IV-B portion of budget)	(47,835)		(14)		(260,458)		$ (308,307)	0	0.00	25% Reduction Reduce training, library purchases, and support group start-up for information and referral, advocacy and support, and crisis intervention.
45		dhs	CW Permanency	Permanency: additional 50% Reduction Post Adoption Services program, impacting supports for over 400 adoptive and guardianship families each year. (IV-B portion of budget)	(71,752)		(21)		(390,687)		$ (462,460)	0	0.00	50% Reduction Eliminate training, library purchases, and support group start-up for information and referral, and crisis intervention only
46		dhs	SS	TANF - Time Limit 48 Months -Full Family Sanction (No Hardship Exemptions) This is additional of the 60 month	(6,911,642)		-		-		$ (6,911,642)	0	0.00	This action establishes a 48 month time limit for TANF receipt for the entire family allowing no exemptions. The current Oregon time limit is 60 months and state statute allows for only the adults needs to be removed from TANF once the 60 month limitation has been reached and the family has no hardship exemption. Oregon's policy provides for the children in the home to continue to receive TANF. For families who have reached the new time-limit, the entire case would close. Some families may see an increase in SNAP benefits as cash benefits end. Ending TANF cash benefits for the entire family may result in family instability and homelessness. Families would have to rely on other community based safety net programs which have already experienced increased demand. During the biennium an average of 3,925 families per month are expected to be impacted. Based on their accrued time, the majority of these family's (3,119 families) will reach their time limitation in April 2018. Families will also be impacted if they come from another state and the accrued time (alone or in combination with Oregon accrued time) equals to or exceeds 48 months. This action requires an amendment to ORS 412.079.

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47		dhs	SS	Admin Portion for TANF Time Limits 48 Months (18 month reduction)	(6,394,099)		-		(9,180,317)		$ (15,574,416)	0	(96.38)	If we reduced the Time Limit to 48 Months, we would be losing 3,952 Cases. Calculation assumptions: Reduce TANF caseload by 3,952 cases from ongoing and case maintenance categories. Assumed 26% of clients are JOBS MANDATORY and do equal reductions to coaching and home visits category as well with approx. 2.64 clients per case.	**7/1/2017**
48		dhs	CW Well Being	Well Being: Reduce Client Transportation Program by 15%.	(710,355)		(140,417)		(108,881)		$ (959,653)	0	0.00	Any reduction to funding for Client Transportation will have a negative impact on direct services for children, negatively impact their education outcomes, and potentially delay child and family reunification. Currently 69% is being spent on transportation for visits between child(ren) and parents, another 20% for transporting children to and from their school of origin, 2% for transportation to medical appointments, and 9% for transportation to/from activities such as court hearings, and case planning activities.	**7/1/2017**
49		dhs	CW Well Being	Well Being: Reduce Court Ordered Other Medical Program by 15%.	(756,720)		(3,556)		-		$ (760,276)	0	0.00	Other Medical funds are used by DHS to obtain services to assist the caseworker in making good case planning decisions for the child and family and to better inform the Courts. Currently, 53% of Other Medical funds are spent on case consultation services, with licensed experts to review case information accumulated over time and assist in developing a timely well-focused case plan; and 47% is spent on psychological evaluations and other testing of parents (including drug testing), used to inform case planning. Other Medical funding also allows the department to request medical records for a child in care and to request formally supervised parent/child, and sibling interactions.	**7/1/2017**
50		dhs	CW Well Being	Well Being: Reduce System of Care (SOC) by 15% - flexible fund resource dollars to meet the individual needs of foster children and their families.	(595,979)		(49,699)		(1,056,938)		$ (1,702,616)	0	0.00	System of Care flexible funds are used by local offices to address not only the individualized service needs of children and parents, but also and more recently payments that promote a parent's ability to maintain housing while working toward reunification with their children. Cutting SOC by 15% will likely result in reduced ability to meet the unique needs of children an families through client specific services.	**7/1/2017**

