City of Ashland
Social Service Grants 2005-06

Agency and Program Name	FY 05-06 Requested	Cate	James	Jay	Kathleen	Lynn	Ray	Russ	Average	FY 05-06 Proposed
ACCESS, Inc.	$ 5,000	$ 5,000	$ 4,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	4,857	5,000
The Art of Yoga Project	18,500	-	-	-	1,000	-	-	-	143	-
CASA of Jackson County, Inc.	2,678	5,356	2,678	2,600	2,500	2,500	2,000	2,600	2,891	2,500
Center For NonProfit Legal Services, Inc	5,500	5,500	3,000	5,000	5,000	5,000	5,500	5,250	4,893	5,500
Children's Advocacy Center	3,060	3,060	3,060	3,000	3,000	2,000	2,000	3,000	2,731	2,700
Children's Dental Clinic of JC	3,000	3,000	3,000	3,000	3,000	3,000	2,000	2,000	2,714	3,000
C.Health Center	30,600	30,600	20,000	30,000	25,000	30,600	30,600	30,000	28,114	30,200
C.W. - Dunn House	20,350	15,000	15,000	19,000	15,000	15,000	10,000	20,000	15,571	15,000
C.W. - Help Line	8,400	8,400	4,000	8,000	8,000	7,500	5,000	8,400	7,043	7,000
C.W. - Parent Education	2,140	2,140	2,140	0	2,000	1,500	2,140	-	1,417	1,400
C.W. - Sexual Assault Victim Services	5,000	2,000	4,000	2,500	5,000	2,000	1,000	5,000	3,071	2,500
C.W. - Personal Safety	1,392	1,392	1,392	0	1,000	-	1,000	-	683	-
Easter Seals	5,000	1,000	4,000	0	1,000	-	-	-	857	-
Help Now! Advocacy Center	8,000	1,000	4,000	0	3,000	1,500	-	-	1,357	1,000
ICCA/CERVS	18,000	12,000	14,000	16,000	8,000	15,000	18,000	15,000	14,000	14,000
Jackson County SART	5,000	7,000	3,000	2,500	2,000	1,000	-	2,000	2,500	2,500
Mediation Works	8,000	2,000	4,000	0	2,000	4,000	4,000	3,000	2,714	2,000
Ontrack, Inc	2,000	2,000	2,000	0	2,000	2,000	2,000	2,000	1,714	2,000
Options for Southern Oregon, Inc.	6,190	5,000	5,000	0	5,000	-	2,000	-	2,429	2,000
Planned Parenthood of SW	5,000	3,000	3,000	0	2,500	1,500	2,500	2,000	2,071	2,000
RV Manor - Senior Volunteer	2,000	2,000	2,000	0	1,000	1,500	2,000	1,000	1,357	1,300
RV Manor -Foster Grandparent	1,500	-	1,500	0	1,000	1,000	1,000	1,000	786	1,000
Rogue Valley SMART	4,500	-	3,500	0	1,000	1,000	3,000	-	1,214	-
Salvation Army, Medford Citadel	5,000	2,000	3,000	5,000	1,000	1,500	1,000	-	1,929	1,900
SOASTC	3,060	1,000	3,060	3,000	1,000	-	-	-	1,151	1,000
So.Ore Child Study and Treatment Cente	3,000	4,000	3,000	3,000	2,000	-	2,000	2,500	2,357	2,500
So.Ore Drug Awareness	10,000	-	7,000	0	1,000	500	5,000	-	1,929	1,000
Trinity Respite Center	3,000	1,000	3,000	1,000	1,000	-	-	-	857	1,000
Sul	194,870	124,448	127,330	108,600	110,000	104,600	108,740	109,750	113,353	110,000
Bu	110,000									110,000
Remainder										-

From Cate

GOAL # 2:

ENSURE THAT THE ALLOCATION OF PROGRAM FUNDING IS FAIR, OBJECTIVE AND CONSISTENT.

POLICIES:

(2-1) Allocate public resources, from within the City's general fund, in an amount set by resolution, for the direct support of essential safety net services.

In recognition of the reality that the costs associated with the provision of essential safety net services increase on an annual basis, give due consideration in the City's budget process to matters pertaining to inflation indexes, environmental factors which may contribute to increased demand for services, and compensation rates (*livable wages*) paid to social service employees.

(2-2) Allocate, as permissible by the CDBG Block Grant process, on an annual basis, fifteen percent (15%) of categorical CDBG resources for the direct support of qualifying safety net services.

