

**FY 2008/2009  
COMPREHENSIVE ANNUAL PLAN  
FOR MULTNOMAH COUNTY**

*Meeting the community's public health needs*

**MULTNOMAH COUNTY, OREGON**



*HEALTHY PEOPLE IN HEALTHY COMMUNITIES*

**JUNE 6, 2008**



**Public Health**  
Prevent. Promote. Protect.

**FY 2008/2009 COMPREHENSIVE ANNUAL PLAN FOR MULTNOMAH COUNTY**  
**MULTNOMAH COUNTY HEALTH DEPARTMENT**

**I. EXECUTIVE SUMMARY**

The FY 2008/2009 Comprehensive Annual Plan for Multnomah County presents a discussion of the needs, services and action items necessary for the Multnomah County Health Department to deliver public health services. The plan also serves to demonstrate Multnomah County's compliance with the public health services outlined in Oregon statute (ORS 333-014-055(2)), which mandate that each county provide a minimum level of service to protect the health of individuals and communities through the implementation of five public health core functions. As presented in Section III, the Health Department will continue to oversee and implement:

- A program to support the investigation and control of communicable diseases, including tuberculosis, STDs, HIV/AIDS, and emerging infections.
- A program to provide services to high-risk children and families, including immunizations.
- A program to support information and referral for residents in need.
- A program to capture and record health statistics.
- An environmental health program that includes control of vectors; and the inspection, licensing, and certification of restaurants, swimming pools, school facilities, care facilities, and food handlers.

Also presented in Section III, the Health Department will continue to implement a variety of programs, services and initiatives to ensure that locally-specific needs for health and safety are addressed, including:

- An organizational structure that assures an effective public health system.
- Health education and information in schools, workplaces, and community settings.
- Health education for high-risk families at home.
- Training for teens about pregnancy prevention, abstinence and nutrition education.
- Prevention programs to address chronic health conditions such as heart disease, obesity, stroke, asthma, lead poisoning, diabetes, etc.
- Systems and initiatives to monitor and address racial and ethnic health disparities.
- Emergency preparedness planning, exercises, and coordination.
- Health services to support the provision of medical and dental care to medically underserved communities throughout Multnomah County. Service sites and programs of the Department, include the following:
  - Five JACHO-accredited community health centers, four dental clinics, and 12 school-based clinics, and a medical van to serve medically underserved residents.
  - Specialty clinics focusing on the treatment of persons with sexually transmitted diseases, tuberculosis, and HIV.
  - Pharmacy, X-ray, laboratory, IT, and language services.
  - A corrections health program providing healthcare to inmates in County jails.

The FY 2008/2009 Plan also contains information about unmet needs (Section V) and the results of an assessment of the local public health system's capacity deficiencies (Section VIII). Individual reports and plans for the WIC Program, as well as the local immunization program are presented among the attachments.

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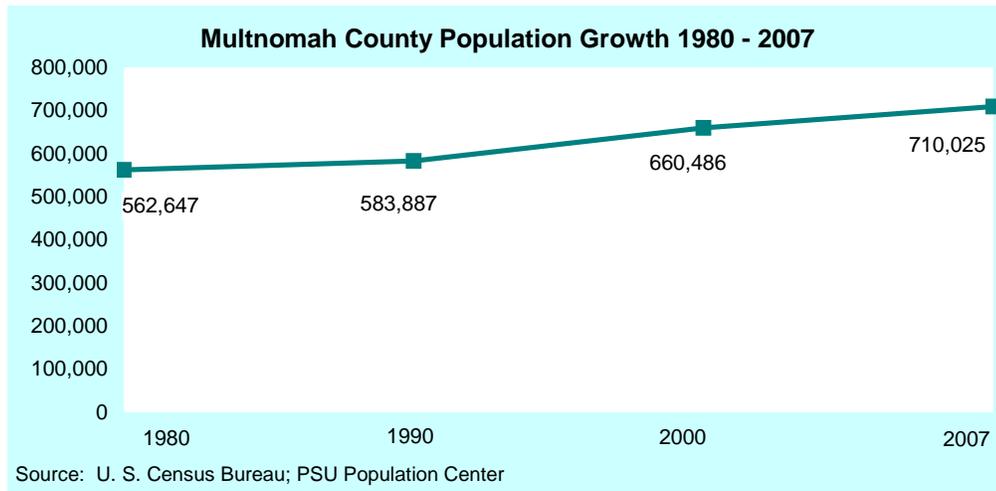
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**II. ASSESSMENT**

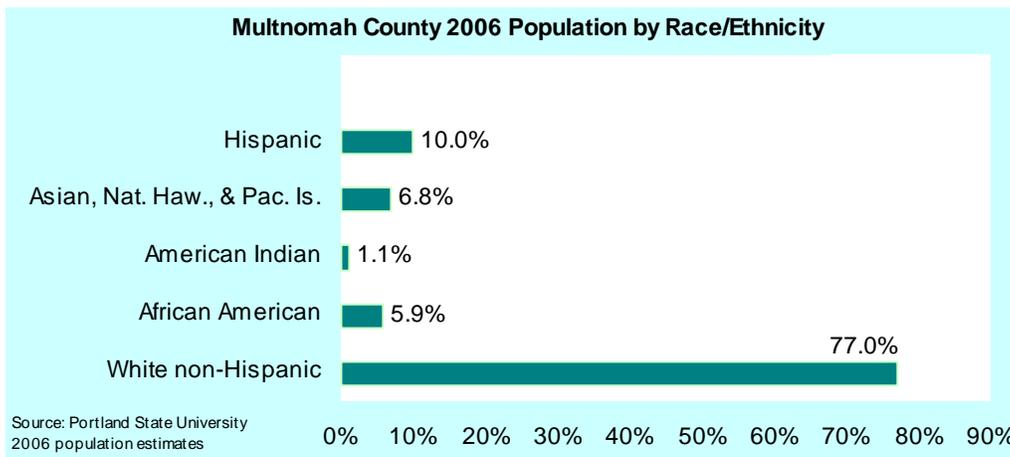
**A. Multnomah County**

**Background Information** - Multnomah County occupies 450 square miles in northwestern Oregon. The county is approximately 90 miles inland from the Pacific Ocean. It borders the Columbia River on the north, Clackamas County to the south, Hood River County to the east and Washington County to the west. Multnomah County is home to Oregon’s largest cities (Portland and Gresham).

**Population** - Multnomah County continues to be the most populous county in Oregon with 19% of the State’s population. Multnomah County grew to 710,025 residents in the year 2007. The population increase from 2000 to 2007 was 7.5%, or 45,539 persons. Over the same period, the population of Oregon increased 9.5%, or 324,056 persons.

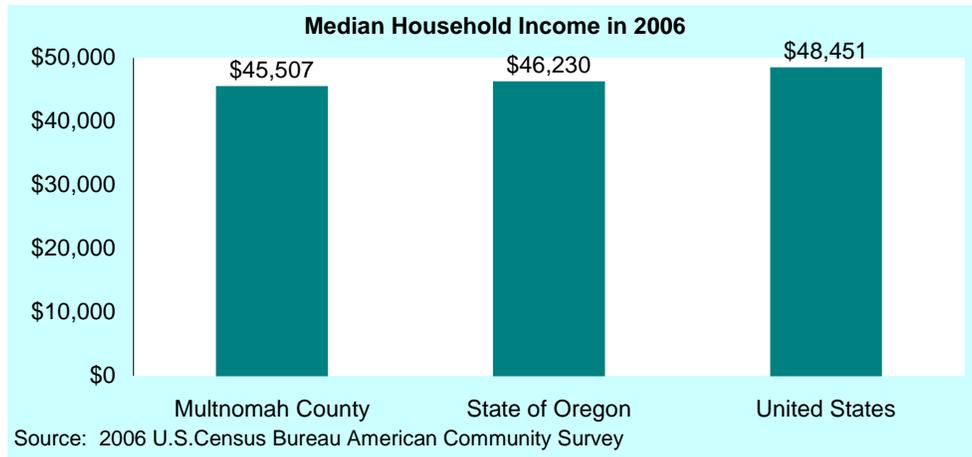


Multnomah County’s population is comprised of 77.0% White non-Hispanics, 5.9% African Americans, 1.1% Native Americans, 6.8% Asians (including Pacific Islanders), and 10.0% Hispanics. The racial and ethnic mix of the population varies in Multnomah County, with north Portland being the most racially diverse geographic area, while the West side is the least diverse.

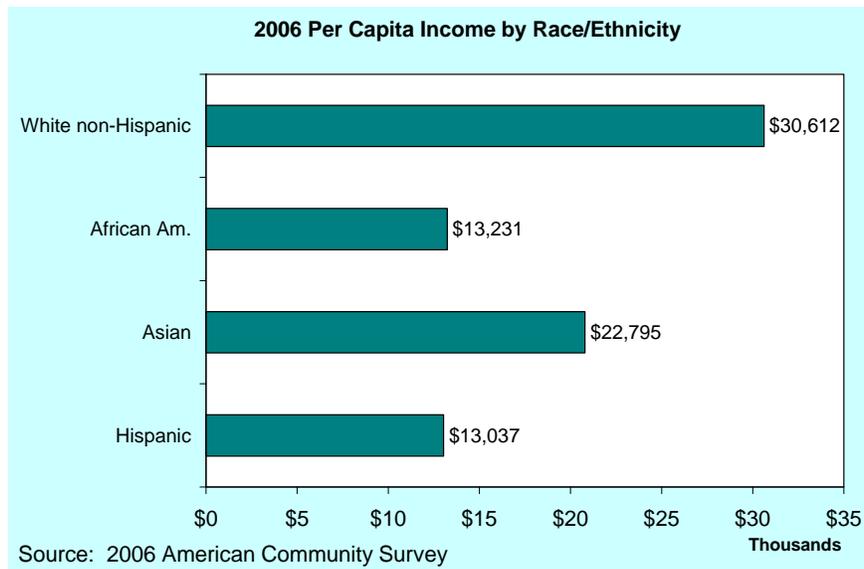


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**Income and Poverty** - Median household income for Multnomah County was \$45,507 in 2006. This is lower than the median income for Oregon and for the United States.



Approximately 15.6% of Multnomah County residents had incomes below the poverty level according to the 2006 American Community Survey. This is higher than the rates for Oregon and the United States (both with 13.3% of the population below the poverty level). The per capita income in Multnomah County was \$30,612 for White non-Hispanics, \$20,795 for Asians, \$13,231 for African Americans, and for Hispanic residents the per capita income was \$13,037.



**Health Care Insurance** - According to the 2006 Oregon Population Survey, 17% of Multnomah County residents were without health care coverage compared to 12.2% in 2000; and 9% of individuals under the age of 18 in Multnomah County were without health care insurance.

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**B. Comprehensive Health Assessment in Multnomah County**

The Health Department's Health Planning and Evaluation Program is responsible for conducting health assessments, evaluations, research, and data analysis in response to important health issues effecting Multnomah County. The program also provides information and data to support the Health Department's staff, community partners and the general public working to address local health issues (the program's role is further discussed on page 27).

The Health Planning and Assessment Program has prepared several reports over the past five years to assess health conditions and services in Multnomah County. These reports include:

- Emergency Medical Services Customer Satisfaction Survey (January 2003)  
<http://www.co.multnomah.or.us/health/hra/reports/EMSreport2003.pdf>
- The Environmental Health of Multnomah County (June 2003)  
<http://www.co.multnomah.or.us/health/hra/reports/enviroreport/>
- Perinatal Periods of Risk Analysis: Multnomah County 1997-2001 (January 2004)  
[http://www.co.multnomah.or.us/health/hra/reports/proreport97\\_01.pdf](http://www.co.multnomah.or.us/health/hra/reports/proreport97_01.pdf)
- The Health of Multnomah County (June 2004)  
[http://www.co.multnomah.or.us/health/hra/reports/health\\_of\\_mc\\_2004.pdf](http://www.co.multnomah.or.us/health/hra/reports/health_of_mc_2004.pdf)
- Latina Maternal and Child Health (June, 2005)  
[http://www.co.multnomah.or.us/health/hra/reports/latina\\_mch\\_2005.pdf](http://www.co.multnomah.or.us/health/hra/reports/latina_mch_2005.pdf)
- Multnomah County Top Ten Leading Causes of Death (June, 2006)  
<http://www.co.multnomah.or.us/health/hra/reports/DeathLeadingCauses2006.pdf>
- Multnomah County Health Department Programs to Address Health Inequities (Sept. 2006)  
[http://www.co.multnomah.or.us/health/hra/reports/addressing\\_inequities\\_2006.pdf](http://www.co.multnomah.or.us/health/hra/reports/addressing_inequities_2006.pdf)
- Racial and Ethnic Health Disparities in Multnomah County: 1990-2004 (October 2006)  
[http://www.co.multnomah.or.us/health/hra/reports/health\\_disparities\\_2006.pdf](http://www.co.multnomah.or.us/health/hra/reports/health_disparities_2006.pdf)
- Report Card on Racial and Ethnic Health Disparities (March 2008)  
<http://www.co.multnomah.or.us/health/hra/reports/reportcard.pdf>
- Unintentional Injury, Violence, and Premature Death Assessment (April 2008)  
This report is currently not available on the Health Department's Web site. Please call 503-988-3674 for information related to this report.

Each of these documents provides quantitative and qualitative data that is used by the Department's leadership and by local organizations working to identify public health initiatives, health promotion strategies and health services. Of the documents that are relevant to understanding the health of the community and specific health issues facing Multnomah County, *The Health of Multnomah County* (June 2004) provides the most comprehensive overview; and the report entitled *Racial and Ethnic Health Disparities 1990-2004* (October 2006) presents a

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thorough overview of a priority public health issue currently being addressed. The findings of each of these reports are summarized below.

- **Summary: The Health of Multnomah County (June 2004)** - This health assessment provides a comprehensive overview of the health and well-being of residents of Multnomah County (see [http://www.co.multnomah.or.us/health/hra/reports/health\\_of\\_mc\\_2004.pdf](http://www.co.multnomah.or.us/health/hra/reports/health_of_mc_2004.pdf)).

**The Health of Mothers and Infants in Multnomah County**

Births and Fertility Rates - The number of births in Multnomah County declined from 9,421 in 1990 to 9,340 in 2002. Fertility rates declined from 66 live births per 1,000 women ages 15 to 44 in 1990 to 61 in 2002. Fertility rates are highest for Hispanic women followed by Asian and African American women, and lowest for White non-Hispanic and Native American women.

Factors Associated with Pregnancy Outcomes - Several factors related to pregnancy outcomes showed substantial improvement during the 1990s. Births to mothers younger than age 20 declined countywide from 13% of all births in 1994 to 8% of all births in 2002. The percent of births to mothers younger than age 20 was down for all racial and ethnic groups. The percent of mothers receiving first trimester prenatal care has increased for White non-Hispanic and Asian women. The percent of African American women who received first trimester prenatal care peaked at 80% in 1997 and has decreased in subsequent years. In the 2000-2002 period, 84% of White non-Hispanic mothers, 78% of Asian mothers, 76% of African American mothers, 69% of Native American mothers, and 67% of Hispanic mothers received first trimester prenatal care. Self-reported use of tobacco and alcohol during pregnancy declined substantially from 1990 to 2002. Despite the decline in use of tobacco, 11% of mothers giving birth in 2002 reported smoking during pregnancy.

Unintended Pregnancy - Births from an unintended pregnancy are higher among women younger than age 20. Risk behaviors before and during pregnancy, such as smoking in the last three months of pregnancy, binge drinking three months prior to pregnancy, and prenatal care that began after the first trimester are more prevalent among mothers who gave birth from an unintended pregnancy.

Low Birthweight - The rate of low birthweight infants increased for all racial/ethnic groups except African Americans and Asians between the periods 1990-1992 and 2000-2002. Increases in low birthweight were particularly large for Native American births, up from 52 low birthweight infants per 1,000 births in 1990-1992 to 82 low birthweight infants in 2000-2002. Although the rate of low birthweight infants declined for African Americans, it remained higher than for all other racial and ethnic groups. The African American rate was 1.8 times that of White non-Hispanic births and 1.7 times that of Hispanic births during 2000-2002.

Infant Mortality - Although infant mortality rates have fluctuated over the decade, the overall trend has been downward, dropping from a high in 1991 of 10.7 deaths per 1,000 births to 4.6 deaths per 1,000 births in 2001. African Americans have experienced the largest decline

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in infant mortality, from 21 deaths per 1,000 births in 1990-1994 to 8 deaths per 1,000 births in 1997-2001.

Despite the decline, African American infant mortality remains higher than for other groups. Unlike other groups, Hispanic infant mortality increased in the late 1990s compared to the early 1990s. Insurance coverage has declined for adults ages 20-64, and Hispanics are the least likely to have health care coverage.

Leading Causes of Death Among Infants - During 1996-2001, sixty percent of the deaths of infants less than 28 days of age were caused by perinatal conditions such as low birthweight, prematurity, and respiratory distress. The second leading cause of death for infants less than 28 days of age was birth defects. Although the rate of death from Sudden Infant Death Syndrome (SIDS) has decreased dramatically since the mid 1990s, 38% of all deaths of infants age 28 days to 1 year during 1996-2001 resulted from (SIDS). The second and third leading causes of death were birth defects (16%), and perinatal conditions (7%).

### **The Health of Children**

Oral Health of Children Ages 6-8 - A 2002 study of Multnomah County elementary school children indicated that about one-third (35%) of 6-8 year olds had no dental cavities. Among White non-Hispanic and African American children, 38% had no dental cavities, while 24% of Hispanic children had no dental cavities. Hispanic children also have the highest percent of untreated tooth decay.

Leading Causes of Deaths of Children - There were 87 deaths of children ages 1-9 in Multnomah County from 1997-2002. The average annual death rate for boys was slightly greater than for girls ages 1-9. Hispanic children had an average annual rate of death slightly higher than other racial and ethnic groups.

Injury was the leading cause of death of children ages 1-9. Of 25 injury deaths during 1997-2002, 11 involved motor vehicles, five were caused by fire, and four were drowning deaths. Cancer was the second leading cause of death among children ages 1-9. From 1997-2002, there were 17 cancer deaths of children ages 1-9.

### **The Health of Adolescents**

Body Weight - Information from the 2001 Oregon Healthy Teens Survey indicates that 26% of eighth graders in Multnomah County and 28% in Oregon were overweight or at risk. Among eleventh graders, 18% in Multnomah County and 21% in Oregon were overweight or at risk.

Nutrition and Physical Activity - Approximately one-quarter of Multnomah County eighth and eleventh graders eat the recommended five servings of fruits and vegetables per day. About 40% of eighth and eleventh graders eat three to five servings of fruits and vegetables per day. Many Multnomah County youth do not participate in the recommended amount of vigorous physical activity on a regular basis. Both eighth and eleventh grade females do not meet Healthy People 2010 vigorous physical activity recommendations (20 minutes, three or more times a week). Eighth grade males meet the Healthy People 2010 objective for vigorous

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exercise; however, vigorous physical activity decreases in boys from eighth to eleventh grade.

Tobacco, Alcohol, and Marijuana Use - Information from the 2001 Oregon Healthy Teens Survey indicates that 21% of eleventh graders and 11% of eighth graders smoked cigarettes in the past 30 days. Alcohol use was reported by 43% of eleventh graders and 24% of eighth graders in Multnomah County. Marijuana use was reported by 26% of eleventh graders and 13% of Multnomah County eighth graders.

### **Adult Health**

Body Weight - The proportion of adults in Multnomah County who are at risk of health problems related to being overweight is consistently lower than Oregon and the nation. However, there has been a steady increase in overweight adults for all population groups since the early 1990s. Over half of the adult population in Multnomah County is at risk for health problems related to being overweight.

Nutrition and Physical Activity - The 2001 Behavior Risk Factor Surveillance System indicated that only 29% of adults ages 18 and older in Multnomah County eat the recommended five servings of fruits and vegetables per day. Half of the adult population participates in the CDC recommended level of physical activity, which is moderate activity for 30 minutes five times a week or vigorous activity for 20 minutes three times a week.

Substance Use - The 2001 Behavior Risk Factor Surveillance System indicated that 20% of adults in Multnomah County and 23% of adults in Oregon smoked cigarettes on at least some days. In 2001, the percent of adults binge drinking (five or more drinks on one occasion, one or more times in the past 30 days) was similar for Multnomah County (28%), Oregon (25%) and the U.S. (27%).

Sexual Activity and Sexually Transmitted Diseases - Over one-third of eleventh graders in Multnomah County and half of eleventh graders in the U.S. report that they have had sexual intercourse. Ninety-eight percent of eighth graders and 90% of eleventh graders practice responsible sexual behavior. Responsible sexual behavior is defined as abstaining from sex, having had sex but not in the past three months, or using a condom the last time they had sexual intercourse. Rates of sexually transmitted diseases tend to be higher among 15-19 year-olds than among other age groups. Chlamydia infections are the most frequently reported STD. Chlamydia case rates among 15-19 year olds declined from 1994 to 1999 and increased in 2000 and 2001, before falling again in 2002.

Teen Pregnancy and Births - Teen pregnancies and births continue to decline in Multnomah County and in Oregon. There were 110 pregnancies per 1,000 girls ages 15-19 in 1990 and 70 pregnancies per 1,000 girls ages 15-19 in 2002. Despite this decline, the rate of teen pregnancy remains higher in Multnomah County (70 per 1,000) than statewide (54 per 1,000).

Leading Causes of Death for Adolescents Ages 10-19 - From 1997-2002, there were 177 deaths of adolescents ages 10-19 in Multnomah County, an average of 36 deaths per 100,000 youths annually. The rate for Asian youth was 1.5 times higher than for White non-Hispanic

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youth. Hispanic youth had the lowest average annual death rate. The leading causes of death among adolescents over the six-year period from 1997 to 2002 were injury (38%), suicide, and homicide (both 11%). Homicide deaths among African American youth 10-19 have declined substantially since the early 1990s, from a rate of 61 deaths per 100,000 population in 1990-1994 to a rate of 15 deaths per 100,000 population in 1998-2002.

Adolescent Suicide - There were 963 suicide attempts and 16 suicide deaths among adolescents ages 13-17 over the eight-year period from 1995-2002. Of the 16 suicide deaths, 75% were boys and 25% were girls.

Leading Causes of Death Among Adults Ages 20-64 - The leading cause of death among adults ages 20-44 during 1998-2002 was unintentional injury. The top two leading causes of death among adults ages 45-64 from 1998-2002 were cancer and heart disease.

### **The Health of Older Adults**

Nutrition and Physical Activity - Information from the 2001 Behavioral Risk Factor Surveillance Survey indicated that compared with younger adults, the 65 and older age group was more likely to eat the recommended five servings of fruits and vegetables per day. Forty-one percent of adults older than 65 reported that they eat five servings of fruits and vegetables per day, while only 26% of adults younger than 65 reported eating the recommended servings of fruits and vegetables.

Men and women ages 65 and older were less likely than younger adults to meet physical activity recommendations. Overall, 45% of adults older than 65 and 50% of adults ages 18-64 report that they engage in moderate activity for 30 minutes at least five times per week or vigorous activity for 20 minutes at least three times per week.

Immunizations - The majority of adults ages 65 and older received immunizations for influenza and pneumonia in 2001. Seventy-six percent received influenza vaccinations and 73% received pneumococcal vaccinations.

Leading Causes of Death Among Adults Ages 65 and Older - The top two leading causes of death for both men and women and across all racial/ethnic groups were heart disease and cancer during 1998-2002. White non-Hispanic and African American adults 65 years and older have higher rates of death from heart disease, cancer, Alzheimer's and stroke than other racial or ethnic groups. Native Americans have the highest rate of death from chronic lower respiratory disease.

### **Communicable Diseases**

Sexually Transmitted Diseases - Chlamydia infections are the most frequently reported STDs in Multnomah County and in Oregon. In 2002, there were 340 chlamydia cases per 100,000 residents in Multnomah County compared to 204 cases per 100,000 residents statewide. Gonorrhea case rates have declined substantially in Multnomah County, from 293 per 100,000 in 1990 to 82 per 100,000 in 2002.

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Rates of syphilis infection per 100,000 residents have declined dramatically in Multnomah County and in Oregon. In 1990-1992, there were 18 new cases of syphilis per 100,000 Multnomah County residents; in 1997-1999, there were 1.5 cases per 100,000 residents. Case rates have increased to 3.8 per 100,000 in 2000-2002.

HIV Infection - There were 103 HIV positive diagnoses during 2002. By gender, 75% of positive tests were among men, 14% among women, and gender was not reported for 11% of cases. Based on public tests, which represent about half of all positive tests for HIV, men having sex with men continues to be the leading risk group for HIV infection.

New AIDS Cases - The rate of new AIDS cases (late stage HIV infection) has declined dramatically since 1993. In 2002, there were 18 AIDS cases per 100,000 residents. The rate of new AIDS cases has declined among White non-Hispanics, African Americans, and Hispanics. There were too few cases among Asians and Native Americans to calculate rates.

Tuberculosis - Rates of tuberculosis (TB) have declined since 1996 in both Multnomah County and Oregon. In 1996, there were 13 TB cases per 100,000 residents of Multnomah County and, in 2002, there were 6 TB cases per 100,000 residents. Over half, 60%, of the 2002 TB cases in Multnomah County were among foreign born residents.

Hepatitis - Rates of new hepatitis A cases have dropped substantially since the mid 1990s in Multnomah County and in Oregon. New hepatitis A case rates were 2 per 100,000 residents in 2002 in both Multnomah County and Oregon. The rate of new hepatitis B cases in Multnomah County has fallen from 27 cases per 100,000 population in 1990 to 6 per 100,000 in 2002. Oregon's rate of new cases fell from 14 in 1990 to 4 in 2002. The CDC estimates that hepatitis C is the most common blood borne infection in the United States and that most cases of hepatitis C remain undetected. From 2000 through 2002, there were 11 cases of hepatitis C reported in Multnomah County.

Vaccine Preventable Diseases - While there are very few pertussis cases (also known as whooping cough) in Multnomah County each year, there was an increase from 13 to 25 cases in 2002.

Diarrheal Diseases - The most common diarrheal disease in Multnomah County is campylobacteriosis, usually transmitted through food. All diarrheal disease rates have declined since 1994, including those caused by E. coli, salmonellosis, giardiasis and shigellosis.

### **Unintentional Injury and Premature Death**

Unintentional Injury Mortality Rate - Unintentional injury mortality rates are similar for Multnomah County and Oregon. The rate in Multnomah County was 39 per 100,000 residents in 2002. Native Americans have the highest unintentional injury death rates. Motor vehicle accidents are the leading cause of unintentional injury deaths.

Homicide Rate - The homicide mortality rate has declined in Multnomah County since the early 1990s. The Multnomah County homicide rate of 5 per 100,000 residents was lower than

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the U.S. rate of 6.9 per 100,000 in 2001. The 2002 homicide mortality rate in Multnomah County was 3.9 per 100,000 residents.