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51		dhs	CW Child Safety	Child Safety: Reduce ISRS budget by 15%, eliminating in-home supports for approximately 390 abused children each year.	(1,153,134)		(29,415)		(1,646,212)		$ (2,828,761)	0	0.00	15% reduction In-Home Safety and Reunification Services (ISRS) provides services to help manage the safety threats within the family, stabilize the family and provide for the immediate safety of children at risk of maltreatment or when children have been placed in protective custody or foster care this service is to help them return to their parents. A 15% reduction to In-Home Safety and Reunification Services will impact child welfare's ability to: 1) safely keep children at home; 2) return children home in a timely manner; and 3) provide the family supports and services to ensure children aren't re-abused and don't re-enter the foster care system. This reduction is estimated to impact approximately 847 children each year who will now need to enter or remain in foster care rather than safely remain in the home with their parents or safely reunify with their parents. This reduction will impact the department's ability to meet Indian Child Welfare Act and other court-ordered requirements. This reduction will also mean more "no reasonable efforts" or "failure to meet active efforts for ICWA children" findings by the courts, which would impact federal funding for Oregon's foster care (out-of-home care) program. In addition to increased costs in foster care, there will be an increase in costs to courts, defense attorneys, Citizen Review Boards, and others involved in the dependency system. Finally, contractors who provide these services will be impacted and may lay off staff.	**7/1/2017**
52		dhs	CW Child Safety	Child Safety: Reduce Strengthening, Preserving, & Reunifying Families (SPRF) budget by 15%.	(1,851,953)		-		(2,769,776)		$ (4,621,729)	0	0.00	15% reduction (ALL ARE IDENTICAL DESCRIPTIONS OF IMPACT FOR SPRF) Strengthening, Preserving and Reunifying Families (SPRF) programs provide a broad array of services that are designed to maintain children safely at home with their parents or caregivers, safely and equitably reduce the number of children in the foster care system, reduce child trauma, reduce the length of stay in foster care, and to reduce the referral or reentry rates of families in the Child Welfare system. SPRF also provides services to families with safe children and moderate to high needs through Admin Only cases through Differential Response and this is the only way these families would be able to access Child Welfare services. A reduction in these services will result in approximately 487 children coming into foster care, staying longer periods of time in foster care or coming back to the attention of child welfare. This reduction will also impact the department's ability to meet Indian Child Welfare Act and other court-ordered requirements. This reduction will also mean more "no reasonable efforts" or "failure to meet active efforts for ICWA children" findings by the courts, which would impact federal funding for Oregon's foster care (out-of-home care) program. In addition to increased costs in foster care, there will be an increase in costs to courts, defense attorneys, Citizen Review Boards, and others involved in the dependency system. Finally, contractors who provide these services will be impacted and may lay off staff.	**7/1/2017**

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53		dhs	APD	Reduce Nursing Facility Rates to the 60th Percentile from the statutory rate - N/A THE BLENDED RATE FOR CSL IS LOWER THAN THE 60TH PERCENTILE RATE PROVIDED BY CINDY SUSEE IN THE LATEST REPORT FOR NF RATES. Provided for context only.	-		-		-		$ -	0	0.00	This would require a statutory change. No impact on consumers or access is anticipated with this reduction. Nursing facilities could likely absorb this without much consequence.	**7/1/2017**
54		dhs	APD	Hold nursing facility rates flat at the rate being reimbursed at 6/30/17. **(281.08; In GB)**	(18,345,151)		(3,706,229)		(39,719,103)		$ (61,770,483)	0	0.00	This would require a statutory change. No impact on consumers or access is anticipated with this reduction. Nursing facilities could likely absorb this without much consequence.	**7/1/2017**
55		dhs	SS	TANF - Time Limit 36 Months - Removing Adult Only	(9,706,948)		-		-		$ (9,706,948)	0	0.00	This action would remove the Adult only on the case which would put the child in a TANF no-adult pay standard table, which would lower their grant. This would result in an average of 6,403 Cases that would result in a significant savings.	**10/1/2017**
56		dhs	SS	TANF - Time Limit 36 Months -Full Family Sanction (No Hardship Exemptions) This is additional to 48 month	(31,861,417)		-		-		$ (31,861,417)	0	0.00	This action establishes a 36 month time limit for TANF receipt for the entire family allowing no exemptions. The current Oregon time limit is 60 months and state statute allows for only the adults needs to be removed from TANF once the 60 month limitation has been reached and the family has no hardship exemption. Oregon's policy provides for the children in the home to continue to receive TANF. For families who have reached the new time-limit, the entire case would close. Some families may see an increase in SNAP benefits as cash benefits end. Ending TANF cash benefits for the entire family may result in family instability and homelessness. Families would have to rely on other community based safety net programs which have already experienced increased demand. During the biennium an average of 6,403 families per month are expected to be impacted. Based on their accrued time, the majority of these family's (5,701 families) will reach their time limitation in April 2019. Families will also be impacted if they come from another state and the accrued time (alone or in combination with Oregon accrued time) equals to or exceeds 36 months. This action requires an amendment to ORS 412.079.	**10/1/2017**
57		dhs	SS	Admin Portion for TANF Time Limits 36 Months (12 month reduction)	(2,704,379)		-		(3,667,349)		$ (6,371,728)	0	(41.00)	If we reduced the Time Limit to 36 Months, we would be losing an additional 2,450 Cases. Calculation assumptions: Reduce TANF caseload by 6,403 cases from ongoing and case maintenance categories. Assumed 26% of clients are JOBS MANDATORY and do equal reductions to coaching and home visits category as well with approx. 2.64 clients per case.	**7/1/2017**
58		dhs	SS	Adult Count 100% of SSI Income for TANF Eligibility	(2,906,869)		-		-		$ (2,906,869)	0	0.00	This action establishes counting 100% of the SSI Adult's Standard Payment as income towards the TANF grant, which would make them ineligible due to the income limit. The standard payment for SSI recipients is $733, which is more than most TANF grants. There would be a small percentage (5%) or so that would be eligible due to special circumstances. Cases closed due to over-income limit would be approximately 2,151 and about 113 cased would be reduced to the lower payment standard.	**10/1/2017**