(2-3) Expend through the City's budget process, resources allocated from the City's General Fund and the proportional share of CDBG funds, in the charitable, private not-for-profit sector for the provision of safety net services such as:

(A) Temporary, emergency food and shelter;
(B) Substance abuse education, prevention and treatment;
(C) The preservation of dignity and equal access to justice;
(D) Primary and preventive health care services;
(E) Critical supportive services for families, seniors and victims.

GOAL #3:

ENSURE THAT FUNDED PROGRAMS DIRECTLY ADDRESS CHANGING PRIORITIES AND ARE ADMINISTERED IN AN EFFECTIVE AND COST-EFFICIENT MANNER

POLICIES:

(3-1) Ensure that the City consults with local agency officials in the design, delivery and evaluation of services, by establishing an Ad Hoc Human Services Task Force with its primary focus on working on the implementation of Policies 1-2, 3-2 and 3-3 and related human services planning and management issues.

(3-2) Develop and adopt techniques for analyzing and measuring the equity of outcomes and benefits of services delivery which can be integrated into planning, evaluation and budgeting components. Programs should be evaluated on the basis of well defined performance standards that relate to program administration and participant development, in addition to the basis of numbers served or placed.

(3-3) Develop a format for presentations to the Budget Committee, to be made every 3-4 years, which utilize the results of the monitoring framework outlined in Policy 3-2.

19 Myrtle Street
Medford, Oregon 97504
(541) 773-3863

246 4th Street
Ashland, Oregon 97520
(541) 482-9741

March 14, 1997

Cate Hartzell
881 East Main
Ashland, Oregon 97520

Dear Cate,

Thanks for your support and advocacy at last evenings meeting. Enclosed, you will find copies of the "Human Services Grants History" I referenced in our discussion following the meeting. As there has been no additional study since 1986, I have continued to utilize the policy guidelines outlined in preparing Community Health Center grant applications to the City of Ashland.

I have often commented that the clarity of prioritization in the Ashland grant process was of benefit to both the Grant Sub-Committee and the applicant organization. The Committee benefits by not feeling overwhelmed by the number of requests and the need to say no to many worthy proposals. The agencies benefit by being able to focus their request and time toward funding sources where they are likely to be successful.

In 1995, I found the Ashland grant award process difficult, as the committee did not reference the study and subsequent policy guidelines in requesting proposals, or making decisions. Albeit, the final decisions were consistent with the overall policy guidelines.

It would be my hope that the city would return to the use of clearly defined guidelines for human service grants. Such a practice is of some urgency in the face of Measure 47 reductions, if we are to utilize available money in the most efficacious manner. **Clearly defined guidelines might also afford an opportunity for applicants to coordinate applications to effect the best outcomes with the available money.** Such a process was used amongst providers funded by Jackson County to provide essential "safety-net" services when County money started to decrease. By working together, the providers were able to agree on a funding distribution, subsequently adopted by the County Budget Committee, which maintained the integrity of the service network.

As funding gets tighter, in the absence of clearly articulated guidelines which reflect the outcomes to be achieved through the sagacious investment of City grant funds, the Grant Sub-Committee will be faced with ever increasing requests for grant from very worthy programs. In addition, as the City is forced to make more difficult decisions regarding the use of available dollars, the absence of clearly measurable outcomes that make a significant contribution to priority needs in Ashland, the City may simply eliminate the grant program in favor of other City services. This last outcome is self evident in the possibility that CDBG funds might be used for flood repairs if a bond measure is not passed.

Cate, thanks for your energy, vision and commitment on behalf of the needy of Ashland. Do give me a call if you have any questions. In general, I am best reached at 773-4563, however, I will be out of town the week of March 17th.

Sincerely,

Peg Crowley, M.P.H., R.N.
Executive Director

Enclosure

A non-profit corporation providing low cost primary HSHth ca

OUTCOMES-BASED EVALUATION GUIDELINES

Funders of human services, including the United Way, are placing more emphasis on the effectiveness of the agencies and programs that they fund. Many believe that evaluation of program outcomes is the best way of determining if a program is accomplishing its stated goals and objectives.

Outcomes-based evaluation is a systematic way to assess the extent to which a program has achieved its intended results.

In the past, the primary focus of evaluation efforts has generally been focused on measuring an agency's activities -- or **what staff do** (e.g., numbers of hours of counseling provided, number of bed nights, number of workshops held, etc.).