Adolescent Violence-Related Activities - The Oregon Healthy Teens Survey indicates that over one-third of eighth graders and one-fifth of eleventh graders in Multnomah County reported in 2001 that they had been in a physical fight during the past 12 months. In 2001, 12% of both eighth and eleventh graders in Multnomah County indicated that they had carried a weapon; 3% of eighth and eleventh graders indicated that they had carried a gun.

Years of Potential Life Lost - Years of Potential Life Lost is a measure of premature death. Cancer was the number one contributor to premature death in White non-Hispanics, African Americans, and Asians in 1998-2002. Injury was the number one contributor for Native Americans and Hispanics in 1998-2002.

### **Leading Causes of Death**

Top Five Leading Causes of Death - The top five leading causes of death in Multnomah County in 2001 were (in order of greatest frequency): cancer, heart disease, stroke, respiratory disease, and unintentional injury. The greatest number of deaths from cancer was due to lung cancer followed by prostate cancer, female breast cancer, and colorectal cancer. While death rates due to cancer and unintentional injury are similar for Multnomah County, Oregon and the U.S., death rates due to heart disease are substantially lower for both Multnomah County and Oregon than for the U.S. Following national trends, death rates due to coronary heart disease have declined for White non-Hispanics and African Americans over the past decade. Stroke and respiratory disease are higher for Multnomah County than for Oregon and the U.S. In Multnomah County, African Americans are 1.5 times more likely than White non-Hispanics to die from stroke. While Asians have a much lower stroke death rate, the rate has increased on average since 1993.

### **Geographic Area Summary**

A comparison of demographic and socioeconomic characteristics, birth, and infant mortality information for six areas of Multnomah County follows. Boundaries for these areas are based on the Multnomah County Health Department service areas.

Southeast - In 2002, Southeast residents were 82% White non-Hispanic, 7% Asian, 5% Hispanic, 2% African American, and 1% Native American. Five percent of residents older than age four were non-English speaking. The majority of the non-English speakers, 49%, spoke an Asian or Pacific Island language, and 29% spoke Spanish. In 2000, 12% of residents in Southeast had incomes that were below the federal poverty level. Southeast had the same percent of population at 200% of federal poverty level as the County (30%). Fertility rates in Southeast were lower than the County average in 2002. Births to women younger than 20 decreased from 1990 to 2002. The percent of mothers receiving first trimester prenatal care increased from 1990 to 2002. Low birthweight rates increased and infant mortality rates were down.

Mid-County - Of the six areas examined, Mid-County had the largest proportion of Asian residents. In 2002, Mid-County was 76% White non-Hispanic, 10% Asian, 8% Hispanic, 3%

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African American, and 1% Native American. Mid-County had the highest proportion of non-English speaking residents. Thirty-six percent of the non-English speaking residents spoke Spanish, 30% spoke an Asian or Pacific Island language, and 33% spoke a language other than Spanish or an Asian/Pacific Island language. In 2000, the same percent of Mid-County residents as Multnomah County residents had incomes below the federal poverty level (13%). Thirty-three percent of Mid-County residents had incomes below 200% of poverty compared with 30% of residents countywide. Fertility rates in Mid-County were the highest in the County in 2002. While some areas of Multnomah County showed substantial improvement in factors associated with pregnancy outcomes, Mid-County did not. Inadequate prenatal care increased from 6% in 1995 to 8% in 2002. The rate of first trimester prenatal care remained the same from 1990 to 2002. Low birth weight rates increased in Mid-County from 52 low birthweight infants per 1,000 births during 1990-1992 to 64 low birth weight infants per 1,000 births during 2000-2002. However, infant mortality rates declined from 8 deaths per 1,000 births during 1990-1994 to 5 deaths per 1,000 births during 1997-2001.

East County - In 2002, East County had the second highest percentage of the Hispanic population in Multnomah County but was one of the least diverse areas for other populations of color. The residents of East County were 81% White non-Hispanic, 11% Hispanic, 4% Asian/Pacific Islander, 2% African American, and 1% Native American. Six percent of East County residents were non-English speaking compared with 4% countywide in 2000. Seventy-four percent of the non-English speaking residents spoke Spanish, 9% spoke an Asian/Pacific Island language, and 17% spoke another language. In 2000, 12% of East County residents had incomes below the federal poverty level compared with 13% of residents countywide. Fertility rates (births per 1,000 women ages 15-44) in East County were higher than the County average in 2002. While some areas showed improvement in factors associated with pregnancy outcomes, East County's measures were mixed. The percent of births to mothers younger than age 20 increased between 1990 and 2002. The percent of mothers receiving first trimester prenatal care was slightly below the County average. The low birthweight rate in East County was lower than in other areas. Infant mortality rates declined substantially from 1990-1994 to 1997-2002.

Westside - Westside is one of the least diverse areas of Multnomah County. In 2002, Westside residents were 87% White non-Hispanic, 5% Asian, 4% Hispanic, 2% African American, and 1% Native American. Only 2% of Westside residents were non-English speaking compared with 5% countywide. In 2000, 12% of Westside residents had incomes below the federal poverty level. In the Westside, 23% had incomes below 200% of poverty compared to 30% of Multnomah County residents overall. Fertility rates among women in the Westside area were the lowest in Multnomah County in 2002. There were fewer births to mothers younger than 20, and women in the Westside were more likely to have received prenatal care than were women in any other area of Multnomah County. The Westside had the lowest rate of low birthweight infants; however the rate of low birthweight births has increased. Infant mortality rates were down in the 1997-2001 period compared to the 1990-1994 period.

Northeast - Northeast is the most diverse area of Multnomah County. In 2002, Northeast residents were 63% White non-Hispanic, 21% African American, 8% Hispanic, 5% Asian, and 1% Native American. Of the six geographic areas examined, Northeast had the highest

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percent of African American residents. Compared to the County as a whole, the same percent of Northeast residents were non-English speaking (5%). Of the non-English speaking residents, 57% spoke Spanish and 26% spoke an Asian or Pacific Island language. In 2000, 14% of Northeast residents had incomes below the federal poverty level compared with 13% countywide. Thirty one percent of the population had incomes below 200% of poverty compared with 30% countywide. Fertility rates were slightly lower in Northeast than the County average in 2002. The percent of births to mothers younger than age 20 was down substantially from 1990 to 2002, and receipt of first trimester prenatal care was up strongly. Northeast was the only area to show a substantial decline in low birthweight rates from 1990-1992 to 2000-2002. In addition, infant mortality declined from the period 1990-1994 to 1997-2001. Despite the decline, infant mortality is highest in Northeast compared to the other service areas.

North Portland - North Portland is the second most diverse area of the County. In 2002, North Portland residents were 66% White non-Hispanic, 12% African American, 11% Hispanic, 6% Asian, and 2% Native American. Compared to other areas, North Portland had slightly higher proportions of Hispanics than East County and had the second highest proportion of African Americans (behind Northeast). Six percent of residents older than age four were non-English speaking. Of those who do not speak English, 66% spoke Spanish and 21% spoke an Asian or Pacific Island language. In 2000, North Portland residents had the highest percent of residents at or below both 100% and 200% of the federal poverty level (16% and 35%) compared with other areas. Fertility rates in North Portland were down from 1996 to 2002. The percent of births to mothers younger than 20 was down from 1996 to 2002. From 1990 to 2002, there was substantial improvement in receipt of first trimester prenatal care by mothers in North Portland. However, low birthweight rates in North Portland were up from 1990-1992 to 2000-2002. Infant mortality was more than halved over the period of 1990-1994 to 1997-2001, from 11 deaths per 1,000 births to 4 deaths per 1,000 births.

### **Healthy People 2010 Leading Health Indicators**

The national Healthy People 2010 indicators cover physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, injury and violence, environmental quality, immunization, and access to health care. On most of the indicators of health, Multnomah County's performance is comparable or slightly better than those reported for that state of Oregon.

Multnomah County has exceeded or is approaching the national objective target rate for:

- Adults who engage in recommended moderate and/or vigorous physical activity.
- Deaths due to motor vehicle crashes.

Multnomah County's rates compare favorably to the U.S. for:

- Adolescent and adult tobacco use.
- Adolescent alcohol use in the past 30 days.
- Adolescents who abstain from sexual intercourse or use condoms if sexually active.

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- Homicide mortality rates.
- Non-institutionalized adults 65 and older vaccinated for influenza and pneumococcal.
- Outdoor air that meets the EPA's health standards for ozone.

Multnomah County rates are similar to U.S. rates for:

- Children, adolescents, and adults who are overweight or obese.
- Adolescents who participate in the recommended vigorous physical activity.
- Adult binge drinking.
- Persons with health insurance coverage.

Challenges for Multnomah County include:

- First trimester prenatal care utilization.

Data is not currently available for Multnomah County for the following Healthy People 2010 objectives:

- Sexually active persons who use condoms.
- Adults with recognized depression who receive treatment.
- Non-smokers exposed to environmental tobacco smoke.
- Persons who have a specific source of ongoing health care.

- **Summary: Racial and Ethnic Health Disparities in Multnomah County: 1990-2004 (October 2006)** - Despite overall improvement in the health of the population over the last 50 years, the health of persons of color lags behind that of White non-Hispanics on many measures. The extent of racial and ethnic health disparities in the county, and the status of disparities discussed in this report are summarized below. The entire report can be viewed at [http://www.co.multnomah.or.us/health/hra/reports/health\\_disparities\\_2006.pdf](http://www.co.multnomah.or.us/health/hra/reports/health_disparities_2006.pdf).

During 2006, the Health Department released its report on racial and ethnic health disparities in Multnomah County. The report examines health disparities for 17 health status indicators. Using White non-Hispanics as a comparison group, health disparities were calculated for four groups of persons of color: African Americans, Asians, Native Americans, and Hispanics. The report also tracked health disparities from 1990 to 2004 in order to analyze trends. Across the 17 indicators and four minority groups, African Americans experienced the greatest number of health disparities, though the magnitude of African American/White non-Hispanic health disparities showed improvement over time. The report concluded that Asians, Hispanics, and Native Americans experienced no significant health disparities when compared to White non-Hispanics.

Health Disparities in the African American Community - Health disparities were found for 14 of 17 health status indicators examined in the 1990-1994 period. Health disparities persisted among 11 of the indicators in the 2000-2004 period. African Americans experienced nearly half of the total number of disparities across all racial groups during both time periods. Health indicators improved, relative to White non-Hispanics on 15 of 17 health status indicators between 1990 and 2004 (five of which were statistically significant

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improvements). Three health disparities in the early time period ceased to be significant in the 2000-2004 time period. Health disparities were at least twice the White non-Hispanic rate for six health measures in the 2000-2004 period: syphilis (five times higher than the White non-Hispanic rate), gonorrhea (over seven times higher), chlamydia (five times higher), teen births (over three-and-one-half times higher), diabetes mortality (two-and-one-half times higher), and homicide (over seven-and-one-half times higher).

Health Disparities in the Hispanic Community - Health disparities for six health status indicators were found in the 1990-1994 period. Health disparities for five indicators persisted in the 2000-2004 period. The syphilis disparity was eliminated. Of the 10 mortality-related health indicators examined, the homicide rate was the one significant disparity found. Homicide rates were over twice the rate of White non-Hispanics in the 2000-2004 period. There were five significant changes in health indicators over time: two health status measures worsened (lack of early prenatal care, and teen births) and three improved (syphilis, gonorrhea, and Chlamydia).

Health Disparities in the Asian Community - Two significant health disparities were found for the 1990-1994 period (low birth weight, and lack of early prenatal care). Health disparities were found for three indicators for the 2000-2004 period (homicide, lack of early prenatal care, and Chlamydia). The low birth weight disparity declined 10% between 1990-1994 and 2000-2004, when it ceased to be a significant disparity. The rate of new gonorrhea cases for Asians relative to White non-Hispanics decreased significantly between 1990-1994 and 2000-2004.

Health Disparities in the Native American Community - Health disparities were found for seven indicators in 1990-1994. Of the 13 health status measures having sufficient data, disparities were found for three measures in 2000-2004. Two new health disparities (HIV Disease mortality and infant mortality) emerged in the 2000-2004 period. No significant changes in health disparities over time were found.

- Progress Made to Address Health Disparities - Some health disparities have been reduced in recent years. Across the 17 health indicators examined for all populations of color, 29 health disparities were identified for the 1990-1994 period. By the 2000-2004 time period, six disparities were eliminated – three of which were in the African American community, and 14 had been reduced.

The Department continues to monitor this impact of health disparities, and in March 2008, it released a report entitled “*Report Card on Racial and Ethnic Health Disparities*,” (see <http://www.co.multnomah.or.us/health/hra/reports/reportcard.pdf>). In examining 17 health indicators, the greatest disparities were in rates of new cases of sexually transmitted diseases. For example, the rate of new cases of gonorrhea infections among African American residents of Multnomah County was six-and-one-half times the rate of White non-Hispanics in the county; the rate of new Chlamydia cases was five times higher among African American residents and about two-and-one-half times higher among Hispanic residents. New syphilis infections occurred at a rate three times higher among African Americans compared to White non-Hispanics. Another area of concern is the rate of births to teenage mothers in communities of color. In the 2001-2005 period the percent of live births to Hispanic teens was more than six times higher than for White non-Hispanic teens. For African American

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residents the teen birth rate was more than two-and-half times the rate for White non-Hispanics. Finally, the homicide death rate was over six times greater among African American residents as compared with White non-Hispanics.

### C. Comprehensive Overview of Public Health Services

The mission of the Multnomah County Health Department is *“In partnership with the communities we serve, the Health Department assures, promotes, and protects the health of the people of Multnomah County.”* The Department promotes its mission through the following strategic goals:

- Goal 1: To assure individuals, families and communities gain greater control of the factors that influence their health.
- Goal 2: To improve health throughout the County’s diverse communities.
- Goal 3: To assure dignified access to needed health care.
- Goal 4: To protect the public, and mitigate the health impacts of natural and human-caused disasters.

The Multnomah County Health Department complies with Oregon statutes (ORS 431.416) to provide basic public health services. Public health services are performed in a manner consistent with the *Minimum Standards for Local Health Departments* adopted by the Conference of Local Health Officials (CLHO). As required under the Chapter 333-014-055(1) of the Oregon Revised Statutes:

*“Each county and district health department [in Oregon] shall perform (or cause to be performed) all of the duties and functions imposed upon it by Oregon Revised Statutes, and by official administrative rules adopted by the State Health Division and filed with the Secretary of State.”*

As directed under ORS 333-014-055(2), this section of the Comprehensive Annual Plan for Multnomah County describes how the Health Department complies with the Oregon Revised State Statutes to meet requirements for the following essential public health services:

- Control of Reportable Communicable Disease.
- Parent and Child Health Services.
- Health Statistics.
- Information and Referral Services.
- Environmental Health Services.

The Department’s various broad reaching public health services, programs, initiatives and activities for each of mandated public health functions are described below.

**Control of Reportable Communicable Disease (ORS 333-014-055 (2)(a)** – The Health Department’s role for protecting the population from reportable communicable disease includes providing epidemiologic investigations to report, monitor, and control communicable disease and other health hazards; providing diagnostic and consultative communicable disease services; assuring early detection, education, and prevention activities which reduce the morbidity and mortality of reportable communicable disease; assuring the availability of immunizations for

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human and animal target populations; and collecting and analyzing of communicable disease and other health hazard data for program planning and management to assure the health of the public. Programs and initiatives implemented by the Health Department to ensure the effective control of reportable communicable disease include the following:

Communicable Disease Prevention and Control Program - The Communicable Disease and Prevention Program limits the spread of communicable diseases through prompt scientific-based investigation and treatment of reported or suspected cases. More than 100 different communicable diseases are monitored, such as TB, meningitis, whooping cough, and food borne and waterborne illnesses (including national outbreaks of diseases caused by contaminated commercial food products). The program directly addresses the basic needs of the community by preventing and controlling the spread of communicable disease with a timely and thorough investigation of suspected cases, providing education to the client and all potential contacts, distributing medications, providing antibody testing and vaccines, requiring quarantine as necessary and providing treatment for those who have contracted or been exposed to a communicable disease. Delay in treatment can allow diseases to spread to others, and left untreated diseases are more expensive to treat and may become debilitating. This program minimizes public health costs and promotes residents' health.

The Communicable Disease Prevention and Control Program is staffed to respond 24/7 by highly-trained, culturally and linguistically competent public health nurses and support staff. The program addresses health inequities and operates the following functions:

- Comprehensive TB prevention and control activities provided through a clinic, home visits, a homeless shelter clinic and outreach.
- Aggressive epidemiologic investigation is provided in response to outbreaks through structured interviews, and education, and with local state and federal law enforcement when an intentional outbreak cause is suspected.
- Occupational Health Office (OHO) requirements are met by providing employees vaccinations, antibody testing and education for blood borne pathogens and TB.
- Traveler's Clinic to provide persons traveling out of the US with appropriate vaccines for diseases (e.g., malaria and yellow fever) after careful review of a traveler's itinerary and history.

STD/HIV/Hepatitis C Community Prevention Program – HIV, STDs and Hepatitis C account for almost two-thirds of all reportable diseases in Multnomah County. This cost-effective program prevents epidemics seen in other west coast cities by controlling diseases spread via evidence-based prevention interventions and STD treatment for those at highest risk. Untreated HIV, especially, leads to poverty, inability to work and maintain stable housing. The program's emphasis on community prevention, outreach and early diagnosis reduces disease transmission and the likelihood of devastating long-term outcomes. It is estimated that each prevented case of Hepatitis C saves about \$66,000, and each prevented case of HIV saves about \$360,000 over a lifetime.

HIV, STDs and Hepatitis C infections disproportionately affect racial, ethnic and sexual minority communities. Gonorrhea and Chlamydia rates are five times higher in African Americans; 81% of syphilis cases occur in men who have sex with men; HIV infection rates are

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rising among Latinos, African Americans, and women. This program helps address such health inequities and provides these populations with needed services.

The program implements prevention as its key strategy, using culturally specific evidence-based approaches; and case investigation through staff contact of infected people to encourage treatment, sexual partner notification, and behavior change. The program's STD clinic reduces disease spread, through early access to evaluation, treatment, and prevention counseling for people without health care access. Through community testing, staff visit bars, jails, internet sites and other "hookup" sites to test, educate, and promote behavior change. Community partners include collaborating businesses, community organizations, and other counties to enhance capacity. Partners also help people at-risk link to care, drug treatment, counseling, etc. A syringe exchange component uses proven techniques to keep infection rates low among injectors, partners and their infants, and it reduces the use of infected syringes. Behavior change and education employs community-based interventions to reduce risky sexual behavior and drug use.

The program implements evidence-based primary and secondary prevention strategies, using culturally specific evidence-based approaches. Strategies to reduce disease spread include investigating reported cases of sexually transmitted diseases (including HIV), providing partner services; ensuring access to care; and providing community-based prevention services. Case investigation includes: follow-up of reported cases to ensure infected people are treated, sexual partners are notified, and cases and partners are provided behavior change support. The Program's STD clinic ensures early access to evaluation, treatment, and prevention counseling for people at highest risk who have no or limited health care access. Through community testing, staff visit bars, jails, internet sites and other "hookup" sites to test, educate, and promote individual and community behavior change. Community partnerships include collaborations with businesses, community organizations, and other counties to enhance capacity. Partnerships also help people at-risk link to care, drug treatment, counseling, etc. A syringe exchange component uses proven techniques to keep infection rates low among injectors, partners and their infants, and it reduces the use of infected syringes. Behavior change and education employs community-based interventions to reduce risky sexual behavior and drug use.

**Parent and Child Health (ORS 333-014-055 (2)(b))** – The Health Department plays a leading role to ensure the health and wellness of parents and children in Multnomah County. This includes initiatives of education, screening and follow up, counseling, referral, health services, family planning, and care for pregnant women, infants, and children. Parent and child health services are shared across all service divisions of the Department, with primary responsibility provided through the Community Health Services (through the Early Childhood Services Program) and Integrated Clinical Services division (through its clinical facilities).

Early Childhood Services Program (ECS) staff (e.g., Community Health Nurses, Community Health Workers, and program-specific staff) utilize a variety of methods to contribute to the health and wellbeing of individuals, families and communities. Examples of ECS programs and initiatives are presented below.

Early Childhood Services for First Time Parents - This program includes services for first-time parents using evidence-based models, including home visits, hospital visits, classes and group services that begin in early pregnancy and continue through infancy to assure optimal maternal and infant health, and assist parents in meeting their infant's basic health and developmental

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needs. A FY 2008/2009 target of 2,325 parents will receive Healthy Start hospital-based Welcome Baby visits, and 850 parents will receive intensive home visit services through the Nurse Family Partnership (a nurse home visit program for first-time pregnant women that starts early in pregnancy and follows families to their child's second birthday). Healthy Start (based on the Healthy Families America model) includes hospital-based Welcome Baby visits at birth to all first time parents in Multnomah County to identify families in need.

Services for High Risk Prenatal Program - The High-Risk Prenatal Program's nurses and Community Health Workers focus on prevention, risk reduction, early screening, and linkage to resources (housing, food assistance, healthcare, etc.). Priority clients include teens; women with prior newborn health problems; African-American women (because of historical birth outcome disparities); and women with medical conditions, domestic violence, or alcohol/drug use. Services include:

- Prenatal and health education: pregnancy discomforts, prenatal care, signs of premature labor, childbirth, not smoking/drinking/using drugs, infant growth and development, back sleeping, safety, parenting, etc.
- Screening for health risks: hypertension, gestational diabetes, substance use, domestic violence.
- Nutrition education: prenatal diet, vitamins, infant feeding.
- Breastfeeding assistance: preparation, techniques, support, and linkage with resources.
- Infant screening for growth and development.

This program will provide home visits and classes to 2,500 mothers and babies during FY 2008/2009. Services begin in early pregnancy and continue through infancy to assure optimal maternal and infant health, and assist parents in meeting their infant's basic health and development needs.

High Risk Infants and Children Program - The High-Risk Infants and Children Program serves more than 2,800 clients, providing home visits to families with young children. Services begin immediately after birth. The program targets high-risk infants as well as teens, parents with mental health problems, and cognitively delayed or addicted parents. These services are part of statewide programs, and County funds are crucial to reaching the greatest number of families.

Family Planning Services – The goal of Family Planning Services is to reduce unintended pregnancies and to improve the health and wellbeing of children and families. Family planning services are offered through primary care clinics, field offices, School-Based Health Centers, and other community sites. Based on 2005 Ahlers data, over 9,480 clients receive family planning services each year of which approximately 42% are teenagers. The Ahlers calculation estimated that 2,100 unintended pregnancies were averted in 2005.

Women, Infants and Children (WIC) – Participants in WIC experience decreased rates of hunger and health care costs, and improved prenatal outcomes by receiving health and nutrition screening, education, food vouchers, and referral to health and social services. More than 30,000 parents of young children (including 46% of the 9,300 infants born in Multnomah County) participate in the Women, Infants and Children's supplemental nutrition program. Also see the WIC Action Plan for FY 2008/2009 beginning on page 45.

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The WIC program operates at three of the Health Department's primary care services sites including the Northeast Health Center, Mid-County Health Center, and East County Health Center. The program serves at-risk pregnant, post partum and breastfeeding women up to one year post delivery, and children under age five, with household incomes of less than 185% of the FPL. It provides monthly food vouchers, health and nutrition screening, nutrition education, breastfeeding support, and referrals. WIC's program services focus on the following:

- One-on-one nutrition education for high risk pregnancy, and special needs children, breastfeeding infants.
- Group education including healthy weight and food choices.
- Screening and evaluations for medical/nutritional risks.
- Monthly vouchers for nutritious foods.
- WIC is a gateway for access to healthcare and other services.

During 2007, the WIC program had a caseload of 30,419 clients and 83,842 visits; during 2006, WIC had a caseload of 30,672 clients and 52,386 visits (although the number of clients has decreased slightly, the number of visits per client have increased by nearly 40%).

Immunization Services - Multnomah County's Community Immunization Program, in collaboration with the Oregon Department of Human Services/Health Services' Immunization Program, is implemented to provide access to the federally subsidized Vaccine for Children Program (VFC) and 317 Program. The VFC Program provides childhood vaccines at little or no cost to uninsured and underinsured children, and the 317 Program provides immunizations to high risk adults. Components of the Community Immunization Program include the following:

- Community Immunization Clinic - A walk-in vaccination service is provided at a central community site during the week and at various off-site locations on Saturdays.
- Vaccine support - To support the Health Department's health clinics in vaccine procurement, storage, handling, inventory, and technical assistance.
- Immunization School Law - The Health Department is mandated to ensure that all children and students in public schools, private schools, certified day care centers, preschools, kindergartens, and Head Start programs are up-to-date or complete on their immunizations.
- Collaboration with the Oregon DHS/Health Services' Immunization Program – The Health Department collaborates with the State of Oregon to implement the Vaccines for Children and 317 programs, and participates in the Oregon Partnership to Immunize Children coalition.
- Partnership initiatives – The Department engages in community partnerships to provide childhood immunizations.
- Occupational support for adults – Services include TB testing, antibody testing, and immunizations.

**Health Statistics (ORS 333-014-055 (2)(c))** – The ability to monitor and analyze trends and assess local health conditions is dependant on the availability of accurate and valid health statistics including birth and death reporting, recording, and registration; analysis of health indicators related to morbidity and mortality; and analysis of services provided. The Health Department's capacity to meet the community's need for health statistics is achieved through the Vital Records Program implemented within the Environmental Health Services unit.

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The Health Department's Vital Records Program is a legislatively mandated, fee supported public health service that produces birth and death certificates in accordance with federal and state statutes to maintain the integrity and accuracy of birth and death information. The information gathered through the Vital Records Program is analyzed to provide essential public health information to plan prevention and intervention activities for positive health outcomes. Populations at risk for poor health outcomes are identified for the provision of proactive interventions. For example: infants of Hepatitis B carrying mothers receive three immunization vaccines in the first six months after their birth. Prevention of Hepatitis B is critical as those infected have a 30% lifetime risk of liver cancer. The number of mothers who transmit perinatal Hepatitis B to their infants is decreasing in Oregon as a result of early immunization of infants in response to local vital records programs across the state.

The Health Department's Vital Records Program is also responsible for issuing birth and death certificates within the first six months after the birth or death, and within 24-hours of receipt of a request for certificate. Assuring accurate, timely and confidential registration of birth and death events minimizes the opportunity for identity theft, assures an accurate record of causes of death, and identifies the legal parents of children born in the county. Death certificates can be issued to family members, legal representatives, governmental agencies, or to the person or agency with personal or property rights. Birth records can be released to immediate family members including grandparents, parents, siblings, as well as legal representatives and governmental agencies. Employees working in the Vital Records Program must be registered with the State to assure competency.

**Information and Referral Services (ORS 333-014-055 (2)(d))** – Providing information and referral services for individuals and communities seeking access to health and human services is an essential function of local public health departments. The Multnomah County Health Department accomplishes this function through the following activities:

**Appointment and Information Center** – For many clientele of the Health Department, the Appointment and Information Center is the gateway to accessing services. Functions of the Center include:

- Scheduling appointments for medical, dental, WIC, and Medicaid eligibility screening.
- Providing information and referral for Health Department medical, dental and social services.
- Providing clinical interpretation in 50+ languages for all Health Department sites, as well as specialty providers used for patient referrals.
- Written translation services are also provided as requested by Department staff.
- Initial eligibility screening for Oregon Health Plan for new clients (e.g., Medicaid or Medicare eligibility).

