

**LOCAL PUBLIC HEALTH AUTHORITY  
FOR  
MULTNOMAH COUNTY, OREGON**

**FY 2009/2010  
ANNUAL PLAN**



*HEALTHY PEOPLE IN HEALTHY COMMUNITIES*



May 1, 2009

**MULTNOMAH COUNTY HEALTH DEPARTMENT  
LOCAL PUBLIC HEALTH AUTHORITY FOR MULTNOMAH COUNTY  
FY 2009/2010 ANNUAL PLAN**

**I. EXECUTIVE SUMMARY**

The FY 2009/2010 Local Public Health Authority Annual Plan for Multnomah County serves to demonstrate compliance with Oregon statute ORS 431.416, which mandates that each county in the state provide a minimum level of service to protect the health of individuals and communities through the implementation of five public health core functions, including:

- Investigation and control of communicable diseases and emerging infections.
- Services to high-risk children and families, including immunizations.
- Health information and referral for residents in need.
- Collection and reporting of health statistics.
- Environmental health services.

As identified in Section II, the Health Department will continue to implement a variety of programs, services, and initiatives to ensure that locally-specific needs for public 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.
- In-home health education for parents of children living in high-risk conditions.
- 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.
- Monitoring and addressing 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.

To ensure the successful delivery of public health services, Section III contains specific action plans that identify the significance of the issues, specific goals to be achieved, specific activities to be implemented, and the processes that will be used to evaluate the outcomes associated with each action plan.

As presented in the Attachments section, this plan also contains program-specific information, plans and evaluation reports for communicable disease, family planning program activities, WIC program activities, and immunization services.

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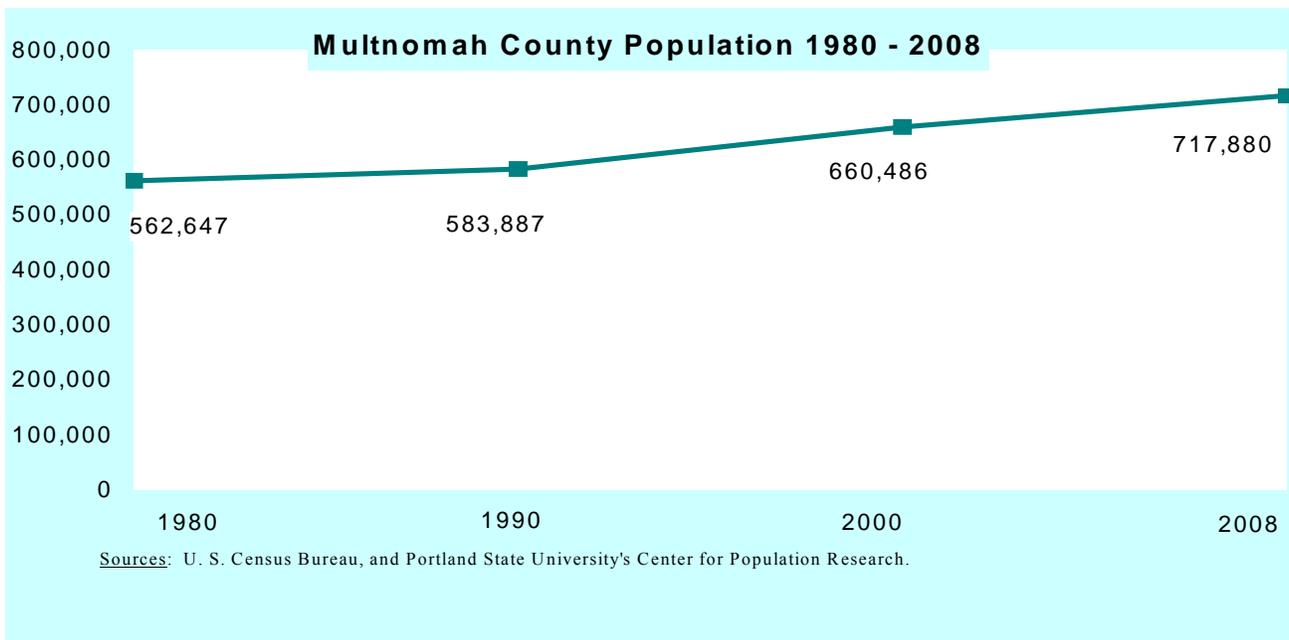
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**II. ASSESSMENT**

**A. Multnomah County Overview**

**A.1 Background & Socioeconomic Characteristics** - Multnomah County occupies 450 square miles in northwestern Oregon and is home to Portland, the largest city in the state. The county is approximately 90 miles inland from the Pacific Ocean; and it borders the Columbia River on the north (a border shared with Clark County, Washington), Clackamas County to the south, Hood River County to the east and Washington County to the west. Other important demographic characteristics including population, income, poverty, and access to health insurance are discussed below.