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59		dhs	I-DD	Reduce PSW Wages by eliminating OT	(7,957,911)		-		(16,798,458)		$ (24,756,369)	0	0.00	Effective 10/1/17 This reduction proposes to reduce bargained PSW wages by not allowing PSW to work overtime.	**10/1/2017**
60		dhs	I-DD	Reduce Supported Living Rates by 25%	(6,178,225)		-		(13,779,287)		$ (19,957,511)	0	0.00	Effective 10/1/17 This reduction proposes to reduce provider rates by 25% for Supported Living services (Service Element 51).	**10/1/2017**
61		dhs	I-DD	Eligibility IQ Requirement	(7,526,316)		-		(17,943,449)		$ (25,469,765)	0	0.00	Effective 7/1/2018 Change the Eligibility requirement for individuals with IDD to a diagnosis of an IQ below 70. This could impact figures above.	**7/1/2018**
62		dhs	I-DD	Increase LOC Requirements	(11,327,325)		-		(26,837,835)		$ (38,165,160)	0	0.00	Effective 7/1/2018 Increase LOC requirements to three areas of significant impairment in adaptive behavior for individuals who qualify due to a Developmental Disability. This could impact figures above.	**7/1/2018**
63		dhs	I-DD	Eliminate ability to disregard parental income	(17,334,185)		-		(34,692,153)		$ (52,026,338)	0	0.00	Effective 7/1/2018 Eliminate the ability to disregard parental income for children with IDD under age 18 who live with family. This could impact numbers above.	**7/1/2018**
				10% SUBTOTAL	**(329,320,938)**	**-**	**(16,272,587)**	**-**	**(304,200,635)**	**-**	**(649,794,160)**	**(21)**	**(294.87)**		
64		dhs	I-DD	Reduce Brokerage and CDDP Equity by 2% (93% equity) **In GB**	(1,748,708)		-		(1,938,550)		$ (3,687,258)	0	0.00	Effective 10/17 Reduces the operating funding to CDDPs and Brokerages by another 2%--Overall reduction of 4%.	**10/1/2017**
65		dhs	I-DD	Reduce Brokerage and CDDP Equity by additional 2% (91% equity) **In GB**	(1,748,708)		-		(1,938,550)		$ (3,687,258)	0	0.00	Effective 10/1/17 Reduces the operating funding to CDDPs and Brokerages by another 2%--Overall reduction of 4%.	**10/1/2017**
66		dhs	I-DD	Reduce Supported Living Rates by an additional 5% - Overall: 30%	(1,235,645)		-		(2,755,857)		$ (3,991,502)	0	0.00	Effective 10/1/17 This reduction proposes to reduce Supported Living (Service Element 51) provider rates by an additional 5%, Overall reduction of 30%.	**10/1/2017**
67		dhs	I-DD	Reduce Brokerage and CDDP Equity by another additional 2% (89% equity)	(1,748,708)		-		(1,938,550)		$ (3,687,258)	0	0.00	Effective 10/1/17 Reduces the operating funding to CDDPs and Brokerages another 2%, overall reduction of 6%.	**10/1/2017**
68		dhs	I-DD	Reduce Supported Living Rates by an additional 5%--Overall 35%	(1,235,645)		-		(2,755,857)		$ (3,991,502)	0	0.00	Effective 10/1/17 This reduction proposes to reduce Supported Living (Service Element 51) provider rates by an additional 5%, Overall reduction of 35%.	**10/1/2017**
69		dhs	DHS	Additional 1% vacancy factor - total of 2% reduction.	(6,440,675)		(1,233,888)		(6,154,258)		$ (13,828,821)			This action reduces the funding for personal services in DHS by taking a second 1% reduction in personal services funding. This is the second 1% reduction totaling 2% across all of DHS. Both reductions include 24/7 SACU. This reduces personal services funding lowering the overall capacity of DHS to complete it's mission.	**7/1/17**
70		dhs	SS	ERDC-Provider Rate Reductions (10% Reduction of Overall Cost) (2 of 2)	(1,088,973)		-		-		$ (1,088,973)	0	0.00	Reduce child care provider rates by 10%. Federal requirements recommend provider rates not lower than the 75th percentile of the current Market Rate Survey. Rates for several areas are currently above the 75th percentile. This reduction would place provider rates below the rates determined during the 2015 - 2017 collective bargaining agreement with both American Federation of State, County and Municipal Employees AFCSME and Service Employees International Union 503 (SEIU). The reduction would have a negative impact on child care providers and parents who use subsidy. Loss of reimbursement dollars for the provider and lowering the number of providers who take subsidy children.	**10/1/2017**