The Appointment and Information Center processes an average of 20,000 client calls per month (these calls would otherwise require handling by various Department staff that are busy serving clients). The centralized function allows for greater efficiency, extended hours of service, focused education and training of operators, and consistent appointment scheduling practices.

**Medicaid Enrollment Assistance Program** – The Health Department's Medicaid Enrollment Assistance Program supports uninsured and underinsured Oregonians to gain access to health services, including behavioral and physical health care, by providing application support and

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advocacy to families and children applying for Medicaid benefits (i.e., Oregon Health Plan, Family Health Insurance Assistance Program, and State Children's Health Insurance Program). The Medicaid Enrollment Assistance Program operates under contract with the State Division of Medical Assistance Programs. In addition, the Program strives to educate, prevent, and/or intervene to keep individuals from experiencing health or economic crisis by assisting individuals whose coverage has been denied or terminated, with the opportunity for reinstatement of benefits. Multnomah County is CareOregon's single largest Medicaid provider, and approximately 90% of the Health Department's eligible clients select CareOregon.

This program's goals are to:

- Educate the uninsured population about OHP and other State insurance services.
- Increase the number of clients who complete the OHP enrollment process.
- Increase access to health care services, particularly for pregnant women and children.

Medicaid Enrollment Eligibility Specialists are stationed in Health Department clinical sites using outreach strategies to screen individuals for Medicaid programs, expedite applications to ensure prompt coverage, monitor Medicaid enrollees, particularly those at high risk, to assure continuity of coverage and care, and recertify for continued coverage on time. Insurance coverage under Medicaid provides access to preventive medical, dental, and mental health services and care for hard-to-cover pre-existing conditions and costly medications. The program aims to provide dignified access to health care for all citizens in collaboration with existing Multnomah County services and community partners and to educate and enroll clients in OHP.

A new initiative of the Medicaid Enrollment Assistance Program is to expand the current partnership between the Health Department, Multnomah Education Service District, and Kaiser Permanente Northwest in an effort to increase access to health coverage for children and low-income families in Multnomah County. This initiative enables the Medicaid Enrollment Assistance Program to provide technical support to the Education Service District and to facilitate efforts to enroll more eligible children and families in Oregon Health Plan health care programs.

(See the Information and Referral Action Plan on page 51 for a discussion of future plans for enhancing access to services through the I&R Program.)

**Environmental Health Services (ORS 333-014-055 (2)(e))** - Environmental Health Services of local public health departments in Oregon include inspection, licensure, consultation and complaint investigation of food services, tourist facilities, institutions, public swimming and spa pools, regulation of water supplies, solid waste and on-site sewage disposal systems, and other issues where the public health is potentially impacted through contact with surrounding environmental conditions. Programs of the Health Department to address environmental health issues are presented below.

**Community Environmental Health Program** – The Community Environmental Health Program supports initiatives designed to reduce health disparities exacerbated by negative and disparate exposure to environmental, social and economic factors. Program activities work to improve health by addressing issues related to environmental health, housing, and the built environment. Strategies include assessment, education/outreach, intervention, information/referral, policy

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development, and community organizing. Program focus areas include healthy home issues such as mold, household toxins, vectors and lead paint, environmental pollutants and toxins, emerging diseases, and reducing the environmental impacts of global warming.

This program supports the basic needs of the community through disease prevention, and it addresses a root cause of health disparities by improving the health of the home environment. These efforts bridge gaps identified by the community as “under” resourced public health issues (indoor air quality, affordable housing, and lead exposure). Grant requirements are focused on healthy home principles and policy development. The program also addresses county residents’ needs for outreach and education related to West Nile virus prevention, food borne illness prevention, and other emerging and climate change-related environmental risks.

Priorities of the Community Environmental Health Program are embedded in three areas (Healthy Homes, Environmental Education, and Environmental Health Resources). Priorities in each of these areas include the following:

**Healthy Home Priorities:**

- Sustain and integrate the Healthy Homes Childhood Asthma Case Management approach into clinics of the Health Department.
- Build capacity for community programs and policies that decrease health disparities associated with health and housing.
- Use the Healthy Homes Community Partner/Advisory Group to develop collaborative programs.
- Expand Environmental Education programs that address environmental toxins and pollutants impacting the built environment.

**Environmental Education Priorities:**

- Conduct community-based training and outreach related to health and housing topics (mold, Indoor Air Quality and toxins).
- Collaborate to integrate environmental health risk reduction with other initiatives (i.e., health disparities taskforce).
- Support core environmental health functions, education and outreach related to West Nile virus, Food borne Illness, and other emerging and climate change related diseases.

**Environmental Health Resources Priorities:**

- Ensure successful implementation of existing grant resources including grants through local, state and federal agencies (e.g., Portland Water Bureau, Oregon Department of Human Services/Health Services, HUD, EPA).
- Continue to apply for grant funding to expand capacity for service delivery, while minimizing the impact of declining County funding.

Lead Poisoning Prevention Health Inspections and Education – This program works to prevent childhood lead poisoning, and is primarily funded with city, state and federal funding. Children who have lead poisoning develop significant brain damage and learning disabilities, which impacts their normal growth and development and reduces their ability to function and develop into a healthy adult. More than 15,000 products have been recalled due to lead hazards by the Centers for Disease Control and Prevention (CDC), and the CDC has lowered the Elevated

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Blood Lead Level investigation criteria from 15 mg/dl to 10 mg/dl resulting in an increase in the number of Home Risk Assessments conducted.

There are an estimated 10,000 older homes in Multnomah County with exposure risk of lead-based paint to children six years old and younger. The Lead Poisoning Prevention Program identifies and helps residents reduce exposure to lead and to promote safe housing conditions. The program administers a statewide LeadLine to provide information and referral in multiple languages, screens for lead levels in blood, conducts environmental investigations, and provides case management and advocacy services.

The Health Department's Environmental Health Services unit works collaboratively with the City of Portland, lead prevention partners, and the Oregon Department of Human Services/Health Services to ensure a seamless system of lead prevention and early intervention for children identified with Elevated Blood Lead Levels. Key components of the Lead Poisoning Prevention Program include the following:

- Educate parents, landlords, and property owners about lead exposure causes and effects, screening, and reducing home lead hazards
- Screen children for Elevated Blood Lead Levels and provide information about free lead screening in the county. This includes implementing a project to increase childhood screening rates in the Department's primary care clinics.
- Investigate Elevated Blood Lead Levels within five days of identification by conducting an assessment of the child's home and family lifestyle to identify exposures to lead, and provide the families with a lead remediation plan and follow up.
- Track all lead screening results and all Elevated Blood Lead Levels to detect program trends and risks, and identify future direction of the program.
- Screen for risk of lead exposure of low-income children in support of improving health equity.

Vector-borne Disease Prevention and Code Enforcement - Vector-borne diseases are transmitted from animals to humans. This program protects the public from emerging and imminent vector-borne diseases and reduces the social and economic impact of uncontained outbreaks. Three major emerging diseases are vector-borne including West Nile virus, avian influenza, and SARS. Intervention strategies include surveillance, analysis, and proactive control/abatement.

Environmental Health Inspections - This fee supported program reduces risk to county residents and visitors from disease and injury by investigating food and waterborne diseases, educating the public about food safety, and performing routine inspections of licensed facilities (restaurants, swimming pools, hotels, child care centers, adult foster care, correctional facilities, and small public drinking water systems). In 2006, the program received the national Crumbine award for sustained excellence in food safety emphasizing innovations in food borne illness tracking, community outreach and education.

- **Health Inspection Facilities:** The Health Inspections program has responsibility for assuring the health and safety in 4,781 facilities including restaurants, mobile restaurants, temporary events, hotel/motels, RV parks, organizational camps, warehouses, commissaries, vending machines, and jails. Most facilities receive more than one inspection per year.

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- Swimming pools and spas: The program inspects and licenses 614 pools/spas to ensure pools are safe from hazards and disease. Field and classroom technical training is provided to pool operators.
- Child and Adult Foster Care Facilities: The program inspects 726 schools, childcare centers, and other service providers to ensure they handle food properly, are clean, and are free of health and safety hazards.
- Drinking Water Systems: Inspected to ensure they are properly maintained and meet EPA water quality standards. Education and training is a priority service for each water system.
- Food Borne Illness Outbreaks: Registered Environmental Health Specialists respond to and investigate local Food Borne Illness complaints in collaboration with the Communicable Disease Program and are key participants in disaster/bio-terrorism response. Multnomah County has significantly fewer food borne illness outbreaks than other Oregon counties.
- Food Handler Training and Certification: Multi-lingual training about safe food preparation in seven languages is provided online and in person to food workers at all literacy levels to support health equity and entry into the workforce.

**Special Programs to Meet Local Needs (ORS 333-014-055 (2)(f))** - In addition the core public health services of local public health departments described above, the Multnomah County Health Department provides programs and services to respond to the special health needs of the community. These programs and services are presented below under the following categories:

- General Public Health Functions and Services
- Specific Public Health Initiatives
- Clinical Health Services and Support Systems

#### **General Public Health Functions and Services**

Coordination/Integration/Leadership – The Department Leadership Team creates and communicates a clear vision and direction for the organization, and it is responsible for systems-based integration of health services and operations to assure:

- Quality best practice services.
- Strategic partnerships.
- Leadership and direction for public health issues.
- Assurance that financial commitments are met.
- Continuous improvement of service delivery systems.
- Maintenance of a diverse and qualified workforce with high job satisfaction.

Additional details about the structure, roles and operations of the Department Leadership Team are presented on page 64.

Health Officer - The Department's Health Officer provides consultation, medical and technical direction, and leadership by public health physicians to support effective public health practice. The program promotes Health Department and community understanding of health issues, and guides appropriate and effective action to address critical issues. Program activities address:

- Identified public health situations.
- Public health program design and operations.

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- Application of appropriate public health practices.
- Wider community approaches to public health issues.

During 2007, the role of the Health Officer was expanded to serve multiple county jurisdictions in the surrounding Portland metropolitan region in addition to Multnomah County, including Clackamas and Washington Counties. Additional details about the roles and functions of the Health Officer are presented on page 64.

Health Planning and Evaluation Program – The Department’s Health Planning and Evaluation Program provides critical support through three units including Health Assessment and Evaluation, Program Design and Evaluation Services, and Grant Development. The roles and impact on public health associated with each unit include the following:

- Health Assessment and Evaluation unit provides data analysis to identify health issues, health inequities, and progress in addressing them; data and analytical support for grant development; reports on the health status of Multnomah County residents; and technical assistance with program planning and quality improvement efforts.
- Program Design and Evaluation Services unit assures evidence-based public health practice and policy development through design and evaluation of programs and interventions in HIV prevention and services; tobacco prevention and control; prevention and interventions addressing under-age drinking; and improvement of health care delivery systems.
- Grant Development unit identifies and tracks public and private sector funding opportunities; develops grant proposals and budgets; and provides technical assistance to Health Department staff and community partners in program planning, proposal writing, and grant management. Over \$20.7 million was procured to address health issues in FY 2007.

Systems and Quality Support Services Program – The Systems and Quality Support Services Program provides coordination, oversight and support for all programs of the Department’s Community Health Services Division (this division oversees the State mandated public health functions and services of the Department, including Communicable Disease, Vital Records, Early Childhood Services, Information and Referral, and Environmental Health). Functions of the program include performance management activities; fiscal accountability; public health informatics systems development and implementation; and internal and external communications. This program supports the delivery of services in a wide range of human and environmental health programs that are operating clinical, technical field-based, outreach and community engagement operations across diverse professional disciplines including medical, nursing, sanitarian, epidemiology and entomology. All of these disciplines are required and necessary in order to operate in compliance with a substantial body of public health and environmental statutes, rules, ordinances and guidelines; and they are based on an accurate collection and analysis of program, environmental, and population data to target resources. The Systems and Quality Support Services Program assures:

- That all programs under the Department’s Community Health Services Division are informed by accurate, high quality data, and analysis.
- Consistent financial oversight of budgeted revenues, expenditures, and cash handling operations.
- Consistent application of performance management standards, measures, reports, and quality improvement processes to assure efficiency, effectiveness and value across all programs.

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- Enhanced connections to federal and state refugee programs and policy guidance for the Department.

Public Health and Regional Health Systems Emergency Preparedness - The Department's day-to-day disease prevention and control activities, and emergency medical services need to be prepared to operate at a significantly high level of efficiency should an event such as a communicable disease outbreak, toxic substance release, mass casualty or other event pose a sudden and acute public health emergency. The Department's focal point for emergency preparedness training and responsibility is the Incident Management Team. Preparedness extends to others in the Department through training and exercises, and is coordinated with health departments in neighboring jurisdictions, as well as many other local agencies (e.g., hospitals, first responders, elected officials, emergency management, etc.).

The Multnomah County Health Department supports hospital and health system emergency preparedness by hosting and participating in the Oregon Health Region I Health Preparedness Organization (Clackamas, Clatsop, Columbia, Multnomah, Tillamook, and Washington Counties). This public/private health partnership is dedicated to emergency response planning and preparedness. Its goal is to prepare for large-scale health emergencies that could severely impact public health in the county and/or region.

Preparing for and responding to emergencies with widespread or severe health impacts requires multi-agency, multi-jurisdictional, and public/private sector collaboration. Three Health Department programs contribute to this effort, including the following:

- Public Health Preparedness Program assures that the Department is able to carry out the County's unique public health responsibilities in an emergency.
- Emergency Preparedness Program assures that hospitals and other private health care providers in the six-county northwest region of Oregon have the capacity to care for victims of large scale emergencies.
- Pandemic Influenza Preparedness Program develops the response and community capacities necessary to respond to the special challenges of an influenza pandemic.

All three programs apply the National Incident Management System (NIMS) framework, and all are coordinated with the County's Office of Emergency Management.

Emergency Medical Services - Emergency Medical Services (EMS) program develops plans, regulates, coordinates, and provides medical supervision and quality assurance for all pre-hospital emergency care provided by an exclusive ambulance contractor and the fire departments in the County. The EMS program has five major functions:

- Administer and oversee the emergency ambulance contract: Emergency ambulance service is provided through an exclusive franchise agreement with a single ambulance company. This is a performance contract; the EMS program administers the contract and assures that performance criteria is met.
- Medical supervision: The EMS Medical Director supervises all pre-hospital medical care provided by paramedics, basic EMTs and first responders. Immediate medical advice for responders is provided via radio by OHSU under supervision of the EMS Medical Director.

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- Continuous Quality Improvement (CQI): The EMS Program coordinates a system-wide data-driven approach to improving the quality of service provided by the EMS system. The program gathers, maintains, and analyzes data on patient care and outcomes necessary for the CQI process. Results are used for planning, and for improving EMS operations, and the quality of pre-hospital patient care.
- EMS Regulation: The EMS program regulates all emergency and non-emergency ambulance business in the county in accordance with the ambulance ordinance, MCC 21.400. This includes licensing, inspections, review of operations, and supervision of medical care.
- Coordination of medical dispatch and medical first response: Dispatch is provided by the City of Portland. The fire departments of Portland, Gresham and districts throughout the County provide first response. EMS coordinates medical supervision, operating protocols, communications, major event planning, and equipment specifications.

The EMS Program is a visible part of the public safety system and contributes to citizens feeling safe. The EMS Program ensures that an immediate medical response is available to all County residents and visitors experiencing a medical emergency. Having this rapid response available increases the public's perception of safety. The program emphasizes coordination of services provided by multiple public and private agencies, and takes collaborative approaches to prepare for individual and community emergencies.

### **Specific Public Health Initiatives**

Initiative to Eliminate Racial and Ethnic Health Disparities - The Health Department, with leadership from the Multnomah County Chair, has initiated a Health Equity Initiative to engage community members and policy makers in an effort to address the root causes of health disparities by identifying and advancing policy solutions and practical solutions. Multnomah County will continue to seek and integrate community input; obtain input from disparities experts; and analyze local data to identify current trends, as well as immediate and long-term solutions to address the root causes of health disparities.

The key component of this initiative is policy advocacy training and evaluation. Policy advocacy will include building capacity within the community of people engaged in health equity work. The Health Equity Initiative is developing a health promotion model that is focused on community engagement and policy change. Engaging in policy advocacy is important to maintaining the value of meaningful community involvement. Community members will learn ways to effectively engage in the policy process, as well as participate in public forums to explore policy options that can promote health equity.

The evaluation of policy advocacy will include a case study, which will describe what policy opportunities were uncovered, what policies were implemented, why some policies were chosen and others not, and who from the County government and communities participated in the process. The evaluation team will also provide ongoing feedback to identify possible program modifications, and develop a summary of lessons learned, and evaluators will develop a plan for assessing the impact of the Initiative on specific health outcomes.

Community Capacitation Center - The Community Capacitation Center assists constituents both internally and externally to develop their capacity to promote health across all levels of the socio-ecological model. The work of the Community Capacitation Center includes:

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- Building skills and developing leadership among Community Health Workers and other individuals who promote health in their own communities.
- Assisting a variety of groups to learn to use popular education (also known as Freirian or empowerment education) to promote health.
- Initiating and conducting community-based participatory research projects that aim to promote health in underserved and marginalized communities.

The Community Capacitation Center also models what it means to address the social determinants of health by actively promoting health in specific communities, including (but not limited to) the disability community, the Latino immigrant community, and the Maple-Mallory neighborhood in NE Portland. In 2007, the Community Capacitation Center led the development of the Health Promotion Framework, conducting a formative evaluation of the Framework, and developing a comprehensive implementation plan (this work will continue).

The Community Capacitation Center program supports the Health Department's goal to develop capacity both internally and externally to promote health and social justice by addressing the underlying social determinants of health. Substantial evidence suggests that only by addressing the underlying social determinants of health can we reduce persistent health inequities. This program contributes to the theoretical grounding, as well as implements practical examples of how to conduct empowering practice at every level of the socio-ecological model. The Community Capacitation Center supports and coordinates its efforts with the work of the Department's Health Equity Initiative.

Health Promotion Coordination and Capacity Building – The Health Department continues to implement a Health Promotion Change Management Process to increase its ability to promote health by empowering communities and addressing the underlying social determinants of health. The resulting Health Promotion Framework represents a change management process that requires a systematic and long-term commitment over several years. During FY 2008/2009, the following three goals (and their related activities) will be implemented, including:

- Increase health promotion competence at the Department (Goal 1). Activities include developing and building the capacity of a health promotion Community of Practice; further developing the health promotion framework; conducting trainings on applying health promotion practice throughout the Department; developing capacity to use popular education for health promotion; providing mentoring and consultation to Department staff; creating an online library of health promotion literature; coordinating the collection and diffusion of targeted health promotion messages; participating in strategically in a variety of service groups; and coordinate a calendar of health promotion events and publicizing events throughout the Department.
- Increase coordination and collaboration among Department programs (Goal 2). Activities include organize and facilitate cross-departmental teams aimed at addressing particular health issues and/or particular determinants of health; and establishing inter-Departmental teams to serve as advocates who will stay informed about projects and connect with people working on the similar issues.
- Make available the successes and challenges of the Health Promotion Framework implementation for others to use in replication efforts (Goal 3). Activities under this goal

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include documenting the process, outcomes and outputs of the process; and developing a plan to assess long-term outcomes impacted by the process.

The desired outcome of this program is to enable Health Department staff to conduct empowering health promotion at every level of the socio-ecological model. In addition, the components of this program will strengthen the Health Equity Initiative by building the skills that Health Department staff need in order to effectively address health disparities in the broader community.

Chronic Disease Prevention Program – The vision of the Chronic Disease Prevention Program is *healthy people in healthy places*, and it emphasizes reducing barriers to healthy living that are shared among the community. The program is based on a socio-ecological model of health to understand the complex social and environmental factors that affect individual behavior and to develop initiatives to address health inequities. The Chronic Disease Prevention Program implements environmental and policy strategies to reduce the burden of chronic diseases most closely linked to physical inactivity, poor nutrition, and tobacco use; also including cancer, diabetes, obesity, heart disease, asthma, and stroke. Key activities include:

- Healthy Eating Active Living (HEAL) initiatives based on emerging and promising practices for obesity prevention with a focus on informing and strengthening community planning decisions related to food, transportation, and land use.
- Coordinating a comprehensive coalition building initiative across North Portland and collaborating with community partners, including the Portland Farmer's Market, the Portland/Multnomah Food Policy Council, and the Oregon Nutrition Policy Council, to work on food policy issues that increase access of county residents to affordable and nutritious food.
- Exploring the feasibility of a fast food and chain restaurant menu labeling policy, and strengthen the Program's efforts to provide coordination of internal stakeholders representing service areas across the Department to plan and implement collaborative chronic disease prevention strategies.

Tobacco Prevention - The Tobacco Prevention Program is organized within the Chronic Disease Prevention Program. Tobacco is the leading cause of preventable death in Oregon, and every year in Multnomah County more than 1,200 people die from tobacco use (22% of all deaths), and 23,700 people suffer from a tobacco-related illnesses. As of 2007, 118,150 Multnomah County residents reported that they smoke cigarettes or use tobacco. The national economic burden of tobacco use amounts to over \$190 million in medical expenses and \$192 million in lost productivity due to tobacco-related disability and death. In Multnomah County, 21% of adults smoke, compared to 20% statewide (2007 BRFSS). According to the 2007 Oregon Healthy Teens Survey, 9% of 8<sup>th</sup> graders smoke (the same percentage statewide), and 16% of 11<sup>th</sup> graders smoke (17% statewide).

The Tobacco Prevention Program's work is population-based so that large segments of Multnomah County benefit from smoke-free environments. An important goal of the Tobacco Prevention Program involves raising awareness of health disparities in tobacco use. The Program develops and implements strategies that are grounded in best practices and make sustainable environmental changes (e.g., such as through the adoption of new policies or activities that help to shift social norms around the use of tobacco). Primary goals of the Program are to 1) reduce and eliminate exposure to secondhand smoke, 2) counter pro-tobacco influences, 3) promote

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quitting, and 4) reduce youth access to tobacco. The program's Work Plan consists of multiple best practice objectives in support of tobacco-free schools, colleges, hospitals, multi-unit housing, and worksites. A key function of the program is to enforce applicable smokefree laws, including the Oregon Indoor Clean Air Act.

The work of the program focuses on creating smoke-free environments through policy change is intended to reduce people's exposure to secondhand smoke as well as to reinforce people's ability to quit smoking and discourage children from starting. Key successes of the program include:

- Passage of Multnomah County's Smokefree Worksite Law (MCC § 21.500).
- Adoption of no-smoking policies by the local public transportation authority serving Multnomah County and neighboring Washington and Clackamas counties.
- Adoption of smokefree playgrounds by the City of Portland.
- Enforcement of the Oregon Indoor Clean Air Act.
- Passage of SB 571 (expansion of the Oregon Indoor Clean Air Act to include several previously exempted work sites).

The program has formed an extensive network of external organizations and multidisciplinary partnerships representing public, private and nonprofit sectors. Key organizational partners include the American Lung Association, Portland Public Schools, Upstream Public Health, Lifeworks NW, IRCO Asian Family Center, and the Native American Rehabilitation Association.

Program funding in the amount of \$300,000 is provided by the Oregon Tobacco Prevention and Education (TPEP) Program. Effectiveness is tracked by the Oregon TPEP as a part of its statewide evaluation activities. For example, since the program started in 1996 and up to 2006, State data has shown that smoking among 8<sup>th</sup> grade students was reduced by 59%; there was a 46% drop among 11<sup>th</sup> graders who smoke; a 41% decline in cigarette consumption, and a 21% decrease in adult smoking.

Future/Planned Programs, Services and/or Initiatives – There is a need to improve local capacity to reduce the burden of tobacco-related and other chronic diseases as well. While tobacco is the leading cause of preventable death in Oregon, poor nutrition and lack of physical activity follow. The Chronic Disease Prevention Program is now at a similar stage of readiness to develop capacity to prevent and manage tobacco-related and other chronic diseases. The program is a grantee of the new State tobacco program, which will enable the Health Department to build upon the successes of previous tobacco prevention efforts and to deepen local public health capacity to address chronic diseases. The additional State funding presents a timely opportunity to build on local tobacco prevention efforts and participate with public health colleagues across Oregon in a coordinated, state-wide planning process.

The state public health capacity building grant will improve the effectiveness of the Tobacco Program by enabling the Health Department to:

- Hire dedicated staff to coordinate a community assessment and planning process.
- Establish an informed starting point for a community assessment. The process of data collection will help the program to: a) determine which types of data are relevant and

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meaningful; b) learn how to share data with multiple audiences; and c) identify gaps in current data.

- Increase knowledge about best and emerging practices in chronic disease prevention by participating in the statewide Chronic Disease Training Institute. Participation in the Training Institute will help the program to: a) dedicate time to learn about and carefully consider emerging and best practices, b) participate in regular networking opportunities with colleagues across the state, and c) collaborate in a mutual learning process with community partners who participate on the training teams.
- Strengthen community partnerships and complete a community assessment to: a) expand the network of community partnerships; b) become familiar with the needs, perspectives, and work activities of our partners; c) develop an inventory of activities across the county; and d) engage in an informed discussion about community priorities.

Combined, these activities will lead the Department's Chronic Disease Prevention Program to develop a community-driven implementation plan for Multnomah County that promotes health equity and includes strategies to create policy, environmental, and systems changes. Also see the Action Plan for Tobacco Prevention beginning on page 58.

Adolescent Health Promotion Program - The Adolescent Health Promotion Program is designed to support kids' academic success by breaking down barriers to staying in school. Teen parents face significant challenges to success in school. Research indicates young people who delay sexual involvement until the age of 16.5 are more likely to protect themselves from pregnancy and disease. This program gives students the skills and confidence to delay sexual involvement and reduces participation in other risky activities while building healthy relationships. It also improves health, access to information and resources for 11,000 school aged students and their parents in five school districts (49 schools total) in Multnomah County, and offers workshops to community-based organizations.

The Adolescent Health Promotion Program (AHPP) is designed to delay sexual activity and build healthy relationships for middle school students using peer educators to teach five sexuality education sessions that focus on media influences, correcting misconceptions about teen sexuality, and building assertiveness skills to refuse pressure. AHPP at the high school level focuses on skill building and assertiveness training to develop healthy relationships for life.

The Adolescent Health Promotion Program employs three proven strategies:

- Youth Development/Leadership Training through the peer education and empowerment approach, provided in a school setting, contributes to developing and ensuring success in school. The program engages teens in discussions and activities allowing them to build skills and confidence in healthy decision making, planning for the future, self-risk assessment, and encourages communication with parents about healthy relationships and sexuality.
- Parent Involvement provides resources and workshops to assist parents in talking to their child about healthy relationships and sex.
- Healthy Relationships and Sexuality Education sessions: The Adolescent Health Promotion Program is culturally and developmentally appropriate and delivered in schools and community-based organizations, focusing on healthy relationships, the effect of drugs and alcohol on sexual behavior, access to health services, and skill building.