Now, outcomes-based evaluation changes the focus to results -- **what agency staff cause to happen.**

Outcomes evaluation focuses on the **"So what?"** question. How has a specific program made a difference? How are the lives of the participants better off than they would have been if they hadn't been part of the program?

THE LOGIC MODEL:
the foundation for effective outcome measurement

Development of the program logic model is an important tool of program evaluation and a **required component of your grant application.** Not only will a logic model help clarify your request, but it will assist the United Way in the evaluation of your proposal.

A program logic model shows the relationships between the activities a program conducts and the kind of changes these activities will produce.

Attached please find a sample logic model which identifies and describes the components of the model. You will also find a blank form which **must be** completed and submitted with your proposal. In completing the form please pay special attention to program outcomes and how these outcomes are related to the goal of the program, and ultimately and the outcomes further your agency's mission.

TECHNICAL ASSISTANCE & TRAINING

Any organization or agencies needing additional assistance completing the logic model may contact the United Way (773-5339) for one-on-one assistance.

CITY OF ASHLAND
Social Services Grant History and Requests

Agency and Program Name	Current Request $	Program $	1 Unit of Service	Funded By Grant Unit Cost $	# Units	# People	Admn %	Previously Awarded 99-00	00-01	Proposed 01-02	Addendum 5/3/01
Childrens Dental Clinic	1,500	42,158	Dental Appt	38.83	39	15	0.0	1,250	1,350	1,500	1,500
RV Manor -Foster Grandparent	1,180	421,845	Volunteer Hour	4.87	242	206	7.2	1,000	1,065	1,065	1,065
RV Manor - Senior Volunteer	2,360	180,818	Volunteer Hour	1.57	1,503	66	7.2	2,000	2,155	2,155	2,155
Community Health Center	28,910	446,547	Contact with Pro	70.00	413	266	6.5	27,130	28,910	28,910	28,910
JC Children's Advocacy Center	2,440	411,599	Service Hour	55.38	44	5	19.0	2,441	2,620	2,620	2,620
JC Community Justice CASA	2,345	240,138	One Child/Year	960.00	2	2	12.0	2,130	2,290	2,290	2,290
Ontrack, Inc	1,500	7,828	Counselor Hour	20.07	75	8	13.0	-	-	1,500	1,200
Center For Non Profit Legal	4,972	665,683	Client Resolution	142.00	35	63	9.0	4,225	4,520	4,520	4,520
Mediation Works	7,462	75,737	Mediation Session	189.00	39	78	12.8	4,260	4,560	4,560	4,560
Southern Oregon Drug Awareness	2,425	19,370	One Person	3.34	726	726	27.0			1,165	865
Access	5,000	288,926	Pound of Food	0.20	25,000	5,000	5.5	2,670	2,860	2,860	3,760
ICCA/CERVS	10,866	119,532	Client Resolution	17.32	627	627	13.0	9,330	9,960	9,960	9,960
Walker School Playground	60,500	140,000	Annual Opportunity	343.75	176	1*	6.0	-	-	-	-
Oregon Child Foundation -SMART	9,990	309,686	Child- 28 Hours	270.00	37	37	11.0	-	-	-	-
Community Works - Dunn House	20,009	448,670	Shelter Use Night	51.60	386	27	15.1	17,075	18,190	18,190	18,190
Community Works - Rape Crises	2,847	81,789	Client Contact	68.15	42	42	15.1	2,430	2,590	2,590	2,590
Community Works - Parent Education	2,311	106,709	Client Service Hour	24.24	95	5	15.1	1,972	2,100	2,100	2,100
Community Works- Personal Safety	2,311	47,684	Client Presentation	7.30	317	317	15.1	1,972	2,100	2,100	2,100
Community Works - Help Line	9,612	104,160	Client Served	4.96	1,938	1,938	15.1	8,203	8,740	8,740	8,740
Community Works - The Grove	2,425	167,968	One Person Activity	6.71	361	10	15.1	-	-	1,500	1,200
Jackson County Juvenile								912	990		
						Subtotal		89,000	95,000	98,325	98,325
Travelers' Aid Fund - based on donations								2,000	2,000		
Total Requested	180,965					Budget		91,000	97,000		

RV Manor '01= 3,230 '02= 3,590
CW '01= 33,720 '02= 39,515
Mediation Wks 4,462 + 3,000 for new
* Agency # Units = 18

HUMAN SERVICES GRANTS HISTORY

Prior to 1986 the City of Ashland used Federal Revenue Sharing monies to fund human services grants. When these funds were no longer available, the city council set policy enabling funding for human services grants from the general fund, adjusted each funding cycle for inflation.