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71		dhs	SS	ERDC-Provider Rate Reductions (5% Reduction of Overall Cost) (1 of 2)	(1,088,973)		-		-		$ (1,088,973)	0	0.00	Reducing the provider incentive payment for 3, 4, 5 star providers would limit the number of providers who chose to become star rated. Children benefit from quality child care situations, especially during the critical years of brain development, birth to 5 years old. Star rated providers must meet additional training requirements in several areas including child development to reach a star rating. Data through Western Oregon Teaching institute showed an increase in the number of providers interested in achieving a star rating due to the incentive payments available when providing child care to a subsidy child full time. The current incentive amounts are 5 star $90, 4 star $72, 3 star $54
72		dhs	APD	Take management actions to reduce average in-home hours by 10%.	(20,574,722)		(344,182)		(47,299,842)		$ (68,218,746)	0	0.00	It is anticipated that most in-home consumers would find a way to manage living at home with decreased hours. Homecare Workers would experience less work and less income.
73		dhs	APD	REDUCE CBC rates by 2.5%.	(6,141,600)		-		(13,838,990)		$ (19,980,590)	0	0.00	Reducing CBC rates may result in decreased access for Medicaid consumers. Medicaid rates are already substantially below rates facilities may secure from private pay consumers.
74		dhs	APD	Reduce Nursing Facility Rates to the 55th Percentile from 60th Percentile	(6,740,460)		-		(12,266,748)		$ (19,007,208)	0	0.00	This would require a statutory change. No impact on consumers or access is anticipated with this reduction. Nursing facilities could likely absorb this without much consequence.
75		dhs	SS	ERDC - Second reduction to caseload cap from 7,262 to an average of 6,762 (500 Cases)	(8,137,500)		-		-		$ (8,137,500)			Caseload cap is currently 7,262 after the first reduction. This would reduce to an average of 6,762. Increase in TANF cases may make it very difficult to get at desired level. This reduction continues the elimination of child care supports for all parents with incomes under 185% of poverty, limiting those supports to only TANF families transitioning to employment; families reapplying for ERDC benefits after a break of less than two calendar months; families with a child in the filing group that is eligible for a current opening in a contracted child care slot or Early Head Start – Child Care Partnership; families that are currently eligible or have been determined eligible for TA-DVS in any preceding three months; or families currently working with Child Welfare (as part of an assessment, open case or transition) and there is an ongoing safety plan in place that states child care is required to keep the child in their home, place the child with a relative or other known adult or when transitioning the child back into the home or out of stranger foster care. This reduction will further impact the ability of parents to maintain employment, the ability of child care providers to provide care and be employed, and the quality of child care children receive. This reduction will impact family child care providers, child care centers, Early Head Start/Head Start and after-school programs and may increase the number of children left home without an appropriate provider. This would affect 1,590 providers. This reduction will reduce the amount of state expenditures that count toward its MOE obligations. ERDC is mainly funded by CCDF federal dollars through an Interagency Agreement with DHS and The Oregon Department of Education (ODE). ODE has a stake in this reduction and has expressed their concern to DHS.

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76		dhs	SS	Count 50% of children's SSI income for eligibility and benefit calculation	(8,346,888)		-		-		$ (8,346,888)			This action establishes counting 50% of the SSI Child Standard Payment as income towards the TANF grant, which would make them ineligible due to the income limit. The standard payment for SSI recipients is $733, which is more than most TANF grants. There would be a small percentage (5%) or so that would be eligible due to special circumstances.	**10/1/2017**
77		dhs	SS	Count 100% of children's SSI income for eligibility and benefit calculation	(1,632,312)		-		-		$ (1,632,312)			This action establishes counting 100% of the SSI Child Standard Payment as income towards the TANF grant, which would make them ineligible due to the income limit. The standard payment for SSI recipients is $733, which is more than most TANF grants. There would be a small percentage (5%) or so that would be eligible due to special circumstances.	**10/1/2017**
78		dhs	APD	Take management actions to reduce average in-home hours by 20%. (ANOTHER 10%)	(20,574,722)		(344,182)		(47,299,842)		$ (68,218,746)	0	0.00	It is anticipated that most in-home consumers would find a way to manage living at home with decreased hours. Homecare Workers would experience less work and less income.	**1/1/2018**
79		dhs	APD	Take management actions to reduce average in-home hours by 25%. (An additional 5%)	(10,287,361)		(172,091)		(23,649,921)		$ (34,109,373)			It is anticipated that most in-home consumers would find a way to manage living at home with decreased hours. Homecare Workers would experience less work and less income.	**7/1/2017**
80		dhs	APD	Reduce Nursing Facility Rates to the 50th Percentile from the 55th Percentile	(2,443,147)		-		(4,432,744)		$ (6,875,891)			This would require a statutory change. No impact on consumers or access is anticipated with this reduction.	**7/1/2017**
81		dhs	APD	Reduce in-home allowance from $500 over SSI to $250 over SSI (1 of 2)	(4,389,120)				(10,241,280)		$ (14,630,400)			Approximately 2,700 individuals have income form $250-$500 over SSI.	**10/1/2017**
82		dhs	APD	Reduce In-Home allowance from $250 over SSI to $0 over SSI. (2 of 2)	(4,169,664)				(9,729,216)		$ (13,898,880)			Approximately 3,000 individuals have income over the SSI level to $250 over SSI.	**10/1/2017**
83		dhs	CW Child Safety	Child Safety: Eliminate Family Support Teams / Addiction Recovery Teams (ART) program, impacting services to approximately 13,400 families and 22,800 abused or neglected children.	(1,511,872)		(208,367)		(2,665,707)		$ (4,385,946)			A 70% reduction would eliminate the statewide program. Elimination of these services will mean more and longer foster care placements; higher re-abuse rates, a decline in parents entering treatment quickly, and an increase in the number of parents who struggle with sustaining their recovery. It will also increase caseworker workload, including A&D referral, treatment monitoring, transport, client tracking and case management, making it more difficult for caseworkers to meet other state and federal mandates. This would eliminate any ability of DHS to respond to clients in relapse, require more children remain in foster care, and eliminate the majority of personnel who serve as DHS liaison to local treatment providers. Longer stays in foster care will increase costs to the state, result in poorer outcomes for children and poorer treatment outcomes for their parents. This would also result in eliminating approximately 50-55 contracted jobs at local employers. Cutting these services will result in increased barrier to children remaining with their parents which means increases in foster care. Additionally, it will increase length of stay in foster care.	**7/1/2017**