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Research shows that teens who delay sexual activity are more likely to have fewer partners and take action to protect themselves against pregnancy and sexually transmitted diseases. Since 1995, statewide evaluations have consistently shown that students who are exposed to adolescent health promotion curriculum out-performed students in the control schools in terms of their knowledge about sexuality and attitudes toward postponing sex. The teen pregnancy rate is one of the primary health indicators for a community, and in Multnomah County the teen pregnancy rate has continued to decline since the mid-1990s. However, the Multnomah County teen pregnancy rate remains higher than the state's rate and is significantly higher for Hispanic teens. When young people have hope for their future, they are less likely to engage in a range of risky behaviors including drug and alcohol abuse, smoking, and early initiation of sex, among others (Wilson, et. al., 2006). Thus, the Adolescent Health Promotion Program works to empower young people, and increase their sense of control over their lives and their health.

Building Better Care Initiative - The Health Department's primary care services are currently undergoing a review and restructuring through the Building Better Care project. The project's goal is "to develop a patient-centered primary care system that emphasizes panel management, team-based care, nursing case management, patient self management, and integrated behavioral health to improve timely access to appropriate level of care, cost-effectiveness of care, continuity and coordination of care, and quality and safety of care."

Major deliverables of Building Better Care include: (1) implementing a plan that effectively redesigns care teams including team roles and responsibilities, and strategies to integrate behavioral health and panel management; (2) documentation of successful processes including guidelines and training materials; (3) implementation of strategies, mechanisms and technology to facilitate care teams in sustaining and spreading the gains to other clinics and facilities.

### **Clinical Health Services and Support Systems**

Primary Care Services – The Health Department operates the largest health care safety net in the state, providing health services for the community's low income, medically underserved residents (approximately 54,000 residents were served in 2007). The Department's six clinics are certified through the Joint Commission for Accreditation of Healthcare Organizations, and they are recognized Community Health Centers through the Federal Bureau of Primary Health Care. Each of the Department's clinics provides culturally competent services, which include primary healthcare, well child care, family planning, and immunizations; health services for homeless children and adults; mental health services; outreach services; drug and alcohol assessment services; and appropriate referrals for specialty care. The clinics are located adjacent to bus routes and/or light rail transit services to facilitate access; they are all wheelchair accessible; many staff members are bilingual; and interpretation services are available upon request. During 2007, primary care services were provided to 31,953 individuals, and included 182,246 visits.

Primary Care Services are overseen by the Multnomah County Community Health Council. The Council addresses issues of budget/finance, policy, scope of services, long range planning, diversity, and other issues associated with providing care to the underserved. The Council includes 17 members; 11 members are consumers of health care, two are providers, and four are community representatives. Council members offer a range of skills, such as legal, business, social services, health care, and consumer membership is balanced in terms of ethnic, racial, gender, age and geographical representation.

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Individual clinic sites include the following:

- East County Health Center, 600 NE 8<sup>th</sup> Street, 3rd floor, Gresham, OR 97030
- La Clinica de la Buena Salud, 6736 NE Killingsworth Street, Portland, 97218
- Mid-County Health Center, 12710 SE Division Street, Portland, 97236-3134
- North Portland Health Center, 9000 N Lombard Street, Portland, 97203
- Northeast Health Center, 5329 NE MLK, Jr. Boulevard, Portland, 97211
- Westside Health Center, 426 SW Stark Street, 5th floor, Portland, 97204

The Department's Primary Care Services also include a Mobile Medical Clinic, which provides health care services at several locations in partnership with organizations that serve homeless families. The Mobile Medical Clinic consists of a 40-foot medical van with two exam rooms, laboratory, pharmacy, and nurse triage. The vehicle is fully self-contained with onboard systems for heating, cooling, water, electrical generation, and refrigeration.

Services for Persons Living with HIV - Since 1981, approximately 4,800 people have been diagnosed with HIV in Multnomah County; over 2,000 people living with HIV/AIDS (PLWH/A) have died, while over 2,700 are still living with this disease. This program aims to address unmet health needs of low-income persons living with HIV disease in the Portland metropolitan area. Local AIDS prevalence increased by 22% from 2001 to 2006, fueling the need for services to address this continuing public health problem. Over 4,000 people with HIV live in the service area; 56% suffer mental illness and 36% have substance abuse problems. The Health Department's HIV care system consists of the HIV Health Services Clinic, and the HIV Care Services Program to meet the health care needs of the community's most vulnerable clients (e.g., 73% have incomes below the federal poverty level, 28% are minorities, 24% lack permanent housing, and 13% lack health insurance). This population is also characterized by co-occurring morbidities including chronic conditions, mental illness, and substance abuse.

During 2007, the HIV Health Services Clinic provided comprehensive primary medical care for more than 883 individuals. Health services address full range of treatment needs from early diagnosis to advanced illness. On-site pharmacy services support compliance with treatment. Intensive medical protocols for pregnant clients prevent mother-to-child transmission. The Clinic integrates prevention into all services to reduce client risk of HIV transmission.

The HIV Care Services Program coordinates a regional system that promotes access to high quality HIV services involving a network of community organizations to meet overall needs of clients. Local funding enables these organizations to leverage additional resources from other social service and medical systems. During 2007, HIV Care Services were provided to 2,051 clients and 48,348 visits.

Regular HIV medical care, linked with case management and support services, prevent costly health crises and hospitalization. Addiction treatment, mental health therapy, and prevention counseling address behavior change issues. Health promotion enables clients to better control their disease and reduce transmission risk. Through contracts with other health departments and community organizations, services include:

- Early intervention: Outreach ensures early identification and treatment.

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- Health care: A coordinated primary care system provides medical, dental, mental health, and substance abuse treatment.
- Service coordination: Case management connects clients with health insurance, housing, and other services critical to staying in care.
- Basic needs: Housing focuses on building life skills and access to permanent housing.
- Health promotion: Behavioral education provides clients with self-management skills.
- Planning: A community-based Council does service planning.

By providing services to persons living with HIV, the Health Department has demonstrated measurable results in terms of HIV health outcomes and care issues. For example, due to improved access to health care and medications, HIV mortality dropped 86% from 1994 to 2004 in Multnomah County; and there are no access disparities for HIV infected racial/ethnic minorities and women. Also see the HIV Services Action Plan on page 55.

Corrections Health Services - As a part of its health services, the Health Department provided health care for adult and juvenile inmates housed at Multnomah County's Justice Center, Restitution Center, Inverness Jail, and Juvenile Detention Center. The Corrections Health Services unit assures that each individual who enters the jail system is evaluated by a nurse. Corrections Health staff are on duty 24 hours a day in the Justice Center and Inverness Jail, and all inmates have access to health care a minimum of three times a day to address health, mental health and dental issues. Correction Health provided services to 24,447 inmates and provided 75,621 visits during 2007.

School-Based Health Centers - Since 1986, School-Based Health Centers have provided access to comprehensive healthcare to uninsured school-aged youth, as well as youth with insurance who cannot or do not access providers. The services are confidential, culturally competent, and age-appropriate. During FY 2008/2009, the Department will continue to operate 13 fully equipped school-based medical clinics. Twelve clinics are located in schools and one clinic is located at a County-owned facility that is school-linked. Program locations are geographically diverse, and all school-aged youth are eligible to receive services (including those attending other schools, drop-outs, homeless, detention). During 2007 these clinics served 6,515 individuals and provided 21,078 visits.

School-Based Health Centers assure access to care by providing service times during and beyond regular school hours and at multiple sites open during summer and school breaks to ensure continuity of care. Staffing at each clinic includes a Nurse Practitioner, Registered Nurse, medical support staff, and an office assistant. Services of school-based health clinics include chronic, acute, and preventive healthcare; age-appropriate reproductive health; as well as exams, risk assessments, prescriptions, immunizations, fitness, and nutrition education/counseling, referrals. Comprehensive approach enables early identification and intervention, thereby reducing risk behaviors.

Dental Services – The Health Department's Dental Services Program provides urgent, routine, and preventative oral health care through clinic based and school-based programs. Poor dental health has been shown to affect a person's overall health, which can result in unnecessary and costly medical care. The Health Department is the largest safety net provider for dental care in Multnomah County; and it focuses on underserved populations including uninsured, at-risk children, pregnant women, homeless, disabled, minorities, and non-English speaking residents.

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During 2007, the Department's four dental clinics served 19,272 individuals, and provided 54,034 clinical visits.

The Dental Services Program is comprised of the following components:

- Clinical dental services provided at four sites.
- School and Community Dental program is the public health section of dental services providing education, fluoride treatments, and dental sealant services to children in Multnomah County schools.
- The "Baby Day" and "Pregnant Women" dental projects provide access for children 0-24 months, and uninsured pregnant women receiving prenatal care in Health Department clinics.
- Dental Access Program provides triage and referrals for uninsured Multnomah County residents seeking dental care for critical, urgent, and routine dental needs.
- MultiCare Dental DCO is a dental insurance plan for approximately 24,000 Oregon Health Plan enrollees managed by Multnomah County, and it ensures members receive all dental services provided under the Oregon Health Plan.

Clinical Services Infrastructure Group – The Clinical Services Infrastructure Group includes Pharmacy, Laboratory, X-ray, and Medical Records Management. This group provides essential support services needed to ensure the delivery of high quality care to clients of the Department's care clinics, which include a large percentage who are uninsured, mentally ill, and women and children. The roles of each component of this group include:

- Pharmacy Services procures medications for dispensing to Health Department clients including high numbers of individuals suffering mental illness; clients of public health programs such as the Tuberculosis, STD, and CD clinics; as well as students in School Based Health Clinics. The program invoices third parties, assists clients in obtaining low-cost/no-cost drugs from manufacturers, and provides staff consultation and patient education regarding medications. During 2007, Pharmacy Services filled 235,331 prescriptions for Health Department clients.
- Laboratory Services tests clinical and environmental specimens, manages contracts, prepares for bio-terrorism and emergencies, and supports surveillance of emerging infections.
- X-Ray maintains diagnostic imaging and film archive.
- Medical Records Management oversees the Department's medical records systems to ensure comprehensive clinical documentation and compliance with all applicable licensing, regulatory and accreditation standards; continue implementation of electronic medical records; and oversees HIPAA requirements for the Health Department.
- Language Services assures that client's health care needs can be provided in a language that they understand and are comfortable with, and it assures that the Department continues to provide services that are linguistically and culturally compatible with the needs of clients.

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### **III. ACTION PLANS**

Action plans are included for the following public health issues that will be partially supported with State funding:

A. Epidemiology and Control of Reportable Communicable Diseases

1. Communicable Disease Prevention and Control Program (page 39, also see Attachment 1 on page 81 for a copy of the Guidelines for BT/CD Assurances.)

B. Parent and Child Health Services

1. Parent and Child Health Services (see page 41.)
2. Babies First! (see page 43.)
3. Family Planning Services (see page 44.)
4. Women, Infant & Children (page 45, also see Attachment 2 on page 85 for a copy of the FY 2007-2008 WIC Nutrition Education Plan Evaluation, and Attachment 3 on page 92 for a copy of the FY 2008-2009 WIC Nutrition Education Plan.)
5. Community Immunization Program (page 46, also see Attachment 4 on page 97 for a copy of the FY 2006-2008 Immunization Plan Evaluation; and see Attachment 5 beginning on page 103 for the FY 2008/2009-2011 Immunization Plan.)

C. Environmental Health (OAR 333-014-0050 (2) (e))

1. Environmental Health Services (see page 49.)

D. Health Statistics (OAR 333-014-0050 (2) (c))

1. Vital Records Program (see page 50.)

E. Information and Referral (OAR 333-014-0050 (2) (d))

1. Information and Referral Program (see page 51.)

F. Other Issues (separate action plans are presented for each of the following issues)

1. Emergency Preparedness (see page 53.)
2. HIV Services (see page 55.)
3. Tuberculosis Prevention and Treatment (see page 57.)
4. Tobacco Prevention and Control (see page 58.)
5. School-Based Health Center Program (see page 60.)
6. Hepatitis Surveillance (see page 61.)

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**A. Epidemiology and Control of Communicable Diseases**

**A.1. Action Plan: Communicable Disease Prevention and Control Program**

- a. **Current condition or problem** - Epidemiology and the Control of Communicable Diseases is addressed through the Department's Communicable Disease Prevention and Control Program (a unit within the Community Health Services Division). The purpose of this program is to protect the community from the spread of communicable disease and to decrease the level of communicable disease in Multnomah County (also see program description on page 18.) The work of the program involves investigating, counseling, and recommending control measures to individuals diagnosed with a communicable disease. Other primary activities include public health surveillance (involving collection and analysis of statistical data), as well as screening and diagnosis of clients in high-risk occupations who have no other source of medical care. With continuing concerns regarding bioterrorism and other incidents involving mass casualties, this program has worked closely with infection control community partners and the Department's Emergency Preparedness Program to improve the Department's capacity to respond to all possible communicable disease threats. Program staff also work collaboratively with the Department's Health Officer and EMS Medical Director, the Environmental Health Program, other local health departments in the Portland metropolitan region, the Oregon Department of Human Services/Health Services, and other public safety responders to improve the reporting, investigation and implementation of control measures for all communicable diseases occurring in Multnomah County. All staff have been trained in the basic Incident Command System, with select staff having additional responsibilities on the Department's Incident Management Team. Program staff have also participated in several multi-agency bioterrorism/emergency preparedness response exercises. All TB Clinic nurses are trained to provide 'surge capacity' in the event of a large outbreak or bioterrorism event. A 24 hour/day "hot-line" is available for use when the volume of calls increases above the ability to provide a personal response. In addition, the Department has created a 24 hours/day, 7 day/week on-call system to assure an appropriate response at anytime (i.e., evenings, weekends and holidays).
- b. **Goal** - The goal of the Communicable Disease Program is to identify, prevent and control an endemic and emerging communicable and environmentally related diseases and threats. See table below.
- c. **Activities** - Target population includes all residents of Multnomah County. Major activities include:
- Providing epidemiologic investigations to report, monitor, and control communicable disease and other health hazards.
  - Providing diagnostic and consultative communicable disease services.
  - Assuring early detection, education, and prevention activities which reduce the morbidity and mortality of reportable communicable disease.
  - Assuring the availability of immunizations for human and animal target populations.
  - Collecting and analyzing communicable disease data and other health hazard data for program planning and management to assure the health of the public.

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- Collaborating with other public and private health care providers and infection control professionals as well as public safety personnel to assure timely response to communicable disease issues of public health importance.

These activities will continue to be carried out on an ongoing basis by staff of the Communicable Disease Program.

- d. Evaluation** - Data collection, data analysis, and program evaluation occurs at the program, division and Department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services and to other funding partners, and upon request. The effectiveness of disease control and prevention is measured by the following types of outcomes:

<b>Program Area</b>	<b>Measurable Outcome</b>
Disease Control	See appended BT/CD Guidelines (page 81).
Health Inspections	Number of food service managers who have received County sponsored food safety training
HIV Care Services Planning and Administration	Percent of funds allocated for health and support services to people living with HIV/AIDS within 60 days of grant award
HIV Health Services	Percent of HIV Health Services visits covered by health insurance
HIV Prevention	Number of HIV risk reduction contacts with injection drug users
Immunizations	Percent of sixth-grade children receiving 3-dose series of Hep B immunization
Immunizations	Unduplicated contacts/children served per year for immunization evaluation/vaccine
Lead Poisoning Prevention Program	Number of Elevated Blood Level (10+ ug/dL) households receiving Lead Poisoning Prevention information and referrals to assistance programs.
Lead Poisoning Prevention	Number of calls to the LeadLine
Occupational Health	Number of Health Department employees documented to have a TB skin test conversion resulting from a workplace exposure
STD Clinic	Percent of STD clinic clients who receive HIV testing
STD Clinic	Percent of HIV counseling and testing service clients identified as high risk
STD Clinic/Epidemiology	Percent of reported cases of gonorrhea assigned, investigated and closed by County Disease Intervention Specialists within 14 days
STD Clinic/Epidemiology	Percent of reported cases of syphilis assigned, investigated and closed by County Disease Intervention Specialists within 14 days
STD Clinic/Epidemiology	Percent of reported cases of chlamydia assigned, investigated and closed by County Disease Intervention Specialists within 14 days
TB Prevention and Treatment	Percent of TB patients (active tuberculosis) who have taken TB medications continuously throughout the year
Vector Control	Number of rodent complaints/ # of initial and follow-up rodent inspections
Vector Control	Number of nuisance complaints/ # of initial and follow-up nuisance inspections
Vector Control	Number of mosquito pools collected of species identified as potential mosquito borne disease carriers
Vector Control	Number of Tobacco Education & Prevention complaints/ # of initial and follow-up Tobacco Education & Prevention inspections

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**B. Parent and Child Health Services**

**B.1. Action Plan: Parent and Child Health Services**

- a. **Current condition or problem** – Children whose parents are without the financial means to prevent and/or address health issues are extremely vulnerable members of the community. A system of care to assure the health and wellbeing of these individuals is addressed as a function of following two separate divisions of the Health Department:
- Community Health Services division’s Early Childhood Services Program consists of community health nurses, community health workers, office assistants, managers and program-specific staff providing services from geographically designated offices, project specific teams or out-stationed with various community-based organizations.
  - Integrated Clinical Service Division’s primary care clinics provide basic medical services, including prevention, diagnosis, and treatment for all ages.
- b. **Goals** - The goal of the Department’s parent and child services programming is to improve the overall health of women, infants, children and fathers through preventive health programs and services that build on the strengths of specific populations and community partnerships.
- c. **Activities** - The target population includes children and families in Multnomah County. The activities of the Community Health Services division and the Integrated Clinical Services division with respect to meeting the community’s needs for parent and child health are presented below.
- Community Health Services’ Early Childhood Services Program will implement a variety of services to contribute to the health and wellbeing of parents and children, including:
    - Early Childhood Services Health Teams work to promote wellness, with an emphasis on families with young children by promoting healthy pregnancy in populations at risk for having poor pregnancy outcomes; and by promoting healthy infant/child growth and development in populations at risk of not achieving healthy growth and development outcomes. Services include home visits, coordination with health providers, group classes, and health promotion activities. More than 7,700 parents and children are served annually, with priority to teen parents, first-time parents, premature infants, children with special healthcare needs, and high-risk families.
    - Healthy Start, a State funded program, provides screening, assessment, referral, and home visit services to first time parents in Multnomah County. Health Department staff visit local hospitals to assess first time parents using the New Baby Questionnaire. Families eligible for home visit services are referred to Early Childhood Services staff and to contracted community agencies for ongoing services of case management and parenting education.
    - Connections Program is integrated into the Healthy Start program to provide intake, assessment, referral, and support services to first time mothers age 17 and under. The primary elements are: assessment and referral, case management, support groups,

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- pregnancy prevention, parent education, and child development education. This service is contracted to non-profit community agencies.
- Babies First! is a developmental screening program for children at risk of developmental delay due to a variety of risk factors including: premature birth; drug exposed infant during pregnancy; low birth weight; age of the parent/caregiver; low income/ poverty and other factors. A separate Action Plan for Babies First! is presented below.
  - Healthy Birth Initiative (HBI), addresses disparities in perinatal health among African American women in Northeast Portland. The project covers pregnancy and interconceptional phases through the infant's second year of life. Home visits, support groups, classes, and community consortium are key activities.
  - Nurse Family Partnership follows the model developed by David Olds research. The Department is an official NFP site contracted by the National NFP Service Office. Services are provided to first time pregnant women beginning early in their pregnancy until the child is age two. Nurse home visitors follow the NFP curriculum and guidelines.
- Activities that will continue to be utilized by Integrated Clinical Services to meet the needs for child and parent health include the following:
    - Women, Infants & Children (WIC) Program is a federally-funded program that promotes healthy families through nutrition education, supplemental foods, and community networking. The WIC program assesses provides education, vouchers for specially chosen supplemental foods, referral to healthcare, and breastfeeding support. A separate Action Plan for WIC services is provided below.
    - The Homeless Children's Project ensures availability and access to preventive and primary health care for children and their families who are at risk of being homeless, with a focus on Latino children and their families.
    - Primary care services include Maternal and Child Health Title V funds to provide family planning/birth control, prenatal care, immunizations, well-child exams, nutrition services, communicable disease screening, drug and alcohol screening, and management and care of acute and chronic medical conditions.
- d. **Evaluation** - The effectiveness of Parent and Child Health services is measured by the following types of outcomes:
- Percent of two-year-olds who are appropriately immunized.
  - Percent of pregnant women in County clinics who receive prenatal care in first trimester.
  - Percent of qualifying children who are up-to-date on well child exams.
  - Percent of all pregnant and parenting teens assessed prenatally and/or postpartum.
  - Percent of women who have been screened for domestic violence.

Data collection, data analysis and evaluation occur at the program, service area, and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, federal funding partners, and others as requested.

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**B.2. Action Plan Babies First! (Parent and Child Health Services, cont'd)**

- a. **Current condition or problem** – The Health Department’s Early Childhood Services Program is responsible for providing services through Babies First! This screening program focuses on children from birth to age four who are at risk of developmental delay due to a variety of factors including premature birth, drug exposed infant during pregnancy, low birth weight, age of the parent/caregiver, poverty and other factors. Referrals come primarily from prenatal providers, WIC and area hospitals. Through Babies First! potential problems can be detected quickly, and interventions started and monitored regularly. Public health nurses conduct in-home health and developmental screening for participating children on a regular basis, and work closely with the families on parenting skills, health education, advocacy, and referrals to services in other agencies. Babies First! focuses on helping families learn to care for and better understand their children.
- b. **Goals** - The goal of Babies First! is to improve the physical, development and emotional health of high risk infants and children, ages birth to four years.
- c. **Activities** - Key activities include:
- Outreach/Advocacy
  - Home visits
  - Health assessment and developmental screening
  - Neurological development and growth monitoring
  - Case management and counseling
  - Parenting education
  - Information and referral

These activities are performed on an ongoing basis by nurses and other staff of Early Childhood Services programs and initiatives, including:

- Early Childhood Services Health Teams work to promote wellness, with an emphasis on families with young children by:
  - Promoting healthy pregnancy in populations at risk for poor pregnancy outcomes.
  - Promoting healthy infant/child growth and development in populations at risk of not achieving healthy growth and development outcomes.

Services include home visits, coordination with community health providers, group classes, and health promotion activities. More than 7,700 parents and children are served annually, with priority to teen parents, first-time parents, premature infants, children with special healthcare needs, and high-risk families.

- Connections Program is integrated into the Healthy Start program to provide intake, assessment, referral, and support services to first time mothers age 17 and under. The primary elements are: assessment and referral, case management, support groups, pregnancy prevention, parent education, and child development education. This service is contracted to non-profit community agencies.

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- Healthy Birth Initiative (HBI) addresses disparities in perinatal health among African American women in Northeast Portland. The project covers pregnancy and interconceptional phases through the infant's second year of life. Home visits, support groups, classes, and community consortium are key activities.
  - The Nurse Family Partnership (NFP) follows the model developed by David Olds Research. The Health Department is an official NFP site contracted by the National NFP Service Office. Services are provided to first time pregnant women beginning early in their pregnancy until the child is age two. Nurse home visitors follow the NFP curriculum and guidelines.
- d. **Evaluation** - The effectiveness of the Babies First! Program is measured by the percent of infants and children who experience normal growth and development. Data collection, data analysis, and program evaluation occurs at the program, division, and department levels.

**B.3. Action Plan: Family Planning (Parent and Child Health Services, cont'd)**

- a. **Current condition or problem** - Family planning services are offered through primary care clinics, field offices, School-Based Health Centers, and other community sites. Based on 2005 Ahlers data, over 9,480 clients receive family planning services each year of which approximately 42% are teenagers. The Ahlers calculation estimated that 2,100 unintended pregnancies were averted in 2005.
- b. **Goals** - The primary goal of family planning effort is to reduce unintended pregnancies and to improve the health and well-being of children and families.
- c. **Activities** - Target population: Multnomah County residents
- Family planning activities through Primary Care and School-Based clinics include:
    - Comprehensive history and physical exam.
    - Breast exam and diagnostic procedures as indicated.
    - Pap smears.
    - Colposcopy for the evaluation of abnormal pap smears.
    - STI testing as indicated, and STI treatment and follow-up.
    - Review of family planning goals, birth control methods education, comprehensive birth control options offered, ongoing B/C management or maintenance provided.
    - Provide preconception health education.
  - Other family planning activities include:
    - Community outreach and education.
    - Computer-based education in clinics to provide access to high quality websites, guidance and printers to enable clients to download information as needed.
    - Technical assistance to teachers, and in-class teaching on reproductive health topics.
    - Educational displays for school hallways.
    - Peer-led abstinence education.
    - Initiation of hormonal contraception and comprehensive contraceptive counseling.

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- Program-related activities include:
  - Monitor contraceptive access in School-Based Health Centers.
  - Invoice all appropriate Medicaid and FPEP contraceptive visits and supplies.
- d. **Evaluation** - Outcome measures include: percent of visits of 19-21 year olds receiving family planning services; percent of 15 to 17-year-old female family planning clients who do not get pregnant during the year; number of clients treated for an STI; and the number of clients evaluated for an abnormal pap smear. Outcome measures include maintaining contraceptive access at the same level as FY 2008; and capture all appropriate Medicaid and FPEP reimbursements for contraceptive visits and supplies. Data collection and analysis occurs at the program level; and information is reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and others as requested.

**B.4. Action Plan: WIC (Parent and Child Health, cont'd)**

- a. **Current condition or problem** - The federally funded WIC program builds healthier families through nutrition education, supplemental foods, and community networking. WIC services are offered at three Multnomah County clinic sites (East County, Mid-County, and Northeast), and during FY 2008 the Health Department provided WIC services to 30,419 individuals (83,842 encounters). WIC is a prevention-oriented program that addresses the need to increase birth weight, lengthen the duration of pregnancy, improve the growth of at-risk infants and children, reduce rates of iron deficiency, and decrease infant mortality. WIC services include the provision of monthly supplemental foods and referral to health care (see Attachment 2 beginning on page 85 to review the annual evaluation of the Multnomah County WIC Nutrition Education Plan for FY 2007-2008).

This Action Plan represents a summary of the FY 2008-2009 WIC Nutrition Education Plan for Multnomah County (this plan was submitted to the Oregon Department of Human Services/Health Services WIC Coordinator on May 1, 2008, and it is appended as Attachment 3 beginning on page 92).