In 1985, a council/lay committee studied human service needs in Ashland. The committee identified the following categories of needs:

children 0-18 years
- treatment and prevention of physical and sexual abuse
- treatment and prevention of mental and emotional disorders

survival needs
- food
- fuel
- shelter
- medical
- transportation
- legal aid
- crisis services
- information and referral

health
- urgent care for indigents
- in-home care - nursing, homemaking
- prevention - primary care
  1) well-baby, well-child clinics
  2) prenatal
  3) family planning
  4) immunization
- dental health for adults
- semi-elective surgical procedures for adults

substance abuse

At the March 28, 1989 human services subcommittee meeting, the human services subcommittee agreed that:
- grant funding would be on a two-year cycle and
- proportional allocation adjustments would be made in the second year of funding, depending on the overall rise and fall of the general fund.

Highlights from

COMMUNITY HEALTH CARE AND FUTURE SOCIAL NEEDS COMMITTEE REPORT

At the request of the Budget Committee for the City of Ashland, a citizen's committee was appointed to address the need for new sources of revenue to cover the City's ongoing commitment to health and social service programs for the needy. One subcommittee focussed on the need: the other focussed on alternative sources of funding.

To qualify for Medicaid in Oregon, income must be below 75% of poverty level. State health planners use 133% to 150% of poverty level as the index of "medically needy." Estimates extrapolated from the 1980 census (with income groups assigned uniform growth rates and state-wide unemployment percentages) indicate that there are 2,641 persons in Ashland who are medically needy. Other statistics suggest that the number is higher.

A formula suggested by the Oregon Department of Health Planning for estimating primary health care needs shows that the population of uninsured/indigent persons need up to 5,000 outpatient visits per year that are not currently provided. Ashland does not have a shortage of physicians but for many underemployed and uninsured residents medical care is unaffordable.

Agencies given grants by the City and the estimated number of Ashlanders served in 1985 are: Children's Dental Clinic- 45; Community Health Center- 1200; CERVS- 304 vouchers (# persons NA), 132 in the gleaning project; Teen Center- 275, Crisis Intervention Services 5,320 calls. Calls from Ashland to CIS average/month: emergency food, shelter, clothing, medicine/health, or transportation- 45, suicide- 6; sexual assault -12; youth issues -19; elderly (?) -19; domestic violence -27; parenting -15; and physical child abuse -11 CIS also referred 2400 calls to other Ashland agencies. They note emergency mental health housing for the homeless and counselors for children as unmet needs. There are no dental services for needy adults.

Forty-five of the 66 delinquent accounts in Sept.'85 - Jan.'86 for Emergency Room treatment at Ashland Community Hospital were for medical needs rather than accidents. Of those 45 cases, 24 were complaints of pain or colds. A review of nurses' notes indicated that only 5 of the 24 might have waited for a regular visit to a doctor

The subcommittee concluded that an information and referral resource was necessary. They felt that the City might reconsider the multi-service center concept. Listed as priorities were:

SHORT TERM (EXISTING) NEEDS

1. Health Care
2. Information and referral crisis services with emphasis on coordination and communication
3. Domestic violence, mental health

LONG TERM (PLANNING) NEEDS

1. Information and referral with emphasis on on-going assessment of coordination. Consider computerized resource guide
2. Enhancing the use of trained volunteers to improve cost effectiveness of service

The financial resources subcommittee found that all alternative sources of funds to replace federal revenue-sharing monies combined would not provide the current level of support for health care and social needs. It is estimated that 50% of the workforce is employed in tourist-related jobs. Since pay and benefits are traditionally low in tourism, the subcommittee recommended that the transient occupancy tax be increased from 6% to 7% The resultant revenues would be assigned to the agencies meeting health and social needs.

Committee- Chair- Caroline Johnson, Don Laws, Ev Elerath, Sue Reid, Linden Crouch, Emil Cloutier, Phil Arnold, Barbara Dunlap, Wes Morie, Craig Mather, Sybil Macy, Nancy Ames; Ex Officio- Brian Almquist, Bob Nelson.