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84		dhs	CW Well Being	Personal Care: 50% This is closely tied to the reduction of Nursing Assessments. Personal Care is a Medicaid State Plan option in Oregon that allows us to maintain children with medical needs safely in a home-like setting.	(1,043,522)		(87,390)		(1,025,006)		$ (2,155,918)			This is closely tied to the reduction of Nursing Assessments. Personal Care is a Medicaid State Plan option in Oregon that allows us to maintain children with medical needs safely in a home-like setting. Payment is made under this state plan option to compensate the foster care provider for the delegated medical services they perform for the child in their care. These services are matched at the Federal Medical Assistance Percentage (FMAP) rate of 64.47% in FFY 2017. A 15% reduction = a loss of $313,056 GF and a total fund loss of $881,103 in direct medical services provided to children in their foster home. Resulting in the need for these children to be placed, and remain, in a hospital like setting. An additional 15% reduction = a loss of $313,056 GF and a total fund loss of $1,762,206 in direct medical services provided to children in their foster home. Resulting in the need for these children to be placed, and remain, in a hospital like setting. An additional 20% reduction = a loss of $417,409 GF and a total fund loss of $2,937,013 in direct medical services provided to children in their foster home. Resulting in the need for these children to be placed, and remain, in a hospital like setting. An additional 50% reduction = a complete elimination of the program and the need for all children with medical needs requiring 24 hour per day care to reside in a hospital like setting.	**7/1/2017**
85		dhs	CW Well Being	Youth Investment Program: 50% Runaway and Homeless Youth programs provide Street Outreach, Drop-in Center, and Shelter services which improve the safety and wellbeing of unaccompanied youth under the age of 18.	(1,461,121)				(4,485,158)		$ (5,946,279)			Runaway and Homeless Youth programs provide Street Outreach, Drop-in Center, and Shelter services which improve the safety and wellbeing of unaccompanied youth under the age of 18. In the past year, Street Outreach and Drop-in services have resulted in 79% of youth accessing food, shelter, educational, job and life skills services. Shelter services have resulted in 81% of youth exiting to a safe home, 60% of those reuniting with family; 53% accessing medical and dental services, and 69% getting connected to educational services. A reduction in funding will result in fewer youth being served by these effective programs resulting in an increase of unaccompanied youth in our State and potentially result in upstream costs, in Child Welfare, Self Sufficiency, and/or the Juvenile Justice and Adult Corrections systems.	**7/1/2017**
86		dhs	CW Well Being	Enhanced Foster Care - elimination The Department reimburses a level of care payment to a certified family on behalf of a child or young adult when the child's behaviors require additional supervision to keep them placed at this lowest level of care	(6,810,351)		(927,184)		(3,767,792)		$ (11,505,327)			The Department reimburses a level of care payment to a certified family on behalf of a child or young adult when the child's behaviors require additional supervision to keep them placed at this lowest level of care. The department uses process controls of allowing this enhanced supervision only after the 20th day in foster care, requires an annual review and use of a standardized screening instrument tool CANS to determine which level of care for the enhanced supervision needs. Approximately 38% of the children have an enhanced level of supervision needs. The current daily rates are $7, $13 and $28 per day based on the level. A complete elimination of this program will further the negative attitude toward the department for not supporting foster parents, increase placement disruption rates for children, decrease the number of foster families willing to care for children and increase the placement crisis for children in Oregon.	**7/1/2017**