- b. **Goals** - The goal of the County's WIC Program is to provide quality nutrition education; nutrition education will be appropriate to the clients' needs; improve the health outcomes of clients and staff; and improve breastfeeding outcomes of clients and staff.
- c. **Activities** - Key activities of the WIC Program for this fiscal year include:
  - Review the Oregon WIC Key Nutrition Messages and identify those staff that will need additional training in order to implement it effectively.
  - Review proposed food package changes and:
    - Select at least three food package modifications (for example, addition of new foods, reduction of current foods, elimination of current foods for a specific category);
    - Review current nutrition education messages most closely connected to those modifications; and

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- Determine which messages will remain the same and which messages may need to be modified to clarify WIC's reasoning for the change and/or reduce client resistance to the change.
  - Identify agency training supervisor(s) and projected staff in-service training dates and topics for FY 2008-2009.
  - Review diet assessment steps from the Dietary Risk Module and identify those that clients may need additional training to follow.
  - Evaluate how clients have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.
  - Develop policies and programs using a worksite wellness toolkit, the state's Breastfeeding Mother Friendly Employer toolkit, or similar publications that provide examples of the benefits of physical activity and healthy eating.
  - Provide families with information and resources promoting physical activity.
  - Offer World Breastfeeding Week celebration in August 2008.
  - Continue working to implement key messages and breastfeeding policy with North Portland Obesity Project.
- d. **Evaluation** - The effectiveness of WIC is measured by the average number of pregnant women served per month as a percent of WIC caseload. Data collection and analysis, and program evaluation occurs at the program level, and results are reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and others as requested.

**B.5. Action Plan: Community Immunization Program (Parent and Child Health)**

- a. **Current condition or problem** - The Community Immunization Program promotes and provides immunizations throughout Multnomah County for uninsured and underinsured children. The Program oversees the immunization school law process for vaccine requirements for children and students in day care facilities, preschools, Head Start programs, and private, alternative and public schools. Blood lead screening for children six years of age and younger, adult immunization services, and antibody testing are also provided. The number of school exclusions decreased in school year 2007-2008, however, there is still difficulty in reaching primary and middle school populations who may not be complete. In addition, there remains great need to continue providing no/low cost vaccination services to children who have no insurance or whose insurance does not cover immunizations. The walk-in clinic serves as a safety net for those children who cannot access immunization services elsewhere. Also see Attachment 4, FY 2006-2008 Immunization Plan and Progress Report beginning on page 97.
- b. **Goals** - The primary goal of the County's immunization efforts is to promote and provide immunizations to prevent vaccine-preventable diseases in children by reaching and maintaining high lifetime immunization rates. A secondary goal is to provide occupational health services (immunizations, TB testing, antibody testing) to adults who are required to

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receive certain services for school, work or in the event of an exposure to a vaccine-preventable disease.

c. **Activities** – The Community Immunization Program works through partnerships with community groups and the Multnomah Education Service District (MESD) to deliver immunization services. Clients are asked to pay a \$15 administration fee per injection, but no child who is eligible to receive immunizations through the VFC (Vaccines for Children) program is refused service for inability to pay. All childhood immunizations are offered. In addition, blood lead level screening for children up through six years of age is provided. Families who have insurance that cover immunization services are encouraged to receive their vaccines at their private provider, unless there is a problem with additional costs. Adult immunizations and antibody testing is also available to which standard fees apply. Key program activities include:

- **Childhood Immunizations**
  - Conducting year-round outreach and educational activities for parents and private providers to increase immunization rates in Multnomah County.
  - Conducting the annual immunization school law process to ensure that children and students in day care centers and schools are up-to-date or complete with their immunizations.
  - Partnering with MESD to provide in-school clinics for uninsured and underinsured children.
  - Collaborating on eSIS immunization database upgrade with MESD to include two new school law requirements in school year 2008-2009.
  - Conducting trainings on the immunization school law process for staff of day care facilities, preschools, kindergartens, Head Start programs, and private and alternative schools.
  - Increasing emphasis on vaccinating infants and children for influenza.
  - Increasing emphasis on vaccinating children (1 year of age and older) for Hepatitis A in compliance with a new school law requirement being implemented in School Year 2008–2009.
  - Integrating service delivery between WIC and Immunization programs to decrease client barriers and increase utilization of services.
  - Collaborating with delegate agencies (community clinics) to facilitate receiving VFC and “317” vaccine, as well as assistance with online vaccine ordering, inventory, and technical support.
  - Participating in the Oregon Partnership to Immunize Children (OPIC) coalition.
- **Adolescent Immunizations**
  - Implementing “catch-up” immunization schedules as needed and particularly among the immigrant and refugee populations.
  - Providing oversight of VFC vaccines for staff at school-based health centers in elementary, middle, and high schools.
  - Replacing Td booster with the Tdap (tetanus, diphtheria, pertussis) vaccine, to increase protection against pertussis.
  - Increasing emphasis on vaccinating students for Tdap in compliance with a new school law requirement to be implemented in School Year 2008–2009 for 7<sup>th</sup> graders.

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- Adult Immunization, Antibody Testing and TB Testing Services
  - Offering immunization services for adults over 19 years of age, including tetanus/diphtheria/pertussis, influenza, pneumococcal, and hepatitis A and B.
  - Procuring and offering State-Supplied vaccine for high risk individuals who qualify, namely IDUs, men who have sex with men, and people living with HIV or HCV.
  - Providing antibody testing for Hepatitis B, measles, mumps, rubella, and varicella.
  - Providing TB testing.
  - Collaborating with various schools and businesses to provide immunizations, and TB testing for students and/or employees as requested.
  
- Technical Support to Integrated Clinical Services (ICS) for Immunizations
  - Monitoring vaccine storage and handling procedures based on administrative guidelines and State quality assurances. This includes:
    - Ensuring proper appliance temperatures for refrigerated and frozen vaccine via electronic datalogger downloads.
    - Responding to temperature excursions.
    - Training on and oversight of online vaccine ordering.
    - Compiling monthly inventories and reporting to the State.
    - Troubleshooting and coordinating vaccine issues among clinics.
    - Collecting wasted/expired/destroyed vaccine for return to the State.
  - Strategizing on ways to improve immunization rates in two-year-olds.
  - Developing and implementing a comprehensive training program for ICS staff which includes Vaccine Coding, Basics of Vaccine Forecasting and use of two statewide immunization databases (IRIS and ALERT).
  - Overseeing quality assurance of vaccine coding to ensure proper use of State-supplied vaccine based on VFC and 317 Program eligibility requirements.
  - Collaborating with clinical management staff when new vaccines become available.
  - Communicating immunization updates (e.g.: vaccine shortages; assist with implementing new vaccines).
  - Conducting a physical inventory of State-supplied vaccine at all Department and delegate agency clinics at the end of each fiscal year.
  - Revising Administrative Guidelines regarding immunizations.
  
- d. Evaluation - Performance of the Community Immunization Program is measured by the annual number of immunizations administered; the (decrease in) number of school exclusion letters sent; percent increase in the number of 2-year-olds up-to-date; and increased accuracy of vaccine coding. Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services, Health Services, and other funders as required.

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## **C. Environmental Health**

### **C.1. Action Plan: Environmental Health Services**

- a. **Current condition or problem** - The Environmental Health Services unit is responsible for assuring the public of safe food, control diseases that can be acquired from food and water, manage vector populations (i.e., rats and mosquitoes), certifying County birth and death records, regulating selected businesses and accommodations, and enforcing State and local environmental health laws and rules. Environmental Health Services staff work in cooperation with other units in the Department and community. For example, staff work in cooperation with the staff of the Communicable Disease Prevention Program to refine procedures for responding to a broad range of disasters and emergencies that can threaten the health of the community including floods, vectors, earthquakes, bio-terrorism and other mass casualty events.
- b. **Goals** - The goals of Environmental Health Services unit are to (1) analyze local environmental health issues from a public health perspective, (2) regulate specified businesses and accommodations, and (3) enforce State and local environmental health laws and rules.
- c. **Activities** - Target population includes all residents of Multnomah County. The following activities are implemented on an ongoing basis by Environmental Health Services staff:
- Environmental health assessment and planning.
  - Food handlers training and certification.
  - Disaster preparedness.
  - Vector and nuisance control.
  - Lead poisoning prevention.
  - Inspection, licensure, consultation and complaint investigation of food services, tourist facilities, institutions, public swimming and spa pools, drinking water systems; to assure conformance with public health standards.
  - Community education about environmental health risks and hazards including: asthma, poor indoor air quality, lead poisoning, food borne illness, and vectors.
  - Data analysis to identify environmental health trends and future service needs.
  - Grant development to support Environmental Health Services.

Environmental Health will continue to support public policy change that reflects the interface between health and housing, and the impact on health disparities as a result of comprehensive implementation of PACE-EH community assessment process. The unit will also work to educate diverse communities about environmental health risks and hazards as a means of protecting public health and reinforcing information provided through the inspection process.

- d. **Evaluation** - The effectiveness of disease control and prevention is measured by the types of measures listed on the table below.

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<b>Program Area</b>	<b>Measurable Outcome</b>
<b>Health Inspections</b>	Number of critical violations identified in food service facilities
	Number of total food program complaints received
	Number of food borne illness complaints received
	Number of food borne illness outbreaks investigated
	Number of food borne illness outbreaks confirmed
	Number of total cases for all confirmed outbreaks
<b>Food Handler Training and Certification</b>	Percent of food handler tests passed
	Number of food handler tests taken by language
<b>Lead Poisoning Prevention Program</b>	Number of Elevated Blood Level (10+ ug/dL) households receiving Lead Poisoning Prevention information and referral to assistance programs
	Number of calls to the LeadLine
<b>Vector Control</b>	Number of rodent complaints/Number of initial and follow-up rodent inspections
	Number of nuisance complaints/Number of initial and follow-up nuisance inspections
	Number of mosquito pools where there were species identified as potential mosquito borne disease carriers
	Number of tobacco education & prevention complaints/Number of initial and follow-up tobacco education & prevention inspections
<b>Community Education and Outreach</b>	Number of educational events conducted
	Number of individuals who attend the educational events
	Pre and post tests of information presented to evaluate if there is an increase in knowledge
	Results from customer satisfaction surveys given to attendees of educational events

**D. Health Statistics**

**D.1. Action Plan: Vital Records (Health Statistics)**

- a. **Current condition or problem** - Health departments in Oregon are mandated by statute to collect and report certain health statistics to the State (i.e., data from birth and death certificates). Birth attendants initiate the birth certification process; and physicians and funeral directors initiate the death certification process. County Registrars complete the certification process by assuring the completeness, accuracy, confidentiality, and proper certification of births and deaths within six months after the event. Analytical capacity exists at the local and State level to evaluate vital statistics for information to identify at-risk populations and assess trends over time. Vital statistics give public health officials access to confidential information that allows for the establishment of effective public health interventions. For example, birth data is used on an on-going basis for the purpose of evaluating the effectiveness of public health programs; and death data is used to supplement communicable disease outbreak information and to map cases. At the State level, the Infant

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Mortality Review Committee receives data of fetal and infant deaths to support analysis of the perinatal system in an effort to promote healthier birth outcomes.

The purposes of maintaining vital statistics as a function of public health are to:

- Assure that birth and death certification is complete and accurate.
- Analyze public health data to determine the health of the community.
- Identify populations at risk in order to provide effective interventions.

**b. Goals** – The goals of the Vital Records unit are to:

- Assure accurate, timely and confidential certification of birth and death events, and minimize the opportunity for identity theft.
- Provide birth and death data to support analyses of health conditions of the population or of a segment of the population.

**c. Activities** – The following are activities that will continue to be undertaken in FY 2008/2009 to support the work of the Vital Records unit:

- Data collection and analysis;
- Birth and death reporting, recording, and registration;
- Analysis of health indicators related to morbidity and mortality; and
- Analysis of services provided.

**d. Evaluation** - The effectiveness of the Vital Records unit is measured by the following types of outcomes: Percent of birth and death certificates provided within 24 hours of receipt; the number of certificates issued; and the kinds of data analysis conducted. Data collection, data analysis and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and other funders as required.

## **E. Information and Referral**

### **E.1. Action Plan: Information and Referral Program**

**a. Current condition or problem** – The Health Department’s Health Information and Referral Program (I&R) provides information and referrals for individuals seeking access to health services in Multnomah County. Health Department staff are available to link callers with existing services by phone only. I&R consists of a telephone-based information and education program serving residents of Multnomah County. I&R’s information specialists serve as guides for individuals and families seeking information and access regarding services provided by the Health Department; schedule prequalification appointments for financial assistance appointments; collect and enter client demographics into a computer-based system for statistical reports; and make referrals to 1-800-SAFENET. I&R staff includes health information specialists who are bilingual in Spanish, Vietnamese, and Russian.

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- b. **Goal** - The goal of the Information and Referral Program is to provide information and referral services to the public regarding Health Department services and referrals. A new goal for FY 2008/2009 is to modify and improve I&R services to reflect the goals of the Department's Building Better Care Initiative.
- c. **Activities** - The Information and Referral Program will continue to provide I&R services into FY 2008/2009. However, the program will undergo a systems change beginning in the fall of 2008 to a new system know as "Primary Care Appointments and Referrals" (PCAR) in response to the Department's Building Better Care Initiative (see description on page 34). Like the existing Health Information and Referral Program, PCAR will strive to ensure that I&R services are delivered in a culturally appropriate and customer service-oriented manner; and it will provide access to primary care services by appointments for underserved, low income, uninsured individuals into the Health Department's primary care services and referrals from primary care to other community providers through standardized referral processes.

Significant differences in the PCAR approach include the following:

- Individuals referred through PCAR will be assigned a Primary Care medical home for comprehensive care.
- PCAR will collaborate with other County organizations that also provide services to underserved individuals and internal service providers, as well as with Corrections Health and other Department providers.
- PCAR will ensure comprehensive, collaborative planning processes that are patient centered, respectful and attentive to resource stewardship.
- PCAR recognizes that once the Building Better Care model spreads across the primary care system, patients who are assigned a primary care "home" will be best served by their respective health centers and care teams (rather than through a call center). These clients will call their medical home for appointments, cancellations and advice during hours of operation.
- WIC appointments will be decentralized to the WIC Programs service sites: East County Health Center, Northeast Health Center and Mid-County Health Center.
- Health Department Information and Referral will continue to be provided from a centralized location, using a new, updated and streamlined database.
- PCAR will focus on appointing new patients into the system, so that resources for uninsured Multnomah County residents are optimized.
- Eventually all new primary care patients will be appointed by PCAR team members and the PCAR Referral Coordinator, and there will be a new phone number for new patient appointments.
- The new processes will be phased in during the fall 2008; and all outside agencies, new CareOregon patients, Corrections Health patients, and uninsured Multnomah County residents will be appointed by the PCAR Team.
- PCAR staff is now working with the Coalition of Community Health Clinics on a pilot for appointing some local acute care patients into a primary care "home." Once the PCAR system is operational, the current I&R phone number, 503-988-3816, will be replaced by a new PCAR number.

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- d. **Evaluation** - The effectiveness of the current Information and Referral Program is measured by the following types of measures: number of human services referral calls taken per FTE; and number of prequalification appointments for financial assistance programming including SCHIP, FPEP, Oregon Health Plan, etc. Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, and other funders as required.

## **F. Other Issues**

### **F.1. Action Plan: Other Issues (Emergency Preparedness)**

- a. **Current condition or problem** - Emergency preparedness activities must ultimately develop the capacity to mobilize all Department resources, and to leverage those of public and private partner organizations to appropriately respond to the public health impacts of any scale of emergency. The Multnomah County Health Department plays two essential roles in responding to public health incidents and events:

1. Emergency Medical System Administration; ensuring medical first responders (e.g., fire department medics), the ambulance system, and hospitals coordinate effective emergency care.
2. Response to communicable disease, environmental health, and bioterrorism events; monitor, evaluate, and respond to these public health threats when manifested as an emergency.

These missions and their supporting authorities are the foundation of the Department's public health emergency preparedness activities.

- b. **Goal** - The emergency preparedness program reflects Goal 3 of the Department's FY05-09 strategic plan, which is to "protect the public, and mitigate the health impacts of natural and human-caused disasters."
- c. **Activities** – As presented below, the activities for the Emergency Preparedness Program are presented under five strategic objectives.

- Objective 3.1 - Improve internal capacity to respond to bioterrorism, major communicable disease outbreaks, and environmental health hazards:
  - Develop and maintain a Regional Health Preparedness Organization and a County Public Health Emergency Response Plan that is aligned with regional partners.
  - Maintain an Incident Management Team as a focal point for preparedness training and responsibility.
  - Build emergency management experience and competence.
  - Improve and maintain a notification, alert, decision, and activation framework for emergency response.
  - Improve emergency communications within the Department and externally.
  - Develop active surveillance in coordination with the State.
  - Maintain CD data base compliance with BT/CD guidelines.
  - Develop depth in CD nurse epidemiology investigators.
  - Maintain and test emergency response CD protocols.

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- Develop, maintain, and test emergency response protocols/plans.
- Objective 3.2 - Assure business continuity during an emergency.
  - Audit risks of workplace vulnerability to disruption.
  - List and prioritize risk reduction activities.
  - Staged operations plan for business continuity.
  - Maintain succession plan.
  - Maintain call-up lists.
  - Develop business continuity competencies and responsibilities.
- Objective 3.3 - Assure that all our diverse communities' needs in emergency preparedness and response are recognized and effectively addressed.
  - Develop and exercise a Community Connector concept.
  - Planning and operational links to community-based organizations.
- Objective 3.4 - Integrate public health response to emergencies across programs and organizational units, with Emergency Management and other Departments, and with other external partner organizations (e.g., hospitals, first responders, etc.).
  - Know, plan, and exercise with partner organizations.
- Objective 3.5 - Develop techniques for managing population responses to events involving mass casualties/exposures.
  - Plan and exercise for such events.

**d. Evaluation** - Various measures are used to assess program success, for example:

- The Public Health Officer, Director of Community Health Services (CHS) Group, Emergency Medical Director, and Emergency Preparedness Manager are responsible for leading and cultivating regional collaborative efforts within public health and emergency medical communities. Performance is measured in the results of those efforts.
- The Director of Community Health Services (CHS) in consultation with the Department Director's Leadership Team provides general guidelines and determines Department-wide investment for Emergency Preparedness activities.
- The CHS Director and Health Officer represent the County on the Regional Emergency Preparedness Policy Group that determines regional public health priorities and projects. Performance is measured by progress toward accepted goals and objectives.
- The Department's Emergency Preparedness Manager is responsible for monitoring, organizing, and leveraging internal preparations for large scale emergency response operations through Incident Management Team (IMT), and plans development and maintenance. Performance is measured by IMT numbers (90 persons are authorized to date).
- Incident Management Team members are the focal point of Department investment to develop emergency response leadership and technical expertise. Team leaders for each of the command and general staff functions of the Incident Command System are responsible for developing IMT members assigned to those functions in consultation with the EP Manager. Performance is measured by evaluation of performance during major annual exercises.
- The Health Preparedness Organization (HPO) is a six county regional initiative to build response capacity and collaboration among medical/hospital community and local public health departments. The HPO is based at the Multnomah County Health Department.

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- Business Continuity is the responsibility of the Department's Deputy Director. Performance is measured by periodic reviews of adequacy.

Data collection, data analysis, and program evaluation occurs at the program, division, and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and other funders as required.

**F.2. Action Plan: Other Issues (HIV Services)**

- a. **Current Conditions/Problems** - STDs, HIV, and Hepatitis C (HCV) account for almost two-thirds of all reportable diseases in the County and disproportionately affect racial/ethnic and sexual minorities. Approximately 4,800 people have been diagnosed with HIV in Multnomah County since 1981; over 2,000 people living with HIV/AIDS (PLWH/A) have died, while over 2,700 are still living with this disease. In addition, an estimated 24,000 County residents use injection drugs, a leading cause of HCV. Delayed diagnosis and treatment increases disease spread, and costly chronic conditions, such as AIDS and liver disease. Preventing these diseases saves money over the course of a lifetime. Each prevented HIV case saves an estimated \$360,000 over a lifetime, while each prevented HCV case saves an estimated \$66,000. Economic studies examining the costs associated with HIV infection have found that the cost per HIV infection prevented by syringe exchange runs about \$4,000 to \$12,000, considerably less than the estimated \$400,000 lifetime medical costs of treating a person who is infected.

HIV and Hepatitis C (HCV) Community Programs target and serve newly affected, emerging, and underserved populations impacted by HIV/STDs and Hepatitis C through testing, prevention services; primary care services; early intervention services; medical case management; and support services. This program's emphasis on community prevention, outreach and early diagnosis reduces disease transmission and the likelihood of devastating long-term outcomes.

Additionally, this program serves as a Ryan White grantee, serving a six-county area including, Multnomah, Washington, Clackamas, Columbia, Yamhill and Clark, WA counties. Over 4,000 PLWH/A are living in this six county area. Local AIDS prevalence has increased 22% from 2001 to 2006, fueling a continuing public health problem. There are high levels of co-morbidities among PLWH/A and an increased need for HIV-related services. PLWH/A have much higher rates of problems affecting the general population, such as poverty, homelessness, substance abuse, and mental illness. Among PLWH/A, 56% have a mental illness (close to three times the general population) while 36% have substance abuse problems. Among the clients served by this program, 73% of incomes below 100% FPL, 24% lack permanent housing, and 13% lack health insurance. The primary care, early intervention, medical case management and supportive services funded by this program result in lower mortality, fewer disease complications and disparities, and reduced HIV transmission.

- b. **Goals** - The overarching goals of the HIV and HCV Community Programs are: (1) to prevent the further spread of HIV and HCV infection, especially among highest risk community members; (2) eliminate African American sexual health disparities through group and

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community awareness strategies; and (3) effectively manage the Ryan White federal grant so clients have access to primary health care and support services.

- c. **Activities** - Target Populations served include Men who Have Sex with Men; Injection Drug Users; Partners of Persons Living with HIV; and Persons Living with HIV at highest risk of transmitting or acquiring HIV, HCV, or STDs. Program activities are divided into four focus areas: prevention services; primary care services; early intervention services; medical case management; and support services.
- Prevention services include:
    - Community testing: Staff visit bars, jails, internet & other "hookup" sites to test, educate, and promote behavior change.
    - Syringe Exchange and Disposal: Proven to keep infection rates low among injectors, partners and their infants.
    - Behavior Change/Education and Counseling: Community-based interventions to reduce risky sexual behavior & drug use. Locations include health department community test sites and STD clinics, correctional facilities, drug treatment agencies, and other targeted community venues.
    - Programs directed at African-American youth between 13-24 include the development and implementation of the KnowSex/NoSex campaign and Male Advocates for Responsible Sexuality (MARS) evidence-based intervention to address local racial/ethnic sexual health disparities.
    - Implementation of a CDC evidence-based intervention, *Community Promise*, is being implemented through a tri-county collaborative targeting highest risk men who have sex with men.
  - Primary Care: Primary care services include medical care, medications, oral health care, substance abuse treatment, mental health therapy, and health insurance premium/co-pay assistance. Services are provided through a combination of public and private health systems and community-based agencies contracted through the HIV and HCV Community Program. Multnomah County's HHSC, which provides outpatient HIV medical care, was also selected to be a clinical training site for physicians, nurse practitioners, and physician assistants in a five state area by the Northwest AIDS Education and Training Center.
  - Early Intervention Services: These services target recently diagnosed PLWH/A and other PLWH/A who have not engaged in primary medical care. To recruit clients, this program works with a network of service providers throughout the community that serve as key points of entry for PLWH/A who are either newly diagnosed or may be out of care. These service providers include public and private HIV counseling and testing sites, substance abuse and mental health treatment programs, detoxification centers, correctional facilities, homeless shelters, health and social service agencies serving youth and racial/ethnic minorities, and local health department HIV prevention programs and STD clinical services.
  - Medical case management: Medical case management in the six county area is coordinated with the major medical health systems and funded by both mainstream and Ryan White resources. Case management develops an individual service plan with each client based on a thorough health and psychosocial assessment of service needs and support systems, and connects clients with health insurance, housing, and other services critical to remaining in care.

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- Support Services: Support services in the TGA promote retention in medical care and assist clients in meeting basic needs. These services include housing, psychosocial support, and food/home-delivered meals, and are provided through a combination of public agencies and community-based organizations.
- d. **Evaluation** - Evaluation of HIV services has demonstrated positive results, including lower HIV mortality (86% drop in 10 years) and better targeted prevention and care services (performed ~5,600 HIV tests in FY 2008, and plan for same or more tests in FY 2008/2009). Expanded access to test results using a phone based system will increase number of clients receiving HIV results. Data collection, data analysis and program evaluation occurs at program levels, and has included the tracking of client service provision at the client-level across all care providers in the past two years. Information is reported to the Board of County Commissioners, Oregon Department of Human Services/Health Services, federal funding partners, and to others as requested.

**F.3. Action Plan: Other Issues (Tuberculosis)**

- a. **Current condition or problem** - The Health Department's Tuberculosis (TB) Program provides case management services for residents with active TB disease, which includes directly observed therapy (DOT) and case contact investigations. The TB Program also provides screening for high risk populations and preventive treatment for those with latent TB infection (LTBI). In 2006, the Oregon TB case rate was 2.2 cases per 100,000 population. The same year Multnomah County reported 32 cases which is 4.6 cases per 100,000 population. This is a decrease from 2005 when the Multnomah County case rate was 5.8 cases per 100,000 population. TB Program staff must continue aggressive efforts in order to maintain current decreasing trends in TB case rates.
- b. **Goals** - The goal of the TB Program is to prevent the spread of tuberculosis and to reduce its harmful effects on individuals and communities. Short term goals include assuring active cases complete treatment, contacts are evaluated and treated as needed, and high risk populations receive screening and evaluation, and treatment when indicated. Long term goals include continuing to decrease TB case rates to the Center for Disease Control (CDC) case rate goal of 3.5 cases per 100,000 population, decreasing LTBI in the community and increasing awareness of TB among all residents especially high risk populations.
- c. **Activities** - The service activities offered by the TB Program include:
- Case Management Services - A TB Nurse Case Manager (TB-NCM) is assigned to each suspected or confirmed active TB case. The TB-NCM assures that the case begins appropriate therapy within one working day of receipt of the case/suspect report or, when appropriate, after disease work up is completed and a decision to treat has been made. A Direct Observed Therapy (DOT) assessment is made for each case of TB. DOT is initiated on all cases. The TB-NCM monitors TB case's treatment and clinical response to treatment through the completion of therapy. They begin the contact investigation within 72 hours of verifying the case/suspect and assure appropriate and timely contact investigation is performed. The TB Program follows infected contacts through the completion of their therapy. The TB-NCM completes all TB reporting forms within required timeframes.

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- Outreach Prevention Services - The TB program screens high risk populations for evidence of TB infection or disease. The high risk populations in Multnomah County are refugees and immigrants from countries with disproportionately elevated TB rates, and dormitory style homeless shelter denizens and employees. Screening services include the TB skin test, QuantiFERON - Gold blood test, chest radiography, history and symptom evaluation, and physician assessment as indicated. Tri-weekly shelter screening clinics are conducted on-site at an established homeless shelter. Residents are given a shelter clearance card that must be renewed annually.

**d. Evaluation** - The effectiveness of TB disease control and prevention is evaluated by monitoring the following indicators.

- The number of active cases, types of case, duration of infectiousness, and the percent of cases that complete treatment.
- The number of contacts, Class B immigrants and refugees, and homeless shelter residents who complete an evaluation and of those found to be infected, the number who start and complete preventive treatment.
- The completion of immigrants and refugees TB evaluation within the required time period.

Data collection and analysis, and program evaluation occur at the program, division and Department levels. Information is reported to the Board of County Commissioners, the Oregon DHS Health Services, and other funding sources as required.