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REPORT OF THE

COMMUNITY HEALTH CARE AND FUTURE SOCIAL NEEDS COMMITTEE

JUNE 1986

Committee:

Carolyn Johnson- Chairperson
Don Laws
Ev Elerath
Sue Reid
Linden Crouch
Emil Cloutier
Phil Arnold
Barbara Dunlap
Wes Hoxie
Craig Mather
Sybil Macy
Nancy Ames
Brian Almquist- Exofficio
Bob Nelson- Exofficio

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In these times of every increasing federal governmental concerns about budget deficits and the rising costs of tax-supported programs, local governments are being forced to provide more and more services to those who cannot provide for their own needs. These federal funding cuts in health care and other social service programs initiated in 1981 while intended to protect the truly needy have actually impacted those on the margin of poverty. This segment of the population has been identified as "falling through the cracks".

In January, Mayor L. Gordon Medaris, at the request of the Budget Committee, appointed a citizen's committee to address the need for new sources of revenue to cover the City's ongoing commitment to health and social service programs for the needy in Ashland. At its first meeting the committee divided into two subcommittees - one to focus on estimating "the need", and the other to focus on identifying alternative sources of funding.

The subcommittee on Human Service Needs Assessment spearheaded by Nancy Ames, Director of the Community Health Center, addressed the following questions:

1. How many Ashland residents have human service needs and what kinds of needs do they have?
2. Are the existing human service agencies addressing these needs? If so, do they have enough resources to address them adequately? If not, what is the magnitude and kind of needs that must still be addressed?
3. Can we identify "the needy" and whether or not their needs would be met if they could afford available services?

Recognizing the limits the committee would face in terms of inadequate time, money, staff, data management resources and the sophisticated methodology needed for a thorough study, we set a goal of determining in general what social service needs exist in our community and to what extent these needs appear to be met by existing services.

Information gathering was confined to brief statistical overviews and subjective testimony from persons either working in human services or working in the community on behalf of people with human service needs. The following sources of information were chosen to prepare this report:

1. An outline of human services needs prepared by the Jackson County Human Services Commission in the course of its ongoing needs assessment process for the county as a whole. Appendix A.
2. Testimony from human service providers regarding the needs they perceive in this community regardless of whether or not those needs are a concern of their own agency. Verbal reports were heard from Crisis Intervention Services (CIS), CERVS, Children's Dental Clinic, Ashland Teen Center, the Community Health Center, and Steve Bohlert a representative of the Ministerial Association.

3. Data submitted by these agencies to the Budget Committee identifying the numbers of persons served.

4. Data collected at Ashland Community Hospital related to use of the Emergency Room as an inappropriate source of health care and the amount of uncollected charges. Appendix B

Using data from the 1977 National Medical Care Expenditure Survey adjusted to 1984, 24% - 37% of the U.S. population under 65 years of age lacks adequate health care coverage. State Health Planners use 133% to 150% of poverty as an index of "medically needy". Although currently one must be below 75% of poverty to qualify for Medicaid in Oregon. That translates to an extimated 2641 persons between 75% and 150% of poverty in Ashland.

THE POPULATION — POVERTY LEVELS IN ASHLAND, OREGON

LEVEL OF POVERTY Incomes as a per cent of Federal Poverty Level	1979 - Number of Persons 1	1986 - Estimated Number of Persons 2
0 - 75%	1481	1555
0 - 100%	2420	2541
76 - 100%	939	986
75 - 124% *	1722	1808
126 - 149% *	794	833
150 - 199%	1384	1453
200% and above	8440	8862

*State Health Planners use 133% to 150% of poverty as an index of "medically needy" although currently one must usually be below 75% of poverty to qualify for Medicaid in Oregon.

1 From 1980 Census, based on 1979 levels of reported income.

2 Using 5% increase in population, based on total figures 1980 and 1986, and estimating each group increase at same rate. NOTE: This is probably conservative, since the December 1984 State of Oregon Labor Market Analysis for District 8 (Jackson and Josephine Counties) reports that the % of population under 100% of poverty in 1979 was 11.7% nationally and by 1983 was 15.2% of the population. Jackson County has stayed generally in a position of higher unemployment and lower median income than either State or National averages during that time.

A study published in the Journal of the American Medical Association (JAMA) in February, 1986 indicated that the segment of the population lacking adequate health insurance protection includes the short-term unemployed and their dependents, persons uninsurable for medical reasons, the working poor and self-employed individuals who do not have access to group coverage and who cannot afford the premiums for adequate individual coverage.