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87		dhs	CW Well Being	Shelter Foster Care: 50% The Department reimburses a certified family a shelter care payment on behalf of a child or young adult during the first twenty days of substitute care in a certified family home	(1,525,316)		(175,636)		(437,918)		$ (2,138,870)			The Department reimburses a certified family a shelter care payment on behalf of a child or young adult during the first twenty days of substitute care in a certified family home. This is the only source of funding support to the foster family in the first 20 days. The daily rate is $24, $28, or $31per day based on the age of the child. These funds cover the food, clothing, shelter, school supplies, hygiene supplies, transportation, additional supervision and other incidentals that are necessary when coming into foster care. The department has process controls in place to allow this service for only the first placement into foster care and for a maximum of 20 days. A 25% reduction in this program will likely increase the negative attitude toward the department in supporting foster families for children when the department rates are so low to start with and any reduction will be seen as a negative toward foster parents. The 25% reduction will be $1.50, $1.75, or $1.75 per day based on age. A second reduction of an additional 25% reduction (50%) in this program will further the negative attitude toward the department in supporting foster families for children and will likely start to experience foster families who will no longer accept foster children on an emergency basis. A third reduction of an additional 50% (total of 100%) will further the negative attitude toward the department in supporting foster families for children and foster families who will not accept children in care or add ultimatum that unless a CANS rate exception can be granted they will not accept children into a shelter care placement. At this stage the department should also anticipate some foster families this is merely too much and end being foster parents.	**7/1/2017**
88		dhs	I-DD	Reduce Brokerage and CDDP Equity by another additional 5% -total reduction of 11% (84% equity)	(4,371,770)		-		(4,486,376)		$ (8,858,146)	0	0.00	Effective 10/1/17 Reduces the operating funding to CDDPs and Brokerages another 5%, overall reduction of 11%. (84% equity)	**10/1/2017**
89		dhs	I-DD	Reduce all non-bargained Provider Rates by 4%-Employment, DSA, Non-Medical Transportation, and Adult Supported Living excluded.	(7,949,157)		-		(17,395,277)		$ (25,344,434)	0	0.00	Effective 10/1/2017 Reduce all non-bargained provider rates by 4%. This would be an across the board reduction of non-bargained rates for all DD service providers who provide services both children and adults, excludes Employment First, Non-Medical Transportation services, DSA, and Adult Supported Living Services.	**10/1/2017**
90		dhs	I-DD	Reduce Employment rates by 4%-DSA excluded	(1,403,501)		-		(2,391,156)		$ (3,794,657)	0	0.00	Effective 10/1/2017 Reduce Employment provider rates by 4%. This would be an across the board reduction of non-bargained rates for all DD service providers who provide employment services, excludes DSA services.	**10/1/2017**
91		dhs	I-DD	Eliminate 1:1 DSA to 24 hr Agency Providers	(3,292,664)		-		(7,520,683)		$ (10,813,347)	0	0.00	Effective 7/1/2017 Eliminate DSA provider services to 24 hour provider agencies such as group homes and foster homes.	**7/1/2017**
92		dhs	DHS	Additional 1% vacancy factor - total of 3% reduction.	(6,440,675)		(1,233,888)		(6,154,258)		$ (13,828,821)			This action reduces the funding for personal services in DHS by taking a third 1% reduction in personal services funding. This is the third 1% reduction totaling 3% across all of DHS. Each reduction include 24/7 SACU. This reduces personal services funding lowering the overall capacity of DHS to complete it's mission.	**7/1/2017**

Agency Name (Acronym)				*DHS*											
2017 - 2019 Biennium															
				modified CSL	$ 3,239,728,566		$ 545,577,869		$ 5,252,837,422	$ 2,214,345,331	$ 11,252,489,188	8238	8164.88		
				Detail of Reductions to 2017-19 Current Service Level Budget											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Priority (ranked with highest priority first)		**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Impact of Reduction on Services and Outcomes**	**Effective Date**
93		dhs	I-DD	Reduce all non-bargained Provider Rates by 3%-Employment excluded (Overall Reduction of 7%)	(6,053,239)		-		(13,262,858)		$ (19,316,097)			Effective 10/1/2017 Reduce all non-bargained provider rates by 3%. This would be an across the board reduction of non-bargained rates for all DD service providers who provide services both children and adults, excludes Employment First services.--Overall reduction of 7%	**10/1/2017**
94		dhs	I-DD	Reduce all non-bargained Provider Rates by additional 3%-Employment excluded (Overall 10% Reduction)	(6,053,239)		-		(13,262,858)		$ (19,316,097)			Effective 10/1/2017 Reduce all non-bargained provider rates by 3%. This would be an across the board reduction of non-bargained rates for all DD service providers who provide services both children and adults, excludes Employment First services. --Overall reduction of 10%	**10/1/2017**
95		dhs	DHS	Forego Other Funds used for local match and/or Reduce DHS programs	-		(60,837,285)		-		$ (60,837,285)			DHS is statutorily required to provide reduction options totaling 10% of CSL for each fund type. This reduction would be accomplished through a series of action including eliminating local match of federal funds and reductions to programs across DHS that are funded by Other Funds. This is not specific as it will depend on which Other Fund funding sources would be reduced as to the exact reduction. Loss of local match would reduce local provider programs who have expenditures that are legally matched with federal funds. This assumes there is no General Fund backfill available.	**7/1/2017**
96		dhs	DHS	Forego Federal Funds and Reduce DHS programs	-		-		(220,629,726)		$ (220,629,726)			DHS is statutorily required to provide reduction options totaling 10% of CSL for each fund type. This reduction would be accomplished through a series of program reductions depending on which federal funding sources are being reduced. This is a real possibility based on the current federal sequestration rules. However, this action is not specific as it will depend on which Federal funding sources would be reduced as to the program needing reduction. This reduction assumes there is no general fund backfill for these reductions.	**7/1/2017**
TOTAL					**(487,010,895)**	**-**	**(81,836,681)**	**-**	**(787,925,614)**	**-**	**(1,356,773,190)**	**(21)**	**(294.87)**		