Data from TB Program Performance Measures for completion of therapy within 12 months for 2007 is unavailable until 2009 due to the length of treatment. Completion of therapy data on infected contacts that are started on treatment for latent TB infection is also unavailable due to the length of treatment.

The TB program developed and implemented a quarterly end of treatment review. Each case that has completed treatment is presented by the nurse case manager assigned to the case. Treatment issues, contact investigation findings, and challenges are discussed. The State of Oregon TB Program and representatives from other local health department TB Programs attend and present cases.

Monthly chart reviews are conducted on cases currently on treatment and clients on preventive treatment for latent TB infection. Charts are reviewed to determine if required evaluation components have been completed and documented. A summary of findings is provided to all staff and individual issues are resolved in one-to-one meetings. Aggregate data reports are reviewed annually. Client satisfaction surveys are reviewed and findings are distributed.

#### **F.4. Action Plan: Other Issues (Tobacco Prevention)**

- a. Current Condition or Problem** - Tobacco is the leading cause of preventable death in Oregon, and every year in Multnomah County, 1,213 people die from tobacco use, 22% of all

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deaths, and 23,708 people suffer from a tobacco-related illness. As of 2007, approximately 118,150 Multnomah County residents reported smoking cigarettes. The economic burden of tobacco use amounts to over \$190 million in medical expenses and \$192 million in lost productivity due to tobacco-related disability and death. In Multnomah County, 21% of adults smoke, compared to 20% statewide (2007 BRFSS). Among 8<sup>th</sup>-graders, 9% smoke the same for statewide, and among 11<sup>th</sup>-graders, 16% smoke, compared to 17% statewide (2007 Oregon Healthy Teens Survey). Also see page 31 for general discussion of Tobacco Prevention activities.

- b. **Goals** - The goal of the Tobacco Prevention Local Program is to develop and implement strategies that are grounded in CDC best practices, and seek to make sustainable environmental change, such the adoption of new policies or activities that help to shift social norms concerning the use of tobacco and smoking. Other goals of the Program include:

- Reduce and eliminate exposure to secondhand smoke.
- Counter pro-tobacco influences.
- Promote quitting and the Oregon Quit Line.
- Reduce youth access to tobacco.

A key function of the Program is enforcement of applicable smokefree laws, including the Oregon Indoor Clean Air Act.

- c. **Activities** - The Program's work is population-based so that large segments of Multnomah County benefit from smoke-free environments. The Program's Work Plan consists of multiple best practice objectives in support of tobacco-free schools, colleges, hospitals, multi-unit housing, and worksites. These best practice objectives include:

- By June 2009, Portland Public Schools clustered in North Portland will implement a comprehensive tobacco-free policy as a part of current 'healthy eating active living' initiatives as a model of policy implementation for the rest of the district.
- By June 2010, a school district outside of Portland Public Schools will implement a comprehensive tobacco-free policy.
- By June 2009, one hospital system in Multnomah County will have passed a comprehensive tobacco-free policy.
- By June 2009, Portland Community College and Mt. Hood Community College in Multnomah County will adopt tobacco-free policies.
- By June 2009, three property management entities will adopt a smoke-free policy.
- Promote the Oregon Indoor Clean Air Act through the coordination of a local "Why Wait?" campaign to encourage local businesses to adopt voluntary smokefree policies prior to implementation date for the expanded Oregon Indoor Clean Air Act.
- Enforce the Oregon Indoor Clean Air Act by establishing an intergovernmental agreement between the county and state, modifying current enforcement protocols, and preparing for the potential surge in complaints and inspections as a result of the implementation of the new law.

In order to meet these objectives, program staff will engage in specific plans of action based on the following key activities: 1) coordination and collaboration, 2) assessment and research, 3) community education, outreach, and media, 4) policy development and 5) policy

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implementation. Much of the work of the Program will be carried out through issue-specific coalitions and multidisciplinary partnerships, including the coordination of a Local Tobacco Prevention Advisory Group. The role of the Advisory Group, comprised of key leaders in each area of work, is to provide strategic direction in the development of the Program's plans of action.

- d. **Evaluation** - Program effectiveness is tracked by the Oregon TPEP as a part of its statewide evaluation activities. For example, state data has shown that the 8<sup>th</sup> grade smoking rates were reduced by 59% between 1996 when the program started and 2006. There was a 46% drop among 11<sup>th</sup> graders during the same time period, as well as a 41% decline in cigarette consumption, and a 21% decrease in adult smoking.

**F.5. Action Plan: Other Issues (School-Based Health Care)**

- a. **Current condition or problem** – Adolescent teens experience unique health care needs, and barriers to accessing health services. Since 1986 the Health Department's School-Based Health Center Program has provided access to comprehensive, confidential, culturally competent, and age-appropriate healthcare to school-aged youth (including those with or without insurance) who cannot or do not access providers.

The vision of the School-Based Health Center Program is to facilitate access to comprehensive preventive, primary, and mental healthcare for Multnomah County school-age youth to keep them healthy and ready to learn. The program assures access to care by providing services during and beyond regular school hours, and at multiple sites open during summer and school breaks to ensure continuity of care. Staffing includes a Nurse Practitioner, Registered Nurse, medical support staff, and office assistants. Clinic locations are geographically diverse and all Multnomah County school-aged youths are eligible to receive services (e.g., attending other schools, uninsured, drop-outs, homeless, detention).

The staffs' proximity to children builds trusting relationships that can empower high-risk youth to seek help and make better life choices, including staying in school. Such positive interventions can be crucial to later independence and success in life. Parent/guardian involvement is fostered to ensure successful clinical outcomes and to support educational success.

- b. **Goals** - In partnership with schools, families, healthcare providers and community agencies, Multnomah County School-Based Health Centers:
- Provide culturally sensitive and age-appropriate healthcare, education, outreach, and referrals to school-age youth.
  - Facilitate early identification of high-risk behaviors and health issues that enable timely intervention and treatment.
  - Reduce barriers to healthcare by being conveniently located in schools and by offering confidential care in a safe environment regardless of the ability to pay.
  - Promote healthy lifestyle choices and empower youth to take responsibility for their health and healthcare.

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- Encourage parent or guardian involvement to support and sustain successful health outcomes.
- c. **Activities** - The program operates 13 fully-equipped medical clinics; twelve clinics are located on school campuses and one clinic is school-linked. A key premise of school-based health is that health care, a basic need, be provided at the most readily accessible locations for school-aged youths. The program strives to ensure that basic physical and behavioral health needs of youths are met to help them attend, participate, and remain in school. School-based health centers foster academic success by early identification and management of chronic diseases such as asthma and obesity; by preventing teen pregnancy, alcohol/drug use; and address other health-related barriers to education. Primary care services include chronic, acute, and preventive healthcare; age-appropriate reproductive health; exams, risk assessments, prescriptions, immunizations, fitness and nutrition education/counseling, referrals. The program's comprehensive approach enables early identification and intervention, thereby reducing at-risk behaviors.
- d. **Evaluation** - The effectiveness of the School Based Health Center program is measured by the following types of outcomes:
- Number of youth who receive preventive and primary health care.
  - Percent of youth that have annual Body Mass Index screening for obesity.
  - Number of patients 5-18 yrs of age diagnosed with persistent asthma that are on appropriate medication.
  - Percent of clients receiving healthcare who are from non-SBHC sites.
  - Percent of female family planning clients that do not get pregnant.

Data collection, data analysis and program evaluation occurs at program and individual site levels, and results are reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and other funders as required.

**F.6. Action Plan: Other Issues (Hepatitis C Surveillance Program)**

- a. **Current condition or problem:** Hepatitis C (HCV) is a chronic liver disease usually spread through direct contact with the blood of an infected person. It can be transmitted by needles, by sharing personal items such as razors or toothbrushes; during sexual activity, and it can be passed from an infected mother to her unborn baby. Because the virus can be undetected for years, many cases were transmitted during medical procedures before screening was conducted.

From September 2005 through August 2006, the Health Department selected a 40% random sample of adults reported to the HCV registry to participate in an interview. Of the 2,201 cases of chronic HCV infection received during the study period, 891 (40%) were selected for participation and 195 of these (22%) were located and agreed to participate. Participants and non-participants were similar in age, sex and race. Participants' mean age was 49 years, 111 (57%) were male and 151 (77%) were white. Forty-five (23%) had been tested at Health Department clinics or outreach sites, and 116 (59%) at private medical practices. Eighty-three percent had at least a high school diploma, 65% reported an annual income <\$15,000;

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25% were homeless in the prior 12 months. One-hundred and twenty-one (62%) participants reported a history of or treatment for depression or other mental health issues. Of 84 enrollees who completed the Beck Depression Inventory, 25 (30%) met the criteria for current major depressive disorder. Ninety-nine (51%) participants reported reducing alcohol intake since diagnosis. Forty-six (27%) reported current alcohol use; 39% of current alcohol drinkers reported drinking >5 drinks/month and 24 (52%) had participated in an alcohol rehabilitation program. Sixty (31%) reported illicit drug use in the prior year; of these, 68% had injected drugs.

The purpose of the Hepatitis C Surveillance Program is to establish and conduct a population-based surveillance of persons in Multnomah County diagnosed with the hepatitis C virus (HCV). Medical laboratories in Multnomah County report Hepatitis C to the Health Department's Communicable Disease Program. The Communicable Disease Program maintains a Hepatitis C Registry of individuals with HCV and confirms the diagnosis of HCV of individuals reported by the medical laboratories. Findings reveal a high prevalence of depression and substance abuse among persons with chronic HCV infection identified in a public health registry. Despite extensive efforts, many persons reported to the registry could not be located for interview. This and the disproportionately high participation rate among persons tested in public health settings may limit the generalizability of these findings. However, they highlight the importance of addressing social issues that impact the medical management of HCV infection for a substantial proportion of persons with the infection. These findings will be presented in the American Public Health Association's 136<sup>th</sup> Annual Meeting and Exposition on October 25-29, 2008.

In addition to the HCV Registry, a more detailed surveillance system is in place for a subset of the individuals in Multnomah County that have been newly identified with the disease. A one page form is faxed to health care provider requesting information on patient race/ethnicity, primary language, reasons for HCV testing, risk factors for HCV infection, referral for specialist care, vaccination and treatment history. Faxes are not sent to facilities where a provider cannot be identified, such as blood/plasma donation centers and correctional facilities. From January to November 2007, 1,006 new HCV cases were reported to the Multnomah County Health Department. After exclusion cases due to insufficient lab criteria, non-County residents, or reports prior to January 1, 2007, 931 faxes were sent to health care providers. Of these, 560 (60%) were completed and returned to the Health Department. Demographic characteristics for the program are listed in the Table below.

- b. **Goal** – To conduct a population-based surveillance of persons in Multnomah County with newly-identified HCV infection.
- c. **Activities** – The primary activity of the HCV Surveillance Program includes collecting data in order to:
- Monitor the demographic and socioeconomic characteristics of persons with HCV.
  - Estimate the burden of the disease among persons newly-identified with HCV.
  - Estimate the duration of infection in order to better understand the extent of ongoing transmission in Multnomah County.

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- Assess the stage of illness and the need for medical and personal preventive services (e.g., health insurance status, access to primary and specialty care, history of vaccination against hepatitis A and B virus, current alcohol/drug use).

Individuals reported to the HCV Registry each month with a confirmed HCV diagnosis were recruited for a more thorough review of their socioeconomic characteristics, medical pathologies, risk factors for HCV and the need for medical and preventive services. After locating the individual and obtaining informed consent, they were interviewed to gather the additional information. Consent from clinicians was obtained to enroll patients in the study if the clinician considered the individual appropriate for the study.

<b>Demographic Characteristics, HCV Physician Fax Surveillance Pilot, Multnomah County, January-November 2007 (N = 931 Faxes Sent)</b>		
<b>Population Characteristic</b>	<b>Response Received Number (%)</b>	<b>Not Received Number (%)</b>
<b>Sex</b>		
Male	295 (52.7)	215 (58.0)
Female	232 (41.4)	136 (36.7)
Unspecified	63 (6.2)	20 (5.4)
<b>Age Group</b>		
18-30	39 (7.0)	28 (7.5)
31-40	103 (18.4)	67 (18.1)
41-50	191 (34.1)	117 (31.5)
51-60	195 (34.8)	129 (34.8)
61-70	23 (4.1)	20 (5.4)
71-80	5 (0.9)	9 (2.4)
>80	4 (0.7)	0 (0)
Unspecified	0 (0)	1 (0.3)
<b>Total</b>	<b>560 (100)</b>	<b>371 (100)</b>

d. **Evaluation** - The effectiveness of the HCV program is measured by collecting the following types of data about the target population:

- Reason for HCV testing (preliminary results indicated that the majority of HCV tests are conducted due for a history of HCV infection (38.9%), evaluation of abnormal liver function tests (23.4%), or the client having risk factors for HCV infection (22.6).
- Risk factors for HCV infection (history of injection drug use (50.7%), history of incarceration (8.1%), or received a transfusion or organ transplant prior to 1992 (5.1%).
- Referred to treatment (38% were referred to a gastroenterologist, 9.1% were currently or received HCV treatment; 5.5% of patients were reported to have cirrhosis; 21.6% reported having received HAV vaccination; while 22.3% received HBV vaccination; 46.6% reported having health insurance.

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Data collection, data analysis and program evaluation occurs at program and individual site levels, and results are reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and other funders as required.

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#### **IV. ADDITIONAL REQUIREMENTS**

**Organizational structure** - The Health Department is one of Multnomah County's seven departments. The Health Department is organized into seven distinct divisions, including the Director's Office, Health Officer, three service divisions, and two support divisions.

- **Director's Office** - The Director's Office of the Health Department is represented by the Department Director and the Department's Assistant Director. The Director's Office is responsible for supporting the development and implementation of County policies regarding public health; supporting the development and implementation of the annual budget and financial management policies; establishment of implementation of internal and external communications; providing leadership to the organization and community regarding public health issues; and assuring that services are responsive to the needs of culturally diverse communities. The Director's Office also oversees the Department Leadership Team to coordinate activities across the organization. This team is comprised of the Director, Assistant Director, Health Officer, and the division directors of the Department's three service divisions and two support divisions.
- **Health Officer** – The Health Officer is the County's legal authority for local administration of laws that govern public health in the State; is responsible for programs in emergency medical services; and provides professional consultation in response to a wide range of public health issues. The Health Officer is also responsible for implementing public health policies to monitor and respond to communicable disease issues; medical director services to provide clinical supervision of providers; utilization review; clinical quality improvement; and implementation of special initiatives.
- **Service Divisions** - The Department's three service divisions include the following:
  - *Community Health Promotion, Partnerships, and Planning (CHP<sup>3</sup>)*. CHP<sup>3</sup> establishes and maintains local partnerships, implements health promotion initiatives (e.g., tobacco prevention, adolescent prevention programs, community capacitation, and chronic disease prevention), and provides project development and evaluation services to Health Department staff and community partners.
  - *Integrated Clinical Services (ICS)*. ICS assures that medically underserved residents have access to affordable, high quality and culturally appropriate health and related services (e.g., primary care, dental, well child care, HIV care, healthcare for the homeless, teen health care, and WIC), and oversees related support systems (e.g., IT, X-ray, pharmacy, laboratory and language services).
  - *Community Health Services (CHS)* – CHS is dedicated to improving the health of the community through a variety of services and programs (environmental health services, TB prevention and treatment, STD prevention and Treatment, HIV prevention, and communicable disease surveillance). The division also implements community-focused initiatives and oversees the Department's emergency preparedness responsibilities.

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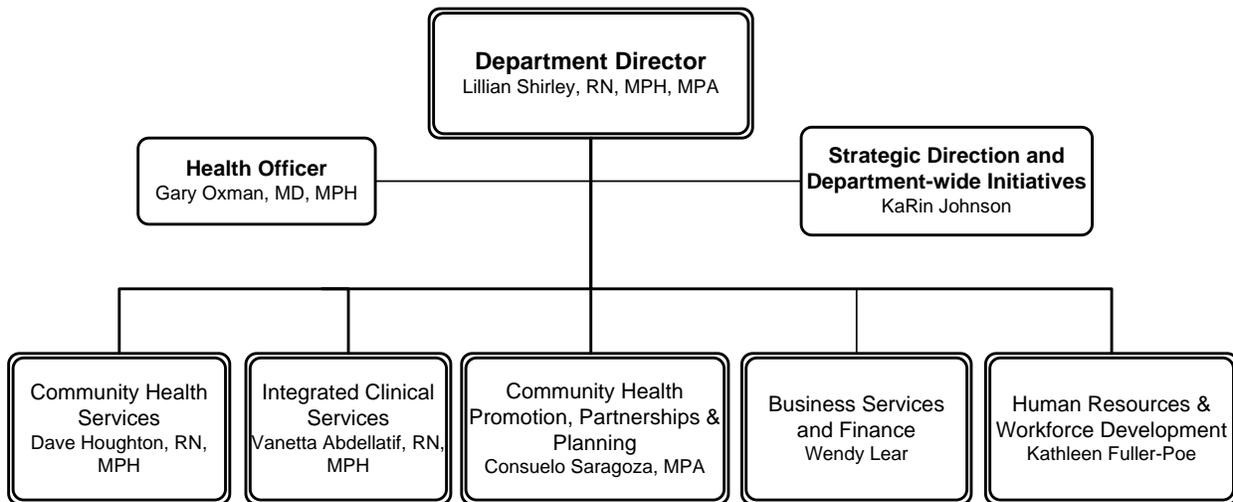
**Support Divisions** - The Department’s financial and administrative functions are supported by the *Business Services and Finance* division, and the *Human Resources and Workforce Development* division. The Business Services and Finance division is responsible for implementing financial management policies (grants management, AR/AP, contracts, and supporting auditing procedures); overseeing the Department’s budget development process; facilities planning; and IT support and training. The Human Resources and Workforce Development division is responsible for implementing Department-specific HR policies; overseeing collective bargaining processes; and implementing workforce development programs. Both Business Services and Human Resources work with the County’s Central Budget Office and Central Human Resources Office to ensure that Department’s operations are appropriately coordinated.

**Organizational chart**

**Multnomah County Health Department**

Organizational Chart

Current as of 05/20/2008



**Coordination with SB 555 Planning Process** - The Multnomah County Commission on Children and Families is responsible for developing the Comprehensive Plan for children under the age of 18 as defined in Senate Bill 555. The Commission has used an extensive community input process in their plan development. For the plan submitted in January 2008, the Commission started the process by reviewing existing community plans that address children and youth issues (approximately 30 plans of various types). Based on the review they identified issues and questions, and invited key partners for input. In order to coordinate the Annual Planning process with the SB 555 Comprehensive Plan, Health Department staff were participants in several input sessions ranging from basic health care needs through school-based health centers to early childhood to prevention efforts. In addition, Health Department staff currently participate as members on the Commission’s ongoing Early Childhood Council and the School Age Youth Council, which also provide input into the planning process.

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**V. UNMET NEEDS**

This section describes the unmet needs regarding the capacity to deliver quality public health services (also see Capacity Assessment beginning on page 76). In addition to the gaps discussed in Section VIII below, the Health Department has experienced a decline in local financial resources available to support public services, which is a continuation of an eight year trend. The decline in anticipated local revenue is passed along to department administrators by the County Board of Commissioners in the form of a funding constraint as a part of the annual budget development process. The County Chair is proposing a reduction in nearly all County services for FY 2008/2009 to support urgent needs for local public safety. It is not known if the budget reductions will be restored in the final FY 2008/2009 budget adopted by the Board, however, the Department has initiated steps to ensure that it is able to respond to budget reductions in order to meet critical timelines.

If adopted, this year's budget shortfall will be felt at the Health Department in terms of fewer facilities to access care by the community's medically underserved residents, and fewer staff to support the delivery of public health services. It is expected that the resulting decline in funding will have a rippling effect into the community in terms of poor health outcomes for individuals, a decline in safety, and greater risk to the health of the public.

In addition to the projected cuts in local General Funding, there is a growing number of medically uninsured residents in the county who seek care at the Department's clinics. This further strains resources as there is an ever-increasing gap between clinic operating costs, and recoverable expenses associated with the delivery of services to uninsured patients. This is particularly true for clients using the Department's School-Based Health Clinics.

As of May 2008, the County is in the process of establishing its FY 2008/2009 budget, and the Health Department will need to assess the impact and programmatic gaps that may result from reduced local funding. The current draft of County's FY 2008/2009 budget will impact services and capacity in the following areas (as compared to the FY 2007/2008 budget level for the Department):

- Primary Care Services (especially for uninsured clients).
- Chronic Disease Prevention.
- Adolescent Health Services.
- Early Childhood Services.
- Corrections Health Services.
- Dental Services.
- Epidemiology and Communicable Disease Services.
- HIV and Viral Hepatitis Prevention Services.
- Information and Referral.
- Environmental Health Services.
- Mammograms for uninsured women.

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**VI. BUDGET**

**For purposes of this plan use your most recent Financial Assistance Contract to project funding from the state. In early July of each year we will send you Projected Revenue sheets to be filled out for each program area. Provide name, address, phone number, and if it exists, web address, where we can obtain a copy of the LPHA's public health budget. Agencies are not required to submit a budget as part of the annual plan; they are required to submit the Projected Revenue information and the budget location information.**

The Multnomah County Health Department will provide budget materials per the above instructions. The Health Department's Director of Business Services & Finance, Ms. Wendy Lear, is responsible for overseeing the budget on behalf of the Health Department. Ms. Lear's contact information is as follows:

Ms. Wendy Lear, Director of Business Services & Finance  
Multnomah County Health Department  
421 S.W. Oak Street, Floor 2  
Portland, OR 97204  
Phone: (503) 988-3674, Ext. 27574  
Fax: (503) 988-3015  
Email: [wendy.r.lear@co.multnomah.or.us](mailto:wendy.r.lear@co.multnomah.or.us)

The Health Department's proposed FY 2008/2009 Budget can be found at the following Web address:

<http://www.google.com/search?hl=en&domains=co.multnomah.or.us&ie=ISO-8859-1&q=Health+Department+2009+Budget&btnG=Search&site=co.multnomah.or.us>

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**VII. MINIMUM STANDARDS**

**To the best of your knowledge are you in compliance with these program indicators from the Minimum Standards for Local Health Departments:**

**Organization**

1. Yes  No  A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes  No  The Local Health Authority meets at least annually to address public health concerns.
3. Yes  No  A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes  No  Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes  No  Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes  No  Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes  No  Local health officials develop and manage an annual operating budget.
8. Yes  No  Generally accepted public accounting practices are used for managing funds.
9. Yes  No  All revenues generated from public health services are allocated to public health programs.
10. Yes  No  Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes  No  Personnel policies and procedures are available for all employees.
12. Yes  No  All positions have written job descriptions, including minimum qualifications.
13. Yes  No  Written performance evaluations are done annually.
14. Yes  No  Evidence of staff development activities exists.
15. Yes  No  Personnel records for all terminated employees are retained consistently with State Archives rules.

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16. Yes X No \_\_\_ Records include minimum information required by each program.
17. Yes X No \_\_\_ A records manual of all forms used is reviewed annually.
18. Yes X No \_\_\_ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes X No \_\_\_ Filing and retrieval of health records follow written procedures.
20. Yes X No \_\_\_ Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes X No \_\_\_ Local health department telephone numbers and facilities' addresses are publicized.
22. Yes X No \_\_\_ Health information and referral services are available during regular business hours.
23. Yes X No \_\_\_ Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes X No \_\_\_ 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes X No \_\_\_ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes X No \_\_\_ Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes X No \_\_\_ Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.
28. Yes X No \_\_\_ A system to obtain reports of deaths of public health significance is in place.
29. Yes X No \_\_\_ Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.
30. Yes X No \_\_\_ Health department administration and county medical examiner review collaborative efforts at least annually.

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31. Yes  No  Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes  No  Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes  No  Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes  No  Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes  No  Confidentiality training is included in new employee orientation. Staff includes: employees both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.
36. Yes  No  A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

**Control of Communicable Diseases**

37. Yes  No  There is a mechanism for reporting communicable disease cases to the health department.
38. Yes  No  Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes  No  Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.
40. Yes  No  Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
41. Yes  No  There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes  No  There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

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43. Yes  No  A system exists for the surveillance and analyses of the incidence and prevalence of communicable diseases.
44. Yes  No  Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes  No  Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes  No  Rabies immunizations for animal target populations are available within the local health department jurisdiction.

**Environmental Health**

47. Yes  No  Food service facilities are licensed and inspected as required by Chapter 333 Division 12, or more frequently based on epidemiological risk.
48. Yes  No  Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes  No  Training in first aid for choking is available for food service workers.
50. Yes  No  Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes  No  Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system. (Note: This public health function is being conducted by the State of Oregon, not Multnomah County.)
52. Yes  No  Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk. (Note: This public health function is being conducted by the State of Oregon, not Multnomah County.)
53. Yes  No  Compliance assistance is provided to public water systems that violate requirements. (Note: This public health function is being conducted by the State of Oregon, not Multnomah County.)
54. Yes  No  All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken. (Note: This public health function is being conducted by the State of Oregon, not Multnomah County.)
55. Yes  No  A written plan exists for responding to emergencies involving public water systems.

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56. Yes  No  Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes  No  A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. (Note: This public health function is being conducted by the City of Portland Environmental Services Bureau, not Multnomah County.)
58. Yes  No  Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes  No  School and public facilities food service operations are inspected for health and safety risks.
60. Yes  No  Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes  No  A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. (Note: This public health function is being conducted by Metro, not Multnomah County.)
62. Yes  No  Indoor clean air complaints in licensed facilities are investigated.
63. Yes  No  Environmental contamination potentially impacting public health or the environment is investigated. (Note this public health function is being conducted by a variety of local, state and federal agencies within the County.)
64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response. (Note: This public health function is being conducted by local HAZMAT agencies within the county. Additional local response may be provided by the county health officer and related bioterrorism response systems.)
65. Yes  No  Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

**Health Education and Health Promotion**

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67. Yes  No  Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.
68. Yes  No  The health department provides and/or refers to community resources for health education/health promotion.
69. Yes  No  The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes  No  Local health department supports healthy behaviors among employees.
71. Yes  No  Local health department supports continued education and training of staff to provide effective health education.
72. Yes  No  All health department facilities are smoke free.

**Nutrition**

73. Yes  No  Local health department reviews population data to promote appropriate nutritional services.
74. The following health department programs include an assessment of nutritional status:
- a. Yes  No  WIC
  - b. Yes  No  Family Planning
  - c. Yes  No  Parent and Child Health
  - d. Yes  No  Older Adult Health
  - e. Yes  No  Corrections Health
75. Yes  No  Clients identified as a nutritional risk are provided with, or referred for, appropriate interventions.
76. Yes  No  Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
77. Yes  No  Local health department supports continuing education and training of staff to provide effective nutritional education.

**Older Adult Health**

78. Yes  No  Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.
79. Yes  No  A mechanism exists for intervening where there is reported elder abuse or neglect.

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80. Yes  No  Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.
81. Yes  No  Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention, and safety education.