The testimony from the human service providers, particularly Crisis Intervention Services and CERVS gave the subcommittee insight into what might be called the "demographics of need" in Ashland.

C.I.S. keeps data collected for one month of every six, on the kinds of calls for help that are generated in Ashland.

5,320 calls of 28,000 total calls are from Ashland. The following is a breakdown of Ashland requests:

CALLS PER MONTH	AREA OF CONCERN
45	Emergency Needs - food, shelter, clothing, medicine/health or transportation
6	Suicide Calls
12	Sexual Assault
19	Youth Issues - all kinds (from "I don't get enough allowance" to "I have just run away" or serious family disputes
19	Elderly
27	Domestic Violence
15	Parenting
11	Physical Child Abuse

In addition, 2400 referrals were made to agencies in Ashland and 36 Ashland residents were sheltered in Dunn House, 13 families per week were receiving support from Parents Anonymous groups and 20 per week from domestic violence support groups. C.I.S. identified that unmet needs included emergency mental health housing for the homeless (including transients) and counselors for children.

CERVS pointed out that there is no current economic index which measures the problem of underemployment. That is, statistics on employment take into account both part-time and seasonal/temporary work and full-time, long-term employment. As a result, it is difficult to measure the numbers of people whose incomes do not provide enough for adequate health care, transportation, medicines, utilities etc. CERVS testimony reiterated the need for adult mental health services and concerns about domestic ciolence. In addition to those who received vouchers for emergency needs, 132 people in Ashland participated in the gleaning project.

Children's Dental Clinic (CDC) reported that there had been a slight decline in requests for children's dental treatments. However, there are no services provided for adult dental care for the indigent.

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The Teen Center noted that although they provided services to a cross-section of young teens in Ashland, there appears to be growing numbers of separations and divorces with resulting single-parent households which add to the problems of adolescence. The Teen Center suggested that more recreational opportunities and more school counseling and other counseling might help offset these emotional stresses.

Community Health Center (CHC) agreed that domestic violence/sexual abuse appeared to be increasing. It was stressed that the problem with the medical service delivery system in Ashland is not a shortage of physicians, but rather that medical care is unaffordable for a large number of underemployed and uninsured. Nancy Ames of CHC illustrated a formula that had been suggested by the State Department of Health Planning to obtain some idea of primary health care needs. The population of uninsured/indigent within the City of Ashland would require up to 5000 outpatient visits per year that are not currently provided. The State of Oregon's Health Planners are preparing a formal study to be completed by the end of this year.

A review of 207 "no-pay" emergency room accounts for visits made in September, October, November 1985 and January 1986 concluded that 62% had no insurance and 64% had no physician. The 50% who were listed as unemployed included retired seniors over age 65, SOSC students and minors bringing the actual unemployed to 23%.

THE SERVICES PROVIDED BY AGENCIES SUPPORTED BY CITY OF ASHLAND GRANTS IN ASHLAND

AGENCY	NUMBER OF ASHLAND SERVICES	EST. NUMBER OF INDIVIDUAL CAS	
Ashland Teen Center	Visits 4500	Est. People Served	275
Childrens' Dental Clinic	Est. + 45 based on Ashland population as a percentage of Jackson County's		45
Community Health Center	2400		1200
CERVS	304		NA
Crisis Intervention Services - separate calls, referrals, residents, group counseling sessions	9472		NA
TOTALS	16,676 or 321/week	Estimated Only	over 1500

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Conclusions:

On the basis of information gathered from these sources, the subcommittee established priority needs for both the short and long term. An attempt was made to limit the list to the number and type of needs the City of Ashland might reasonably expect to address.

Short Term (Existing) Needs

1. Health Care
2. Information and Referral Crisis Services with emphasis on coordination and communication
3. Domestic Violence and mental health

Long Term (Planning) Needs

1. Information and Referral with emphasis on on-going assessment of, coordination. Consider implementation of computerized resource guide
2. Enhancing the use of trained volunteers to improve cost effectiveness of service delivery

Taken together, the information provided both from testimony and statistics very clearly supported the value of keeping some sort of information and referral resource active to avoid unnecessary inefficiences such as inappropriate emergency room use, and people not taking advantage of available services when needed. C.I.S. stated that if their funding was cut they would decrease their emphasis on I & R. The subcommittee felt that the City of Ashland might need to reconsider the multi-service center concept and set its own Information and Referral system.