Agency Name (Acronym)				*DHS*											
2017 - 2019 Biennium															
				modified CSL	$ 3,239,728,566		$ 545,577,869		$ 5,252,837,422	$ 2,214,345,331	$ 11,252,489,188	8238	8164.88		
	Detail of Reductions to 2017-19 Current Service Level Budget														
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Priority (ranked with highest priority first)		**Agency**	**SCR or Activity Initials**	**Program Unit/Activity Description**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**Impact of Reduction on Services and Outcomes**	**Effective Date**
											$ -				
				5%	$ 161,986,428	$ -	$ 27,278,893	$ -	$ 262,641,871		$ 451,907,193				
				10%	$ 323,972,857	$ -	$ 54,557,787	$ -	$ 525,283,742		$ 903,814,386				
				15%	$ 485,959,285	$ -	$ 81,836,680	$ -	$ 787,925,613		$ 1,355,721,579				
				Target											
				5%	$ (163,475,078)	$ -	$ (10,873,731)	$ -	$ (114,398,968)	$ -	$ (288,747,778)				
				Dif	$ (1,488,650)	$ -	$ 16,405,162	$ -	$ 148,242,903	$ -	$ 163,159,415				
				10%	$ (329,320,938)	$ -	$ (16,272,587)	$ -	$ (304,200,635)	$ -	$ (649,794,160)				
				Dif	$ (5,348,081)	$ -	$ 38,285,199	$ -	$ 221,083,108	$ -	$ 254,020,226				
				15%	$ (487,010,895)	$ -	$ (81,836,681)	$ -	$ (787,925,614)	$ -	$ (1,356,773,190)				
				Dif	$ (1,051,611)	$ -	$ (0)	$ -	$ (0)	$ -	$ (1,051,611)				

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2013-15 & 2015-17 BIENNIA**

Agency: Department of Human Services
Contact Person (Name & Phone #): Ralph Amador, 503-569-1632