**Parent and Child Health**

82. Yes  No  Perinatal care is provided directly or by referral.
83. Yes  No  Immunizations are provided for infants, children, adolescents, and adults either directly or by referral.
84. Yes  No  Comprehensive family planning services are provided directly or by referral.
85. Yes  No  Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.
86. Yes  No  Child abuse prevention and treatment services are provided directly or by referral.
87. Yes  No  There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.
88. Yes  No  There is a system in place for identifying and following up on high risk infants.
89. Yes  No  There is a system in place to follow up on all reported SIDS deaths.
90. Yes  No  Preventive oral health services are provided directly or by referral.
91. Yes  No  Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.
92. Yes  No  Injury prevention services are provided within the community.

**Primary Health Care**

93. Yes  No  The local health department identifies barriers to primary health care services.

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94. Yes  No  The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.
95. Yes  No  The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.
96. Yes  No  Primary health care services are provided directly or by referral.
97. Yes  No  The local health department promotes primary health care that is culturally and linguistically appropriate for community members.
98. Yes  No  The local health department advocates for data collection and analysis for development of population based prevention strategies.

**Cultural Competency**

99. Yes  No  The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.
100. Yes  No  The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.
101. Yes  No  The local health department assures that advisory groups reflect the population to be served.
102. Yes  No  The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

**Health Department Personnel Qualifications**

103. Yes  No  The local health department Health Administrator meets minimum qualifications:

A Master's degree from an accredited college or university in public health, health administration, public administration, behavioral, social or health science, or related field, plus two years of related experience.

104. Yes  No  The local health department Supervising Public Health Nurse meets minimum qualifications:

Licensure as a registered nurse in the State of Oregon, progressively responsible experience in a public health agency;

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AND

Baccalaureate degree in nursing, with preference for a Master's degree in nursing, public health or public administration or related field, with progressively responsible experience in a public health agency.

105. Yes X No \_\_\_ The local health department Environmental Health Supervisor meets minimum qualifications:

Registration as a sanitarian in the State of Oregon, pursuant to ORS 700.030, with progressively responsible experience in a public health agency

OR

A Master's degree in an environmental science, public health, public administration or related field with two years progressively responsible experience in a public health agency.

106. Yes X No \_\_\_ The local health department Health Officer meets minimum qualifications:

Licensed in the State of Oregon as M.D. or D.O. Two years of practice as licensed physician (two years after internship and/or residency). Training and/or experience in epidemiology and public health.

**VIII. LHD CAPACITY ASSESSMENT**

During February 2008, the Conference of Local Health Officials of Oregon (CLHO) voted to have its membership participate in an assessment to gauge the capacity of the local public health system in Oregon. The assessment involved the following two components: (1) utilization of a nationally established assessment tool, and (2) participation in one of several regional summits attended by Health Department representatives, and culminating in a gap analysis. The results of this assessment and gap analysis for Multnomah County are discussed below.

**Results of Local Health Department Assessment Tool** - The National Association of City and County Health Officials' (NACCHO) "LHD Self-Assessment Tool" was used to provide a capacity assessment of Multnomah County's public health system. The table below summarizes scores that reflect the greatest needs for the 282 assessment items listed in the capacity assessment tool. Of the scores given, eight items received a score of "0" (meaning that the Department has no capacity to address these issues), and 18 items received a score of "1" (meaning that the Department has only minimal capacity to address these issues).

<b>Public Health Capacity Assessment Scores for Multnomah County</b>			
Total number of assessment items = 282			
<b>Possible Score</b>	<b>Description of Score</b>	<b>Number of Assessment Items Given this Score</b>	<b>Percent of Assessment Items Given this Score</b>
0	No capacity (0%)	8	2.8%
1	Minimal capacity (< 25%)	18	6.4%
2	Moderate capacity (25% - 50%)	34	12.0%
3	Significant capacity (51% - 75%)	87	30.8%
4	Optimal (76%-100%)	147	52.1%

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- The following eight assessment items were given a score of “0” (no capacity):
  - LHD has a written protocol in place to respond to specific information requests.
  - Partnership effectiveness in improving community health is assessed.
  - System partner organizations’ work plans, action plans, and program plans to address public health goals.
  - LHD maintains data systems for capacity, availability, quality, cost, and utilization of health services.
  - LHD evaluates the accessibility, quality, and effectiveness of personal health services.
  - LHD assures that a systematic process for assessing consumer and community satisfaction with external agency services is in place.
  - LHD assures that a systematic process for assessing consumer and community satisfaction with external agency services is in place.
  
- The following 18 assessment items were given a score of “1” (minimal capacity):
  - Broad participation of community stakeholders in the assessment process is secured.
  - LHD conducts gap analysis of the needs of populations who may encounter barriers to services.
  - LHD uses principles of social marketing to understand the information needs of specific populations.
  - LHD has an overall strategy/plan for its delivery of population-based health promotion and disease prevention programs (e.g. which programs are developed, how they are implemented, and when they are evaluated).
  - LHD staff are available to offer technical assistance to the community in development of health promotion programming.
  - LHD involves a variety of disciplines in the design and implementation of health promotion programs (e.g. Educators, Faith Institutions, Nursing, Environmental, Community-development for the built environment).
  - LHD assesses the target population for how they accept information.
  - LHD evaluates health promotion efforts every two years, the results of which are used to improve programs.
  - LHD develops and revises performance measures, goals and objectives for annual program planning based on information obtained through evaluation of health promotion activities.
  - LHD provides technical assistance to communities and community agencies on health promotion activities.
  - Community satisfaction is assessed and gaps are identified.
  - Goals and objectives are established in the community health plan.
  - A policy agenda is developed.
  - LHD, in partnership with community partners, interprets qualitative and quantitative information on program gaps, developed through surveys, focus groups, interviews or other means of primary data collection.
  - LHD uses criteria periodically to evaluate access, quality, appropriateness, and effectiveness of preventive and personal health services in the community.

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- LHD identifies community health and prevention priorities to reduce access barriers every five years.
- Agreements between LHD and external agencies for evaluation are in place.
- LHD provides consultation and technical assistance on program implementation and evaluation of prevention services provided by other community agencies.

**CLHO Gap Analysis** – During the spring of 2008, the Health Department participated in a summit of local public health officials to discuss capacity issues. The resulting gap analysis included the following areas in which the Department has insufficient capacity to meet local public health needs:

- Gap in Essential Services Category Area: Data collection, research and evaluation results in insufficient capacity to:
  - Work with communities to frame public health issues and to sustain coalition participation to reach agreements on community health goals.
  - Assure that all program areas are thoroughly evaluated for effectiveness, cost-effectiveness and adherence to best practices.
  - Assure systematic coordination with academic institutions within Oregon and the NW Region for the purposes of research and linking academics to practice.

These items address several essential service areas including I, IX, and X.

One recommended solution to address this gap is to expand the Department's current Electronic Health Record system capacity to enable mobile field-based staff of the Early Childhood Services Program to enter and access client data. The cost of expanding EHR capacity in this fashion is approximately \$1 million in the first year for software, hardware, training, and related activities.

- Gap in Essential Services Category Area: Protecting people from communicable diseases and emergency response (area is included in essential service II). Federal funding is rapidly declining within this Essential Service Category, and the Portland Metropolitan Area is a highly complex environment with multiple jurisdictions, agencies, and business organizations that require sustained planning relationships in preparation for public health emergencies. Staffing needed to address this gap would include 1.0 FTE to support planning and exercise design, and 1.0 FTE to support community and coalition/partnership engagement.
- Gap in Essential Services Category Area: Providing information to people through health education (area is included in essential service III). Insufficient capacity for systematic, sustained and strategic relationship development across multiple communities and public health issues/programs. To overcome this capacity gap additional staffing is needed, including 2.0 FTE Health Education/Health Promotion staff, and 1.0 FTE Program Manager (MPH-level).
- Gap in Essential Services Category Area: Health Promotion capacity for systematic, sustained and strategic relationship development across multiple communities and public

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health issues/programs (area is included in essential service III). The Health Department is developing in this area, but insufficient capacity remains. Additional staffing is needed to overcome this capacity gap in the form of an additional 2.0 FTE Health Education/Health Promotion staff, and 1.0 FTE Program Manager (MPH-level).

- Gap in Essential Services Category Area: Community planning, engaging the community, strategic planning and policy (areas are included in essential services IV, V and VII). To address the gap in this essential service category area the Health Department would require staffing, management and skill sets to establish and sustain ongoing structured community-based assessment and engagement. Staffing needed to address this gap would include 1.0 FTE Community Health Planner (MPH), 1.0 FTE Program Manager (MPH), 1.0 FTE Program Evaluator, 1.0 FTE Senior Analyst, 1.0 FTE Public Information Specialist, and 1.0 FTE Web Designer Specialist.
- Gap in Essential Services Category Area: Increased capacity for sustained public health-specific training, with systematic curriculum review and related changes i.e., workforce development (essential service VIII). In order to address this gap the Health Department would need additional staffing, including: 1.0 FTE to staff curriculum development, adult learning theory (Health Educator); and 1.0 FTE staff to serve as a liaison to public/private/non-profit agencies.

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**Include with the submitted Annual Plan:**

The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375–431.385 and ORS 431.416, are performed.

Lillian Shirley, BSN, MPH, MPA  
**Local Public Health Authority**

Multnomah  
**County**

June 6, 2008  
**Date**

**Note: A hard copy of this page with original signature will be delivered to Oregon DHS/Health Services.**

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**ATTACHMENT 1**

**Guidelines for BT/CD Assurances (August 14, 2002)**

**Note:** A highly functioning local public-health communicable-disease program is the best guarantee of rapid detection, investigation, and response to a bioterrorism-related outbreak of any communicable disease. CLHO Bioterrorism Assurance 2.C. requires local health departments to “Meet Conference of Local Health Officials Minimum Standards for reportable Communicable Disease Control, investigation, and prevention...” These Minimum Standards will be measured as specified in these Guidelines, but they describe only part of an adequate preparedness for bioterrorism. Other important components are described in the other CLHO Assurances related to Bioterrorism Cooperative Agreement 99051.

**Outbreak Management for the identification and control of BT or CD Events:**

1. Surveillance & Investigation
  - a.  $\geq 90\%$  of suspected outbreaks will have investigation initiated within 24 hours of report.
  - b.  $\geq 95\%$  of reported outbreaks will be reported to DHS-Health Services within 24 hours of receipt of report.
  - c. Reports on 100% of investigations will be forwarded to DHS-Health Services within 30 days after the completion of the investigation.
2. Disease Prevention
  - a. In the event that a facility is implicated, environmental evaluation will be initiated in 100% of foodborne and waterborne outbreaks within 1 working day.
  - b. The local public health authority will maintain a generic press release and letters to use in case of an outbreak.

**General Communicable Disease Management for the identification and control of BT or CD Events:**

1. Surveillance
  - a. Infection-control professionals (ICPs) in 100% of hospitals within the jurisdiction will be contacted twice a year to encourage reporting.
  - b.  $\geq 90\%$  of reported cases will be reported to DHS-Health Services within specified time frames (see Table).
2. Disease Investigation
  - a)  $\geq 95\%$  of cases will have case investigation and contact identification initiated within specified time frames (see Table).
  - b) 100% of case report forms will be sent to DHS-Health Services by the end of the calendar week of the completion of the investigation.
3. Disease Prevention
  - a. Information and recommendations on disease prevention will be provided to 100% of exposed contacts located.
  - b. The local public health authority will have access to educational materials on each of the diseases in the table below.

**Hepatitis A**

1. Surveillance
  - a.  $\geq 95\%$  of reported suspect cases (e.g., fever, malaise and jaundice) will be evaluated within 1 working day of report.
  - b.  $\geq 95\%$  of confirmed or presumptive cases will be reported to DHS-Health Services within 1 working day of receipt of report.
2. Disease Investigation and Management
  - a. 100% of cases will have case investigation and contact identification initiated

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- within 1 working day of report.
  - b.  $\geq 95\%$  of case investigations will be completed within 7 days of report.
3. Disease Prevention
- a. Information and recommendations regarding hepatitis A will be provided to 100% of locatable contacts.
  - b. 100% of establishments associated with commercial food handler and day-care-associated cases will have an environmental inspection within 1 working day.
  - c.  $\geq 90\%$  of household and day-care contacts (staff and classmates) of hepatitis A cases will be offered IG and recommended vaccine within 7 days of report.

**Hepatitis B, Acute**

1. Surveillance
- a.  $\geq 95\%$  of suspect cases of acute hepatitis B will be evaluated within 1 working day of report.
  - b.  $\geq 95\%$  of confirmed or presumptive cases will be reported to DHS-Health Services within, as soon as possible but no later than, the end of the calendar week.
2. Disease Investigation and Management
- a. 100% of confirmed cases will have case investigation and contact identification initiated within 2 working days of report.
  - b. 100% of confirmed case investigations will be completed within 7 days of report.
3. Disease Prevention
- a. Information and recommendations regarding hepatitis B will be provided to 100% of locatable contacts.
  - b.  $\geq 90\%$  of locatable household contacts will be offered vaccine within 7 days of report.
  - c. HBIG and vaccine will be recommended to  $\geq 90\%$  of persons with sexual or percutaneous exposure to cases within 7 days of report, if such prophylaxis is within the window of effectiveness.

**Meningococcal Disease**

1. Surveillance
- a.  $\geq 95\%$  of reported suspect cases (e.g., petechial rash) will be evaluated within 24 hours of report.
  - b.  $\geq 95\%$  of confirmed or presumptive cases will be reported to DHS-Health Services within 1 working day of receipt of report.
2. Disease Investigation and Management
- a. 100% of cases will have case investigation and contact identification initiated within 24 hours of report.
  - b. 100% of cases will have pertinent case information collected and contacts identified within 7 days of report.
3. Disease Prevention
- a. Prophylaxis will be recommended to  $\geq 90\%$  of identified close contacts of cases within 48 hours of report to local public health authority.
  - b. Antibiotics effective in eliminating meningococcal carriage will be recommended to 100% of cases.
  - c. Information and recommendations regarding meningococcal disease will be provided to 100% of locatable close contacts of cases.

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<b>Reportable Disease</b>	<b>LHD Investigation</b>	<b>Exception</b>	<b>Report to DHS-HS</b>	<b>Prophylaxis/Disease Prevention Activities</b>
Animal Bites	Day of receipt		Not required	Recommend physician visit and case follow up with testing or quarantine according to guidelines. Rabies prophylaxis when necessary.
Botulism-foodborne	Immediately		Within minutes	Investigate/prevent access to toxin sources within 24 hours.
Campylobacter	Optional unless it exceeds the Prevalence	Outbreak: 1 working day	EOCW*	
Category 'A' Bioterrorism Agents: <ul style="list-style-type: none"> <li>• Anthrax</li> <li>• Botulism</li> <li>• Hemorrhagic Fevers</li> <li>• Plague</li> <li>• Smallpox</li> <li>• Tularemia</li> </ul>	Immediately		Within minutes	In development.
Cryptosporidiosis	Optional	≤3 yr old & in day care or case numbers indicate possible outbreak: 1 working day	EOCW	
<i>E coli</i> O157 & HUS	1 working day		EOCW	Determine source of infection whenever possible. Remove contaminated source.
Foodborne Outbreak	Same day		Same day	Collect samples as soon as possible & complete summary report within 30 days in 100% of outbreaks.
Giardiasis	Optional	≤3 yr old & in day care or case numbers indicate possible outbreak: 1 working day	EOCW	
<i>H influenzae</i>	1 working day		EOCW	Hib: identify contacts and recommend prophylaxis within 24 hours.
Hepatitis A	1 working day		Within 1 working day	Investigate 100% of reported cases. Conduct active surveillance on all high-risk exposed. Provide IG and either provide or refer for Vaccine to >90% of the exposed.
Hepatitis B	1 working day		EOCW	Investigate 100% of reported cases. Recommend HBIG and/or vaccine within 48 hours, as indicated.
Hepatitis C	Within 1 week		EOCW	
Listeriosis	1 working day		EOCW	Investigate 100% of reported cases. Removal of possible contaminated source.
Lyme	1 working day		EOCW	Test 100% of reported cases at the OSPHL for confirmation.
Malaria	1 working day		EOCW	Ensure adequacy of treatment based on infecting species and provide education re: needle sharing to 100% of cases.
Measles	1 working day		Within 24 hours	Initiate control measures within 24 hours in 100% of suspect, presumptive or confirmed cases.
Meningococcal Disease	1 working day		EOCW	Identify and recommend prophylaxis to 90% of contacts within 48 hours.
Pertussis	1 working day		EOCW	Identify >90% of contacts and recommend prophylaxis within 72 hours.
Psittacosis	3 working days		EOCW	Investigate source of condition in 100% of cases. Contact Department of Ag in 100% of cases who own birds for trace back purposes.
Rubella	1 working day		Within 24 hours	Initiate control measures within 24 hours and complete within 72 hours.

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<b>Reportable Disease</b>	<b>LHD Investigation</b>	<b>Exception</b>	<b>Report to DHS-HS</b>	<b>Prophylaxis/Disease Prevention Activities</b>
Salmonellosis	1 working day		EOCW	
Shigellosis	1 working day		EOCW	
Typhoid Fever	1 working day		EOCW	Identify contacts of cases. Test contacts for typhoid. Provide or refer vaccination for asymptomatic contacts.
			*End of calendar week	

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**ATTACHMENT 2**

**EVALUATION OF WIC NUTRITION EDUCATION PLAN  
FY 2007-2008**

WIC Agency: Multnomah County Health Department

Person Completing Form: Mary Kay DiLoreto, Elizabeth Berol-Rinder, Joy McNeal

Date: 4/24/2008 Phone: 503-988-3663 x24354

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2008

Please use the outcome evaluation criteria to assess the activities your agencies did for each Year One Objectives. If your agency was unable to complete an activity please indicate why.

Goal 1: Oregon WIC staff will have the knowledge to provide quality nutrition education.

Year 1 Objective: During plan period, staff will be able to correctly assess nutrition and dietary risks.

*Activity 1: All certifiers will complete the Nutrition Risk Module by December 31, 2007.*

Outcome evaluation: Please address the following questions in your response.

- Did all certifiers successfully complete all the activities of the Nutrition Risk Module by December 31, 2007?
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier?

Response: Each clinic site held a series of training sessions covering the Nutrition Risk Module during September and October, 2007 for certifying staff with a wrap up on the October 25, 2007. Posttests and follow-up occurred by December 31, 2007.

*Activity 2: All certifiers will complete the revised Dietary Risk Module by March 31, 2008.*

Outcome evaluation: Please address the following questions in your response.

- Did all certifiers successfully complete all the activities of the Dietary Risk Module by March 31, 2008?
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier?

Response: All certifying staff have successfully completed the activities of the Dietary Risk Module by March 31, 2008.

*Activity 4: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2007-2008.*

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Outcome evaluation: Please address the following questions in your response.

- Did your agency conduct the staff in-services you identified?
- Were the objectives for each in-service met?
- How do your staff in-services address the core areas of the CPA Competency Model?

<b>Quarter</b>	<b>Month</b>	<b>In-Service Topic</b>	<b>In-Service Objective</b>
1	August 23, 2007	Bid Formula Changes Teen Parent Program	To communicate implementation plan update on potential referral source
2	October 25, 2007	Share Nutrition Assessment Data Discuss how Classes we offer meet needs of clients Nutrition Risk Factors	To include all certifier staff in needs of our population and discussion of classes  To complete Nutrition Risk Module training
3	February 28, 2008	Presentation/Training on new Healthy Pregnancy and Moms on the Move classes Hemoglobin update, lancet technique	Improve curriculum and skills
4	May 5-6, 2008	Oregon WIC Listens	Provide training and launch Oregon WIC Listens statewide

Goal 2: Nutrition Education offered by the local agency will be appropriate to the clients' needs.

Year 1 Objective: During plan period, each agency will implement strategies to provide targeted, quality nutrition education.

*Activity 1: Using state provided resources, conduct a needs assessment of your community by September 30, 2007 to determine relevant health concerns and assure that your nutrition education activity offerings meet the needs of your WIC population.*

Outcome evaluation: Please address the following questions in your response.

- Was the needs assessment of your community conducted?
- What health concerns did you determine were relevant to your community?
- What did you do with the information you collected?
- Who did you communicate the results of your needs assessment with?

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Response: **Needs Assessment:** We did conduct a needs assessment. We reviewed the nutrition risk prevalence report, Oregon Department of Human Services, Center for Health Statistics data, and *Racial and Ethnic Health Disparities in Multnomah County: 1990 – 2004* as data sources.

In the DHS Center for Health Statistics data, Multnomah County frequently matched the state rates in many areas which might be expected given the population density of the county. One statistically significant difference was that Multnomah County had a lower incidence of overweight and obesity than the state as a whole.

The health disparities report highlights that a number of our populations of color share disproportionately higher rates of health risk and disease. Of particular relevance to our WIC population, the Hispanic population has a higher incidence of teen pregnancy and no prenatal care in the first trimester, and the African American population has a higher incidence of low birth weight than the majority, white population.

Nutrition Risk Prevalence varied slightly by clinic site, but the findings were generally consistent.

**Pregnant Women:**

1. Overweight prevalence of: 49 - 53%
2. Inadequate vitamin/mineral intake: 30 – 36%
3. Low maternal weight gain: 30 – 31%
4. Closely spaced pregnancies: 26 – 27%
5. Lack of Prenatal care: 22 – 23%

**Postpartum Women:**

1. Overweight: 46 – 56%
2. High maternal weight gain: 39 – 54%
3. Low hemoglobin: 20 – 39%
4. Closely spaced pregnancies: 20 – 33%
5. Recent major surgery, trauma, burns: 21 – 27%

**Children 2-5 years:**

1. Inadequate vitamin/mineral intake: 44 -53%
2. Dietary inadequacy (Food groups): 5 – 32%
3. Slow weight gain: 15 – 17%
4. Monitor Weight : 11 -17%
5. At risk for overweight: 14 – 15%
6. Low hemoglobin: 8 – 13%

**Children 1 -2 years:**

1. Inadequate vitamin/mineral intake: 45 – 50%
2. Low vegetable intake: 13 – 22%
3. Low hemoglobin: 17 – 22%
4. Slow weight gain: 15 -17%
5. Short stature/monitor growth: 9 – 13%
6. Underweight: 6 – 9%

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Infants:

1. Infant born to WIC mom or WIC-eligible mom: 83 – 88%
2. Short stature/monitor growth: 9 – 23%
3. Underweight: 9 – 14%
4. Large for gestational age: 5 -13%
5. Slow weight gain: 5 – 10%

**How we used the data:**

We identified that we did not offer any nutrition education classes targeted specifically to postpartum women and exercise/weight control, and that our prenatal nutrition class should be updated to include some information on exercise and closely spaced pregnancies. We had each of our 2 dietetic interns develop or revise these class offerings. We reviewed and edited the classes and presented them to our nutrition assistants and dietitians at the February 2008 Nutrition Forum and have added them to our class offerings. The classes are *Moms on the Move* and *Healthy Pregnancy*.

**How we shared the data:** We presented the highlights of the needs assessment to the nutrition assistants and dietitians at the October 2007 Nutrition Forum.

*Activity 2: Complete Activity 2A or 2B depending upon the type of second nutrition education activities your agency offers.*

*Activity 2A: By October 31, submit an Annual Group Nutrition Education schedule for 2008.*

Outcome Evaluation: Please address the following questions in your response.

- If your agency offers group nutrition education, did you submit your Annual Group Nutrition Schedule for 2008?
- How do you assure that your nutrition education activities meet the needs of your WIC population?

Response: See attached class lists for FY 2007-2008 at each clinic. We offer a variety of classes in English and Spanish at each clinic site and a more limited number of other language classes at or near the Mid-County site, to meet a variety of needs for our WIC participants based on category, nutrition risks, and interests. We offer breastfeeding and breast pump classes, infant feeding, and child nutrition classes every month, and frequently offer classes focused on improving fruit and vegetable consumption, physical activity and seasonal and periodic classes of general or specific interest.

Goal 3: Improve the health outcomes of WIC clients and WIC staff in the local agency service delivery area.

Year 1 Objective: During plan period, each local agency will develop at least one specific objective and activity to help facilitate healthy behavior change for WIC staff and at least one specific objective and activity to help facilitate healthy behavior change for WIC clients.

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*Activity 1: Local Agency Objective to facilitate healthy behavior change for WIC staff. Local Agency Staff Activity.*

Outcome Evaluation: Please address the following questions in your response.

- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response: At our All Staff meeting in May, 2007, each clinic site staff met and identified a potential goal to work on and shared it with the larger group.

NEHC: Improve exercise and consumption of 5 fruits and vegetables using a tracking chart. We developed a sticker chart to track both eating fruits and vegetables and exercise. We used the form for about a month, but it was cumbersome and difficult to track. We revised the form, but never fully implemented the changed form. Staff have made consistent efforts to eat fruits and vegetables and be physically active. We have continued to focus on fruits and vegetables for staff functions and limited foods with high caloric density.

ECC: Continue with exercise promotion chart and activities.  
This activity has helped us meet our objective with 90% staff participation. It is helpful we have the same break times. We added weekend hiking opportunities. We have used a sticker calendar to track participation in spring, summer and fall months. Different staff walk with one another depending on who is free but most participate.

Mid-County: Drink more water. Survey of staff revealed that most staff are consistently drinking more water than previously.

*Activity 2: Local Agency Objective to facilitate healthy behavior change for WIC clients. Local agency Client Activity.*

Outcome Evaluation: Please address the following questions in your response.

- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response: We did continue to offer physical activity classes and classes promoting fruits and vegetables, including "Taste of WIC" and "Taste of Fruits and Vegetables". We also continued to participate in the Fruit and Vegetable grant. We started a women's postpartum exercise/activity class, offered cooking classes to include low fat, increased vegetable intake; and FI appointments to focus on client concern such as increasing BMI.

Evaluation: Classes were offered monthly on physical activity and/or fruits and vegetables. See attached class list.

Goal 4: Improve breastfeeding outcomes of clients and staff in the local agency service delivery area.

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Year 1 Objective: During plan period, each local agency will develop at least one objective and activity to help improve breastfeeding outcomes for WIC staff or WIC clients.

Activity 1: Local Agency Breastfeeding Objective. Local Agency Breastfeeding Activity.

Outcome Evaluation: Please address the following questions in your response.

- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response: Breastfeeding Objective: To promote and support breastfeeding among WIC participants and staff.

Breastfeeding Activity supporting the about objective:

1. Refer participants who have breastfed to World Breastfeeding Week celebration.
2. Offer breast pumps to eligible clients.
3. Continue pump partnerships.
4. Offer breastfeeding classes and breast pump classes throughout the year.
5. Continue procedure having EBF moms requesting formula talk with a CPA before formula is issued.

Evaluation: We did continue all of these activities. At ECC, they began offering a more detailed Breastfeeding II class to address the questions and concerns of breastfeeding mothers with the Breastfeeding I class is more targeted toward pregnant women learning how to breastfeed.

World Breastfeeding Week celebrations: A total of 226 clients attended the World Breastfeeding Week celebrations at all 3 clinics with average show rate of 78%.