The Financial Resources Subcommittee studied several alternative sources of fundings to replace the loss of federal revenue sharing funds that have supported human resources in the past. Several small sources of funding were identified but added together they would not provide the current level of support to these agencies on an ongoing basis.

Ashland has a unique economy which results in there being substantial numbers of working poor in this community. The tourist industry traditionally has low salaries and minimum health care benefits. The latest figures used by the Ashland Chamber of Commerce are "approximately 50% of Ashland's work force is involved in tourist-related jobs," many of which typically pay base rate between $3.50 and $5.00 per hour. After average withholdings the weekly take home pay is below the poverty line.

Therefore, Ashland has a need for low-cost primary health care and logically the funding for these programs could be tied to the tourist industry. Through the use of the hotel/motel tax, the citizens could maintain a program meeting human services needs without direct cost to themselves. The tourists, the visitors that we serve would pay.

The committee therefore recommends an increase in the transient occupancy tax from 6% to 7% with the increase to be used to fund those agencies identified by the Budget Committee and the City Council as meeting the objectives discussed herein.

PRELIMINARY HUMAN SERVICES PRIORITIES
PREPARED FOR DISCUSSION PURPOSES FOR THE PUBLIC HEARING
NOVEMBER 7, 1985

CHILDREN

Two age categories identified: 0-12 years and 13-18 years

a) Treatment and prevention of physical and sexual abuse

b) Treatment and prevention of mental and emotional disorders

SURVIVAL NEEDS

a) Food

b) Fuel

c) Shelter

d) Medicine

e) Transportation

f) Legal Aid

g) Crisis Services

h) Information and Referral

HEALTH

a. Urgent care for indigents

b. In-home care -- nursing, homemaking

c. Prevention - Primary Care

   1. Well-Baby, Well-Child Clinics
   2. Prenatal
   3. Family Planning
   4. Immunization

d. Dental Health for adults

e. Semi-elective surgical procedures for adults

SUBSTANCE ABUSE

Appendix A

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The Oregon Strategy for Social Support

Introduction

An overarching objective of the Kitzhaber Administration is to improve the social and economic health of Oregon in ways that will be sustainable over time. Investing in people is the best -- and perhaps the only -- way to achieve that goal, since the strength and stability of any society depends on a body of citizens who are as independent and productive as possible.

The reality is, however, that not all citizens are equally productive and self-sufficient. Many of them depend, either permanently, or temporarily at different times of their lives, on some form of support from others, including that provided by state government.

Oregonians have a long tradition of helping to care and provide for those who are unable to do so for themselves. Governor Kitzhaber endorses that tradition. At the same time, he believes that changing circumstances in the late 20th century warrant a re-examination of the way in which the state provides support for our citizens in need.

With few exceptions, the state's method of delivering social supports has not changed for the last 30 years. In order to determine what changes may be necessary, the Governor believes we must first answer some fundamental questions:

- What are our intended outcomes?
- What are we currently doing to achieve them?
- Are we doing it right?
- Are the right people doing it?
- Are the right people getting the help they need?
- And are we getting the outcomes we want?

The following paper describes a new vision for Oregon's system of social support. It outlines Governor Kitzhaber's Human Investment Framework, summarizes the findings and recommendations of his Work Group on Social Support Investment, and suggests policy directions as a basis for

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future action, aimed at achieving the highest possible degree of independence and productivity for all Oregonians.

Underlying Assumptions

Governor Kitzhaber's policy on Human Investment and Social Support rests on
several underlying assumptions:

- That everything we want to accomplish as a state depends on a thriving economy. A strong economy provides the resources necessary to fund the services and programs for which the state is responsible -- education, public safety, transportation, environmental protection, economic development, and a variety of human service programs.

- That a strong economy depends on the wide availability of well-paying jobs *and* on a workforce capable of filling those jobs. A key factor in the ability of communities to maintain or increase their well being is the economic opportunities available to their residents. When people lack decent-paying jobs or a way of moving into them, the social and economic health of the state as a whole is diminished.

- That a well-trained, highly skilled workforce depends upon the strength of our education system. While a great number of jobs could once be performed by workers with less than a full high-school education, success in the 21st century will require both a wider range of knowledge and a higher level of skills than has ever before been necessary. In fact, much of the increased demand on our social service, welfare, and criminal justice systems is due to the new inability of under-educated individuals to find work that pays well enough to support themselves and their families.