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	Program Area (SCR)	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory	2013-15 Ending Balance In LAB	2013-15 Ending Balance Revised	2015-17 Ending Balance In CSL	2015-17 Ending Balance Revised	Comments
Limited	060-02-00-00000	0401-General Fund	Fees Related to CFAA & Marriage License Tax	409.300 & 409.273	1,021,951	1,021,951	227,304	1,796,000	Marriage License Tax revenue and CFAA revenue are projected and do not have funds available at the start of the Biennium so we carry forward enough money to fund contracts for Community Based Domestic Violence the first quarter of the new biennium allowing the contracts to continue until
Limited	060-02-00-00000	0401-General Fund	Fees Related to CFAA & Marriage License Tax	409.300 & 409.273	106,882	106,882	29,866	95,000	CFAA revenue are projected and do not have funds available at the start of the Biennium so we carry forward enough money to fund Community Based Sexual Assault Victims contracts for the first quarter of the new biennium allowing the contracts to continue until revenue is received.
Limited	060-07-00-00000	0401-General Fund	Matching funds for YTP provided by school districts	CFR 34 Part 74.24 Program Income	1,229,767	1,229,767	1,229,767	2,681,886	School districts do not bill for the final payment against the contract until after the close of the biennium. These funds allow us to make those payments with out impacting the new bienniums budget. These are dedicated funds as the Interagency Agreement requires the school district to provide matching funds to OVRS making the dollars Program Income and can only be used for
Limited	060-02-00-00000	0401-General Fund	Children's Trust Accounts		-	-	-		Dedicated Funds. Children's Trust Care of State Wards Trust Accounts are balanced to expenditures prior to the final close of the biennium.
Limited	060-01-00-00000	0401-General Fund	Childcare Development Fund Grant (209001)	CFR 45 Pt 98, 93.596, 93.575 Interagency Agreement with Employment	-	-	-	-	Federal Funds come in as Other Funds form Employment. Any recoveries will be used to offset expenditures. All funds are expended with in the biennium.
Limited	060-01-00-00000	0401-General Fund	TANF Recoveries	93.558, 45 CFR Pt 263	-	-	-	-	All funds are used to offset expenditures as these are recovery dollars.
Limited	060-02-00-00000	0401-General Fund	Children's Trust Accounts		-	-	-		Dedicated Funds. Children's Trust Care of State Wards Trust Accounts are balanced to expenditures prior to the final close of the biennium.
Limited	060-02-00-00000	0401-General Fund	Children's Trust Accounts		-	-	-		Dedicated Funds. Children's Trust Care of State Wards Trust Accounts are balanced to expenditures prior to the final close of the biennium.
Limited	060-02-00-00000	0401-General Fund	Family Drug Court Program		-	-	-		Revenue comes in from the Deschutes County Mental Health program.
~~Limited~~	~~060-01-00-00000~~	~~0401-General Fund~~	~~Food Stamp Admin.~~		~~-~~	~~-~~	~~-~~	~~-~~	~~Overpayment recovery for Food Stamps. This is used to offset expenses paying for the positions and FTE for the Overpayment Recovery Unit.~~
Limited	060-02-00-00000	0401-General Fund	Travel Tracking Grant		-	-	-	-	Not cash related - VISA travel tracking only.
Limited		1030-HUM RES VOLUNTEER DONATED FUND.	Volunteer Program Donated Funds	OREGON LAW: 1999 c.421 §9 (3)	-	-	-	261,740	Indicates private donations shall be deposited to the Volunteer Program Donated Fund Account, and all funds deposited in that account shall be used for direct program expenditures for the Volunteer Program.
Limited	060-09-00-00000	1029 DD COMMUNITY HOUSING FUND	DD Community Housing Maintenance Account	ORS 427.340 and OAR 411-315-0010 through 411-315-	3,514,066	3,514,066	550,000	550,000	Oregon Housing and Community Service Department (OHCDSD) agreement requires $500,000 be kept in reserve to assure the maintenance of assets purchased with GO bonds.
Limited	060-09-00-00000	1112 COMMUNITY HOUSING FUND 95% SALE	Fairview Trust for DD Community Housing Fund	ORS 427.340 and OAR 411-315-0010 through 411-315-	2,108,462	5,020,241	,	5,112,741	At least 95% of all Fairview State Training Center sale proceeds shall remain in this account in perpetuity. Note the significant decrease in 2011-13 is the result of December 2012 Rebalance allowing DHS to use 6.9M of the funds with the expectation that it will be recouped in BI 13-15.
Limited	060-09-00-00000	1113 COMMUNITY HOUSING FUND 5% & INT	Fairview Trust for DD Community Housing Interest Account	ORS 427.340 and OAR 411-315-0010 through 411-315-0090	750,000	916,600	916,600	993,340	PER ORS 427.340 DHS may expend, for the purposes of ORS 427.330 to 427.345, any earnings credited to the account, including any income from the lease of surplus property and any interest earned on monies deposited in the account, and up to 5% of any sale or transfer proceeds initally credited to the account by DAS.
Limited	060-08-01-00000	0401-General Fund	Nursing Facilities Provider Tax	ORS 2003 Chapter 736 Section 15	-	-	-	-	Dedicated funds generally expended within the biennium, however, carry over is allowed within statute and such funds should be moved to the Long Term Care Facility Quality Assurance Fund.
Limited	060-01-00-00000		State Family Pre SSI/SSDI	CAF MISC. Funds					V-PRE-SSI ST FAMILY GRANT SSA REFUNDABLE
Limited	060-01-00-00000		State Family Pre SSI/SSDI	STATE FAMILY PRE SSI OTHER					V-PRE-SSI ST FAMILY GRANT SSA REFUNDABLE
Limited	060-08-01-00000		Medicaid Estates Recovery Revenue	ORS 416.350	-	-	-	-	Reimbursement revenue from Medicaid estates - collected in proportional share of Fed/State cost sharing. Used to offset costs for Nursing Facilities.
		1346 Quality Care Fund	Qualtiy Care Fund	Chapter 837 Oregon Laws 2009 section1 & 5				3,000,000	Restricts spending for training, technical assistance, quality improvement initiatives and licensing activities as indicated in section 1. Chapter 837 Oregon Laws 2009 section 20 establishes a license fee for health care facili.ty licenses to be paid to DHS. Subsection 13 indicates all moneys received from Long term facilities shall be deposited to the quality care assurance fund established in section 1. Enabling legislation is established in OR Law c 837, therefore this fund is restricted R3.

Objective: Provide updated Other Funds ending balance information for potential use in the development of the 2015-17 legislatively adopted budget.

Instructions:

Column (a): Select one of the following: Limited, Nonlimited, Capital Improvement, Capital Construction, Debt Service, or Debt Service Nonlimited.

Column (b): Select the appropriate Summary Cross Reference number and name from those included in the 2013-15 Legislatively Approved Budget. If this changed from previous structures, please note the change in Comments (Column (j)).

Column (c): Select the appropriate, statutorily established Treasury Fund name and account number where fund balance resides. If the official fund or account name is different than the commonly used reference, please include the working title of the fund or account in Column (j).

Column (d): Select one of the following: Operations, Trust Fund, Grant Fund, Investment Pool, Loan Program, or Other. If "Other", please specify. If "Operations", in Comments (Column (j)), specify the number of months the reserve covers, the methodology used to

Column (e): List the Constitutional, Federal, or Statutory references that establishes or limits the use of the funds.

Columns (f) and (h): Use the appropriate, audited amount from the 2013-15 Legislatively Approved Budget and the 2015-17 Current Service Level as of the Agency Request Budget.

Columns (g) and (i): Provide updated ending balances based on revised expenditure patterns or revenue trends. Do not include adjustments for reduction options that have been submitted unless the options have already been implemented as part of the 2013-15 General Fund

Column (j): **Please note any reasons for significant changes in balances previously reported during the 2013 session.**

Additional Materials: If the revised ending balances (Columns (g) or (i)) reflect a variance greater than 5% or $50,000 from the amounts included in the LAB (Columns (f) or (h)), attach supporting memo or spreadsheet to detail the revised forecast.