NEHC: We held celebrations for World Breastfeeding Week in both English and Spanish and invited all breastfeeding mothers. Activities included games, food, information sharing, and Nursing Mother's Council.

ECC: At WBF week we had a table for IBCLC staff from Mt. Hood Hospital, had a BF knowledge quiz and gave out raffle prizes for winners; baby massage people attended to train breastfeeding mothers; used a power point video going on breastfeeding techniques and benefits.

MCC: Mid-County WIC: Exclusively breastfeeding, partial breastfeeding and pregnant women were invited to celebrate World Breastfeeding Week. We partnered with the Medical Clinic to include pregnant women to encourage moms to breastfeed when the baby was born. All women had access to services provided by Nursing Mother's Counsel. Community vendors provided prizes which included florist certificates, Starbuck certificates, pizza certificates, picture frames donated by Hallmark and much more. Refreshments were provided, including fresh fruits and juice. There was information about breast feeding and breast pumps and those who qualified were trained and given pumps. Each woman had their picture taken and the picture was put in a special scrapbook along with a page in which each woman shared their breastfeeding experience.

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**ATTACHMENT 3**

**FY 2008 - 2009 WIC Nutrition Education Plan Form**

**County/Agency:** *Multnomah County Health Department*  
**Person Completing Form:** *Mary Kay DiLoreto, Elizabeth Berol-Rinder, Joy McNeal*  
**Date:** *April 29, 2008*  
**Phone Number:** *(503) 988-3663 x24354*  
**Email Address:** *mary.c.diloreto@co.multnomah.or.us*

Return this form electronically (attached to email) to: [sara.e.sloan@state.or.us](mailto:sara.e.sloan@state.or.us)  
by May 1, 2008  
Sara Sloan, 971-673-0043

Goal 1: Oregon WIC Staff will have the knowledge to provide quality nutrition education.  
Year 2 Objective: During plan period, through informal discussions, staff in-services and/or targeted trainings, staff will be able to describe the general content of the new WIC food packages and begin to connect how these changes may influence current nutrition education messages.

Activity 1: By October 31, 2008 staff will review the Oregon WIC Key Nutrition Messages and identify which one's they need additional training on.

Resources: American Academy of Pediatrics, MyPyramid.gov, Maternal and Child Health Oral health website – <http://www.mchoralhealth.org/Openwide/> Information from the 2008 WIC Statewide meeting.

Implementation Plan and Timeline:

By October 31, 2008 we will have certifier and RD staff review Oregon Key Nutrition Messages and identify which ones for which they need additional training.

Activity 2:

By March 31, 2009 staff will review the proposed food packages changes and:

- Select at least three food packages modifications (for example, addition of new foods, reduction of current foods, elimination of current foods for a specific category),
- Review current nutrition education messages most closely connected to those modifications, and
- Determine which messages will remain the same and which messages may need to be modified to clarify WIC's

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reasoning for the change and/or reduce client resistance to the change.

Resources: WIC Works Website WIC food package materials, Information from the 2008 WIC Statewide meeting, State provided materials.

Implementation Plan and Timeline:

By March 31, 2009 staff will review the proposed food packages changes and:

- Select at least 3 food packages modification,
- Review current nutrition education messages connected to those modifications, and
- Determine which messages will remain the same and which messages may need to be modified to clarify WIC's reasoning for the change and/or reduce client resistance to the change.

Activity 3:

Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2008-2009. Complete and return Attachment A by May 1, 2008.

Goal 2: Nutrition Education offered by the local agency will be appropriate to the clients' needs.

Year 2 Objective: During Plan period, each agency will assess staff knowledge and skill level to identify areas of training needed to provide participant centered services.

Activity 1: By September 30, 2008 staff will review the diet assessment steps from the Dietary Risk Module and identify which ones they need additional training on.

Implementation Plan and Timeline:

By September 30, 2008, staff will review the diet assessment steps from the Dietary Risk Module and identify which ones for which they need additional training.

Activity 2: By November 30, 2008 staff will evaluate how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.

Resources include: State provided guidance and assessment tools.

Implementation Plan and Timeline:

By November 30, 2008 staff will evaluate how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.

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Goal 3: Improve the health outcomes of clients and staff in the local agency service delivery area.

Year 2 Objective: During Plan period, in order to help facilitate healthy behavior change for WIC staff and WIC clients, each local agency will select at least one objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Activity 1: Identify your setting, objective and strategy to facilitate healthy behavior change for WIC staff.

Setting: Worksite

Objective: By 2012, increase by 10 percent the number of worksites with policies and programs that promote and support physical activity and healthy eating for employees and their family members.

Strategy: To develop policies and programs, employers should use a worksite wellness toolkit, the state's Breastfeeding Mother Friendly Employer toolkit, or similar publications that provide examples of the benefits of physical activity and healthy eating.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

We will explore our County Wellness Program resources and identify ways we can promote exercise and healthy eating among staff. We chose this objective because our county has a wellness program, but we would like to access its resources more fully. We want to continue to encourage healthy eating and physical activity among staff in a new way. At our August in-service, we will share county resources and identify strategies to implement as a staff. To evaluate our progress, we will revisit plan at the January All Staff meeting.

Activity 2: Identify your setting, objective and strategy to facilitate healthy behavior change for WIC clients.

Setting: Home/Household

Objective: III. By 2012, increase by five percent the number of Oregon adults and children who meet the recommendation for physical activity.

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Strategy: f). Educational and health organizations should provide families with information and resources promoting physical activity.

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

Promoting physical activity is an on-going campaign to promote health and reduce obesity. We hope to continue making progress in facilitating behavior change among our participant population. We will monitor our class schedules to ensure that we are offering classes promoting physical activity on a regular basis.

Goal 4: Improve breastfeeding outcomes of clients and staff in the local agency service delivery area.

Year 1 Objective: During Plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one setting, objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Activity 1: Setting: Home/Household

Objective: I – By 2012, maintain the current level of breastfeeding initiation and increase by two percent a year the number of mothers who breastfeed exclusively for the first six months of a child's life.

Strategy: d). Health plans, health systems, hospitals and others shall promote breastfeeding campaigns targeting the entire family.

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

We chose this objective because we know that support and encouragement is important for breastfeeding mothers. We have a strong initiation rate, but we would like to see an increase in more mothers breastfeeding exclusively and breastfeeding for a longer duration. We would also like to strengthen and improve breastfeeding support across the agency, initially in North Portland and then across the county.

Implementation Plan:

1. Offer World Breastfeeding week celebration in August 2008.

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2. Continue working to implement key messages and Breastfeeding policy with North Portland Obesity Project. This project is a cross-sectional group across the agency representing programs that serve children and include: Early Childhood Services (field team and Healthy Birth Initiative, a targeted intervention toward African American families), Dental, Primary Care, Health Promotion, School Based Clinics, and WIC. Initial products and implementation and evaluation timeline will be completed by June 2008.

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**ATTACHMENT 4**

Local Health Department: **Multnomah** Plan A: Continuous Quality Improvement Focus Area  
*Goal: To improve immunization rates among 35-month-olds seen at MCHD clinics over two years.*  
**Fiscal Years 2006-2008 (May 2007 – LAST YEAR’S)**

<b>Year 2: July 2006 – June 2007</b>				
<b>Objectives</b>	<b>Methods/Tasks (Activities)</b>	<b>Outcome Measure(s) (Outcome of Efforts)</b>	<b>Outcome Measure(s) Results<sup>1</sup></b>	<b>Progress Notes<sup>2</sup></b>
<p><b>Create and implement a plan to increase the 4:3:1:3:3 immunization rates among 35-month-olds by 6% over two years in the six ICS clinical sites.</b></p>	<ul style="list-style-type: none"> <li>Assure that: 1) all patients at all clinic visits have their immunization status reviewed; and 2) all needed immunizations are given according to minimal spacing recommendations.</li> <li>Review and update, if necessary, MCHD policies for all clinical staff regarding: a) reviewing immunizations at each pediatric clinic visit; and b) forecasting future immunization visits.</li> <li>Conduct training for clinical staff on important immunization practices: a) assessing patients’ immunization status at every visit; b) administering vaccines at minimal spacing intervals; and c) forecasting and notifying parents of next immunization visit.</li> <li>Provide training classes to immunization staff to increase understanding of minimal interval spacing. Use pre/post tests.</li> </ul>	<ul style="list-style-type: none"> <li>Increase of <math>\geq 3\%</math> in UTD rate of 35-month-old children in two years.</li> <li>Updated screening policy in place.</li> <li>Trained all staff who forecast and give immunizations on minimal spacing and the importance of immunizing at every clinic visit.</li> <li>Evaluated by number of trainings held; number of staff trained and results of pre-post testing.</li> </ul>	<ul style="list-style-type: none"> <li>Periodic assessments show an increase of nearly 6% from 11/1/06 through 4/1/07 using the new “valid dose scheme.” Strategies on improving rates are routinely discussed at Immunization Steering Committee (ISC) meetings.</li> <li>Performance measurement to improve immi rates was established by primary care managers. Each clinic reassessed immunization practice to review histories of all children at each visit, use minimal spacing, and maximum doses administered.</li> <li>Two trainings held on vaccine updates, forecasting, minimal spacing for vaccine leads, and clinical supervisors (~20) and providers (~10).</li> <li>Provided additional vaccine-related trainings and updates at four ISC meetings and presented at three other staff meetings for SBHC, Clinical Leadership, and Clinic Managers.</li> <li>Developed guidelines establishing seven injections as maximum number doses that can be given at one visit.</li> </ul>	<ul style="list-style-type: none"> <li>OHS public health nurse and AFIX staff have been very helpful in conducting trainings and providing information and technical support on immunization rates.</li> <li>Business case begun to study the interoperability between EMR (Epic) and ALERT systems. First round results due in June 2007.</li> </ul>

<sup>1</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>2</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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Local Health Department: **Multnomah County**  
 Plan A: Continuous Quality Improvement Focus Area

*Goal: To improve immunization rates among 35-month-olds seen at MCHD clinics over one year.*

**Fiscal Years 2006-2008 (May 2008)**

<b>Year 3: July 2007 – June 2008</b>				
<b>Objectives</b>	<b>Methods/Tasks (Activities)</b>	<b>Outcome Measure(s) (Outcome of Efforts)</b>	<b>Outcome Measure(s) Results<sup>1</sup></b>	<b>Progress Notes<sup>2</sup></b>
<p><b>Increase the 4:3:1:3:3 immunization rates among 35-month-olds by 6% over one year in the six ICS clinical sites.</b></p>	<ul style="list-style-type: none"> <li>Reassess minimal interval spacing/no missed opportunity strategies and update as needed.</li> <li>Update yearly training on minimal spacing.</li> <li>Continue to communicate with ICS Management Pediatric Leadership regarding status of IRIS/EMR interface to facilitate forecasting immunizations at all visits.</li> </ul>	<ul style="list-style-type: none"> <li>Increased immunization rate of 35-month-olds by at least 3% for a total of 6% over three years total (FY '06, '07, '08).</li> <li>Decreased rate of missed shots.</li> <li>Increased number of staff trained/retrained in use of minimal interval spacing.</li> <li>Decreased duplication of data entry effort by clinic staff by implementing EMR downloads into OHS database (ALERT).</li> </ul>	<ul style="list-style-type: none"> <li>Periodic assessments show a slight decrease in the Up-To-Date (UTD) immunization rate of 2% over the past year. See Progress Notes for discussion.</li> <li>The assessments also show an increase in the rate of missed shots by approximately 6% since last reporting period (May 2007). Many clinics are still revaccinating children who had subpotent doses. Per State guidelines, children should not receive more than six total DTaP vaccinations (subpotent and good doses). If a child receives three or more subpotent DTaPs, they cannot receive more than three additional doses. As a result, these children will always show up as “missed shot” and artificially drive down our 4<sup>th</sup> DTaP rates and ultimately the overall rates.</li> <li>Approximately 75 staff have attended the forecasting training at the biannual Skills Fairs at which time they review recommended childhood immunization schedules, minimal spacing, and catch up schedules.</li> <li>Systems interoperability (EMR w/ OHS IIS): See Progress Notes.</li> </ul>	<ul style="list-style-type: none"> <li>Clinics are feeling the impact of the more rigid “valid dose scheme” whereby only immunizations given at the recommended age and at recommended intervals/spacing are counted. According to the State, a decrease of 6% to 10% in immunization rates was to be expected with this implementation.</li> <li>Primary care sites have been in the process of decentralizing their services. With this configuration, more staff are tasked with giving both childhood and adult immunizations.</li> <li>Pediatric pilot teams are doing quality improvement (Plan/Do/ Study/Act) activities to improve their immunization rates. They are also working with EPIC Practice Mgmt to build their reports base with the goal of implementing an immunization recall system for children not UTD on their 4<sup>th</sup> DTaP dose.</li> <li>The business case researching systems interoperability was completed in August 2007. The State selected a new registry system from Wisconsin which has superior technical and application architecture and will enable interoperability with EHR. Go-live date will be in 2009.</li> </ul>

<sup>1</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>2</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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**Local Health Department:** Multnomah  
Plan B – Choice Core Public Health Function Focus Area

*Goal: To improve quality assurance related to vaccine coding, storage, and handling among MCHD clinics over two years.*

Fiscal Years 2006-2008  
May 2007 – LAST YEAR’S

Year 2: July 2006 – June 2007				
Objectives	Methods / Tasks (Activities)	Outcome Measure(s) (Outcome of Efforts)	Outcome Measure(s) Results <sup>1</sup>	Progress Notes <sup>2</sup>
<p><b>1. Increase staff knowledge and accuracy of vaccine coding by 5% over two years.</b></p> <p><b>2. Increase staff knowledge and accuracy of vaccine storage and handling by 5% over two years.</b></p>	<ul style="list-style-type: none"> <li>• Check IRIS coding performed by clinic staff on a quarterly basis, minimum.</li> <li>• Communicate results to clinic staff members for correction.</li> <li>• Continue to hold trainings as needed to minimize mistakes.</li> <li>• Continue to hold trainings as needed to minimize mistakes.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased accuracy of vaccine coding by at least 3% as illustrated in Doses Administered Report.</li> <li>• Decreased number of wasted and destroyed doses by <math>\geq</math> 3%.</li> <li>• Increase knowledge, practice and comfort levels related to vaccine coding, storage, and handling as shown by pre and post test results, number of trainings held and number of staff trained.</li> </ul>	<ul style="list-style-type: none"> <li>• Accuracy of vaccine coding has increased over the past two years.</li> <li>• Amount of wasted/destroyed doses decreased by 42% from FY’05-’06 to FY’06-’07.</li> <li>• Tailored VFC and 317 coding “menus” were developed for each clinic. Clinic staff were trained in group settings and one-on-one.</li> <li>• Codes trainings were conducted during the year at all primary care clinics and at SBHC staff meeting. Eight trainings conducted; 80 staff members trained.</li> </ul>	<ul style="list-style-type: none"> <li>• Due to double entry of immunization information by clinic staff (into EMR then into IRIS), potential for coding errors will continue to exist until systems interoperability is concluded.</li> <li>• Introducing three new vaccines in one fiscal year (HPV, rotavirus and MMR/V) is challenging at best.</li> </ul>

<sup>1</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>2</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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Local Health Department: **Multnomah**  
 Plan B – Choice Core Public Health Function Focus Area

*Goal: To improve quality assurance related to vaccine coding, storage, and handling among MCHD clinics over one year.*

**Fiscal Years 2006-2008    May 2008**

<b>Year 3: July 2007 – June 2008</b>				
<b>Objectives</b>	<b>Methods / Tasks (Activities)</b>	<b>Outcome Measure(s) (Outcome of Efforts)</b>	<b>Outcome Measure(s) Results<sup>1</sup></b>	<b>Progress Notes<sup>2</sup></b>
<p><b>1. Increase staff knowledge and accuracy of vaccine coding by 5% over three years.</b></p> <p><b>2. Increase staff knowledge and accuracy of vaccine storage and handling by 5% over three years.</b></p>	<ul style="list-style-type: none"> <li>• Reassess knowledge of vaccine coding performed by clinic staff.</li> <li>• Evaluate staff members' knowledge, practice and comfort levels regarding vaccine coding, storage and handling using pre/post tests.</li> <li>• Conduct refresher course(s) as needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased accuracy of vaccine coding, storage and handling by at least 2% for a total of 5% over three years.</li> <li>• Decreased number of wasted and destroyed vaccine.</li> <li>• Increase knowledge, practice and comfort levels related to vaccine coding, storage, and handling as shown by pre and post test results, number of trainings held and number of staff trained.</li> </ul>	<ul style="list-style-type: none"> <li>• Based on figures from the State, MCHD's vaccine coding accuracy increased to 99.9%.</li> <li>• Amount of wasted/destroyed doses decreased by 20% from FY'06-'07 to FY'07-'08.</li> <li>• A yearly training calendar was developed on Vaccine Coding, Forecasting Basics and database. To date, 38 staff have attended the trainings this Fiscal Year. Pre and post training assessments revealed that all attendees felt more comfortable and knowledgeable in these areas.</li> </ul>	<ul style="list-style-type: none"> <li>• Qualitative data shows that clinic staff are much more responsive in event of vaccine temp excursions.</li> <li>• Staff are more familiar with the vaccine refrigerators/freezers and more comfortable downloading electronic temperature data onto their computers.</li> <li>• In addition to the regular trainings to be held this year, an online training program is in the works.</li> </ul>

<sup>1</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>2</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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Local Health Department: **Multnomah**  
**Outreach Activities:** July 2007 – June 2008

<b>Activity 1:</b>				
<b>Objectives</b>	<b>Methods / Tasks (Activities)</b>	<b>Outcome Measure(s) (Outcome of Efforts)</b>	<b>Outcome Measure(s) Results<sup>1</sup></b>	<b>Progress Notes<sup>2</sup></b>
<b>Increase child care facility staff knowledge of Immunization School Law by October 31, 2006.</b>	<ul style="list-style-type: none"> <li>• Develop pre and post tests on immunization school law.</li> <li>• Conduct two trainings for child care facility staff.</li> <li>• Administer pre and post tests to each participant.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase knowledge and confidence in conducting school law process.</li> <li>• Evaluate by number of trainings held, number of child care facility staff trained, results of pre and post tests, and the reduced number of school exclusions by facilities whose staff attended training.</li> </ul>	<p>Revised Immunization School Law presentation. Held four trainings for 17 participants from approximately 10 different agencies.</p> <p>Pre/post tests were not conducted however the quality of Primary Review Summary reports from attendees were more accurate than were those who did not attend the training.</p> <p>Held trainings for 19 Portland Public School admin staff regarding school law requirements, recommendations and referrals.</p>	<p>Acting on feedback from the previous year's trainees, trainings were scheduled on several evenings and Saturdays this season. However, this resulted in a lower attendance rate at this years' trainings.</p>

<sup>1</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>2</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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<b>Activity 2:</b>				
<b>Objectives</b>	<b>Methods / Tasks (Activities)</b>	<b>Outcome Measure(s) (Outcome of Efforts)</b>	<b>Outcome Measure(s) Results<sup>1</sup></b>	<b>Progress Notes<sup>2</sup></b>
<b>Increase community awareness on the importance of immunizations.</b>	<ul style="list-style-type: none"> <li>• Develop pre and post tests on immunizations in general.</li> <li>• Conduct one training for staff and/or clients of a community agency/clinic.</li> <li>• Administer pre and post tests to each participant.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase knowledge about the importance of immunizations.</li> <li>• Evaluate by number of participants attending and results of pre and post tests.</li> </ul>	<p>Immunization staff presented at three HD skill fairs for 75 attendees.</p> <p>Conducted three Adult Immunization Trainings for approximately 20 staff.</p> <p>Trained 15 provider staff of a delegate agency on the importance of immunizations and forecasting basics.</p> <p>Provided opportunities for nursing students to receive practical clinical experience on immunizations.</p>	<p>Qualitative results of trainings show participants came away with increased knowledge, understanding and comfort level around vaccinations.</p>

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**ATTACHMENT 5**

FY 2008/2009 Immunization Plan

**Local Health Department:** Multnomah County Health Department

**Plan A - Continuous Quality Improvement:** To improve immunization rates among 24-month-olds seen at MCHD clinics over three years.

**Plan B – Chosen Focus Area:** To improve the technical capacity of staff who manage/support vaccine administration over three years (2008–2011).

<b>Year 1: July 2008-June 2009</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>3</sup></b>	<b>Progress Notes<sup>4</sup></b>
<p><b>A.</b> Meet the HRSA immunization rate goal of 85% among 24-month-olds according to the 4:3:1:3:3:1 measure over three years.</p> <p>January 2008 rate among primary care clinics is 74% so ideal rate increase will be 3.66% or higher each year to meet goal.</p>	<p>Develop and implement a reminder/recall system for children aged 15-24 m/o missing the fourth dose of DTaP.</p> <p>Provide training for clinical staff on:</p> <ul style="list-style-type: none"> <li>- Reducing missed opportunities by giving every shot due at each visit.</li> <li>- Deferring shots only when medically appropriate.</li> <li>- Utilizing minimal spacing.</li> </ul> <p>Work with WIC staff to ensure understanding of immunization screening and referral.</p>	<p>Improved immunization rates by 3.66% and decreased missed shot rates based on quarterly assessment reports from OHS.</p> <p>Evaluate by:</p> <ul style="list-style-type: none"> <li>- Number and dates of trainings.</li> <li>- Number of staff trained.</li> <li>- Results of pre/post tests or by qualitative method.</li> </ul>	<p>To be completed for the FY 2008/2009 Report</p>	<p>To be completed for the FY 2008/2009 Report</p>

<sup>3</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>4</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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<b>Year 1: July 2008-June 2009</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>5</sup></b>	<b>Progress Notes<sup>6</sup></b>
<p><b>B.</b> Develop and implement a sustainable vaccine education training program over three years.</p>	<p>Develop curriculum and materials for vaccine education training.</p> <p>Develop a plan to conduct trainings on vaccine coding, forecasting schedules and data entry.</p> <p>Implement trainings for new hires and current staff.</p> <p>Explore feasibility of developing an online training curriculum or utilizing pre-existing online resources.</p>	<p>Description of classes and schedule established.</p> <p>Evaluate by number of trainings held, number of staff trained, results of pre/post tests (or other method of evaluation), decrease in number of coding errors and increase in immunization rates.</p> <p>Evaluate various pre-existing online programs and compare to what is needed for staff development and training within the Department.</p>	<p>To be completed for the FY 2008 Report</p>	<p>To be completed for the FY 2008/2009 Report</p>

<sup>5</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>6</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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<b>Year 2: July 2009 – June 2010</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>7</sup></b>	<b>Progress Notes<sup>8</sup></b>
<p><b>A.</b> Meet the HRSA immunization rate goal of 85% among 24-month-olds according to the 4:3:1:3:3:1 measure over three years.</p>	<p>Continue providing training for clinical staff on:</p> <ul style="list-style-type: none"> <li>- Reducing missed opportunities by giving every shot due at each visit.</li> <li>- Deferring shots only when medically appropriate.</li> <li>- Utilizing minimal spacing.</li> </ul> <p>Reassess current plan and modify as needed.</p>	<p>Continued improved immunization rates by 3.66% and decreased missed shot rates based on quarterly assessment reports from OHS.</p> <p>Evaluate by:</p> <ul style="list-style-type: none"> <li>- Number and dates of trainings.</li> <li>- Number of staff trained.</li> <li>- Results of pre/post tests or by qualitative method.</li> </ul>	<p>To be completed for the FY 2010 report</p>	<p>To be completed for the FY 2010 report</p>
<b>Year 2: July 2009 – June 2010</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>9</sup></b>	<b>Progress Notes<sup>10</sup></b>

<sup>7</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>8</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

<sup>9</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

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<p><b>B.</b> Continue implementation of a sustainable vaccine education training program over three years.</p>	<p>Continue in-person trainings for new hires and current staff.</p> <p>Conduct various activities related to planning and implementation of online training. Pilot the training with a particular clinic staff.</p>	<p>Evaluate by number of trainings held, number of staff trained, results of pre/post tests (or other method of evaluation), decrease in number of coding errors and increase in immunization rates.</p> <p>Evaluate by surveying participants in pilot of online training program.</p>	<p align="center">To be completed for the FY 2010 Report</p>	<p align="center">To be completed for the FY 2010 Report</p>
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<sup>10</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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<b>Year 3: July 2010 – June 2011</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>11</sup></b>	<b>Progress Notes<sup>12</sup></b>
<p><b>A.</b> Meet the HRSA immunization rate goal of 85% among 24-month-olds according to the 4:3:1:3:3:1 measure over three years.</p>	<p>Continue providing training for clinical staff on:</p> <ul style="list-style-type: none"> <li>- Reducing missed opportunities by giving every shot due at each visit.</li> <li>- Deferring shots only when medically appropriate.</li> <li>- Utilizing minimal spacing.</li> </ul> <p>Reassess current plan and modify as needed.</p>	<p>Continued improved immunization rates by 3.66% and decreased missed shot rates based on quarterly assessment reports from OHS.</p> <p>Evaluate by:</p> <ul style="list-style-type: none"> <li>- Number and dates of trainings.</li> <li>- Number of staff trained.</li> <li>- Results of pre/post tests or by qualitative method.</li> </ul>	<p align="center">To be completed for the FY 2011 Report</p>	<p align="center">To be completed for the FY 2011 Report</p>

<sup>11</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>12</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

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<b>Year 3: July 2010 – June 2011</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>13</sup></b>	<b>Progress Notes<sup>14</sup></b>
<b>B.</b> Continue implementation of a sustainable vaccine education training program over three years.	Continue in-person trainings for new hires and current staff.  Conduct various activities related to refining online training.	Evaluate by number of trainings held, number of staff trained, results of pre/post tests (or other method of evaluation), decrease in number of coding errors and increase in immunization rates.  Increased number of staff taking the online training program.	To be completed for the FY 2011 Report	To be completed for the FY 2011 Report

<sup>13</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>14</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

**FY 2008/2009 COMPREHENSIVE ANNUAL PLAN FOR MULTNOMAH COUNTY  
MULTNOMAH COUNTY HEALTH DEPARTMENT**

**Outreach Activities: July 2008 – June 2011**

**Activity 1**

<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>15</sup></b>	<b>Progress Notes<sup>16</sup></b>
Increase knowledge of Immunization School Law among child care facility staff over three years.	Conduct two trainings per year in the Fall on school law for staff working at children's facilities, Head Starts and private/alternative schools.	Increase in knowledge and understanding of school law purpose and process.  Evaluate by number of trainings held, number of staff attending, results of pre/post tests (or other method of evaluation) and quality of reports submitted.		

**Activity 2**

<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>17</sup></b>	<b>Progress Notes</b>
Increase knowledge and understanding of vaccine storage and handling among delegate agency staff.	Conduct annual trainings for delegate agency staff based on OHS Standard Operating Procedures for Vaccine Management and MCHD's Administrative Guidelines.	Evaluate by number of participants attending and results of pre/post tests (or other method of evaluation).  Increased notification rate by agencies when vaccine appliance excursions occur.		

<sup>15</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>16</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help meet these objectives in the future.

<sup>17</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.