- That in order for children to be successful in school, and in order for adults to be successful at finding and maintaining employment, certain social supports must be present in their lives. Not only are these supports necessary for educational and/or workforce success, their presence make achieving success easier for most people, while their absence will usually produce a bad outcome. Examples would be access to health care, access to transportation, adequate nutrition, and safe, affordable housing. Such supports are provided in some cases by

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government, but more often by families, neighbors, churches, and community organizations.

- That in an era of limited resources and a growing number of competing demands, it is essential that we invest prudently. Efforts should be focused and money should be spent in ways that will produce the greatest long-term benefit for the state as a whole. In particular, increasing the independence and productivity of needy Oregonians would allow more public dollars to be spent on further increasing the productivity and livability of our communities and our state.

This means, in part, eliminating inefficiencies and redundancies in current programs, as well as identifying and filling any gaps that may exist or may be likely to develop. It also means promoting a greater degree of partnership and shared responsibility among state agencies, between state and local government, and between the public and private sectors.

Historical Background

- Human Investment Framework

In the spring of 1996, Governor Kitzhaber developed a Human Investment Framework which established the goals for Oregon's approach to investing in its people. It recognized that no individual is literally self-sufficient, that everyone depends on support from family and community (both public and private) at various points in a lifetime in order to achieve success in school and in the workplace.

It held that such success was a matter of shared responsibility among state and local, public and private partners, including Oregonians as individuals. Government is responsible for the cost-effective use of public resources and is accountable for measurable results from the use of those resources. Private employers, as important community members, are responsible to act as good citizens and provide economic opportunities to the public. Individuals are responsible for working to improve their lives by striving for economic independence, rather than relying on public support for their daily expenses.

The Human Investment Framework also held that it is in the best long-term interests of all concerned -- individuals, families, the community and the

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state as a whole -- to provide those social supports that will ultimately allow as many citizens as possible to become contributing members of society, rather than merely maintaining them in positions of dependence.

- Social Support Investment Work Group

The task of determining which social supports were most necessary to achieving the highest possible degree of independence and productivity was given to the 28-member Social Support Investment Work Group, appointed by the Governor in May of 1996. The Group was asked to identify the specific social supports most critical to achieving educational and workforce success, to define the most appropriate role of state government in providing those "core" supports, and to recommend some strategic investments and/or interventions which would increase the availability of such supports to those most in need of them.

(A "support" should be distinguished from a "service," which is simply one means of delivering a support. Supports are delivered in numerous ways by numerous people and organizations -- e.g., families, churches, community service groups, government agencies.)

- Core Social Supports

The Work Group compiled a list of 26 social supports which appear to be most critical in helping individuals achieve success in school and in the workplace. From this list, the Group then selected ten which they recommended should be focused on immediately. The rationale was that, because of the inter-relationships which exist between various social supports, focusing attention in certain areas first could, in some cases, lessen the need for other supports later on. For example, availability of child care is critical to individuals getting and maintaining employment -- or finishing their education so they can obtain family-wage jobs. This abbreviated list includes, in alphabetical order:

Access to diagnosis and early evaluation
Access to in-home assistance
Access to health care (including specialized medical care)
Access tobacco, alcohol and other drug treatment
Affordable, safe housing
Available and accessible child care

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Employment opportunities
Life skills assistance
Non-residential physical and mental health therapy
Opportunities to learn outside the formal educational system.

The other sixteen core supports identified by the Work Group are (listed alphabetically):

Access to Alcohol, Tobacco and Other Drug Education
Access to Community Support Networks
Access to Transportation
Adequate Nutrition
Assisted Decision Making
Family Safety and Protection
Healthy and Accessible Environment
Information About Child and Human Development
Opportunities for Positive Interaction with Peers and Role Models
Opportunities to Explore Career Options
Parental Standards and Positive Discipline
Prenatal Care and Preparation
Responsible Health and Sexual Interactions
Safe and Accessible Work Environment
Safe and Secure Residential Settings
Understanding Financial Management

- Levels of Vulnerability

Individuals will need different types and amounts of social support, depending on their circumstances and on their stage of life. In order to make it easier to understand who may need what kind of support, and when, the Work Group divided the normal lifespan into six stages: early childhood, school age, adolescence, young adult, adult, and seniors. It also designated three types of population according to the degree of social support likely to be needed by each.

Those who make up the **general population** (the majority of Oregonians) need very little social support from state government either because their situation does not require it or because they are able to obtain it from family or community.

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