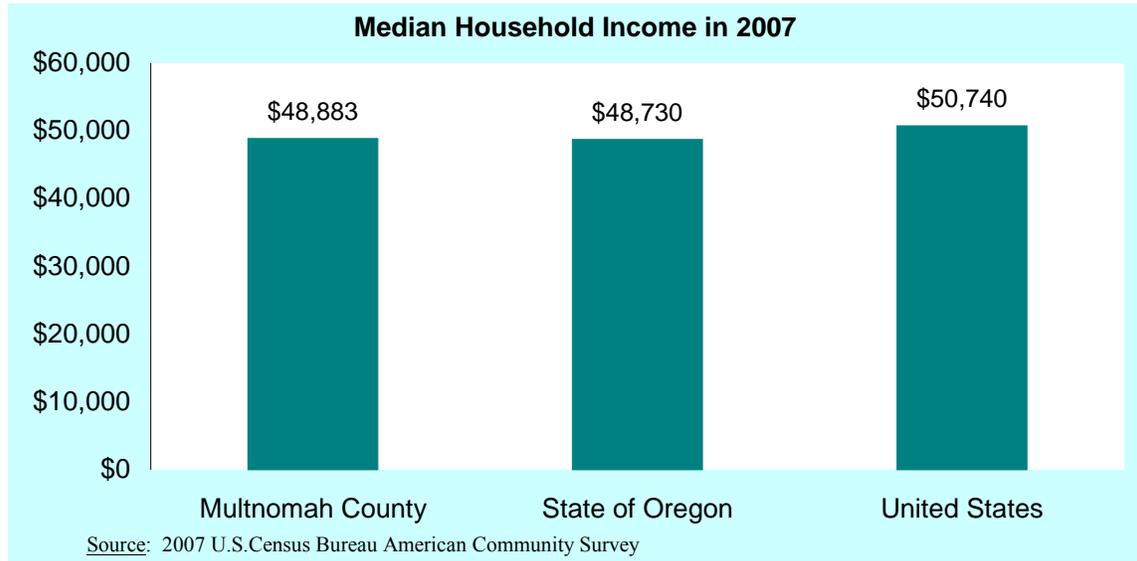
Population - Multnomah County continues to be the most populous county in Oregon with 19% of the state's population. The county's population increased to 717,880 residents as of 2008. The population increase from 2000 to 2008 was 8.7%, or 57,394 persons (the population of Oregon increased 10.8% over the same period).



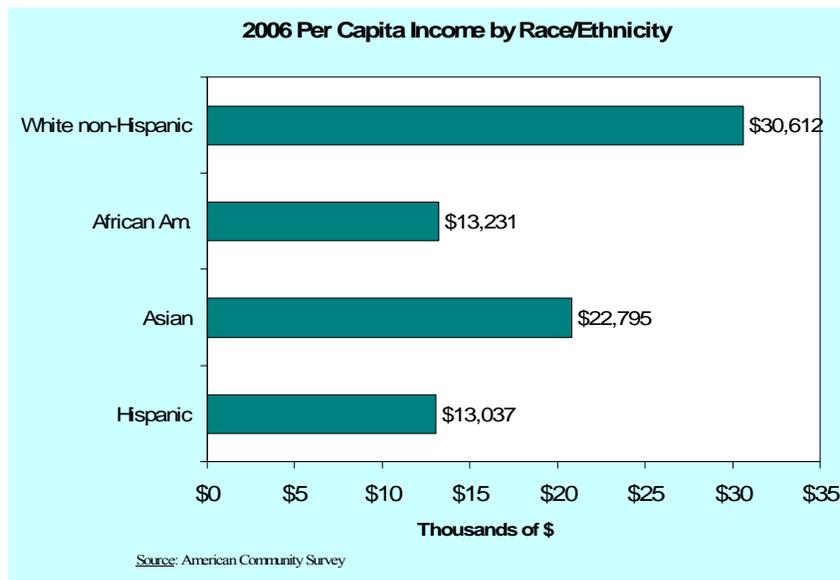
In 2008, Multnomah County was comprised of 77.4% White non-Hispanics, 6.1% African Americans, 1.1% American Indians, 6.7% Asians, Native Hawaiians and Other Pacific Islanders, and 10.1% Hispanics. The racial and ethnic mix of the population varies in Multnomah County. North Portland is the most racially diverse geographic area, while the area encompassing downtown Portland is the least diverse.

Income - Median household income for Multnomah County was \$48,883 in 2007. This is slightly higher than the median income for Oregon and lower than that of the United States.

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Poverty - Approximately 15.2% of Multnomah County residents had incomes below the federal poverty level according to the 2007 Census Bureau American Community Survey. This is higher than Oregon (12.9%) and the United States (13.0%). The per capita income in Multnomah County was \$31,627 for White non-Hispanic or Latino, \$21,661 for Asians, and \$15,276 for African Americans. Hispanic or Latino per capita income was \$14,320.



Health Care Insurance - According to the Selected Metropolitan/Micropolitan Area Risk Trends Behavioral Risk Factor Surveillance System (SMART BRFSS), 16.5% of Multnomah County adults were without some type of health care coverage in 2007, compared to 12.8% without health insurance in 2002.

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**B. Summary of Health Indicators for Multnomah County**

**B.1 Healthy People 2010: Leading Health Indicators in Multnomah County** - The national Healthy People 2010 health 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. For nearly all of the health indicators, Multnomah County's performance is comparable or slightly better than those reported for Oregon and the U.S. For example:

- Multnomah County has exceeded or is approaching the national objective target rates 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.
  - 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's rates are similar to U.S. rates for:
  - Children, adolescents, and adults who are overweight or obese.
  - Adolescents who participate in the recommended amount of vigorous physical activity.
  - Adult binge drinking.
  - Persons with health insurance coverage.
  
- Challenges for Multnomah County include:
  - First trimester prenatal care utilization.
  
- Local data is not available 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.

**B.2 Racial and Ethnic Health Disparities in Multnomah County** - Despite overall improvement in the health of the nation's population over the last 50 years, the health of persons of color lags behind that of White non-Hispanics on many measures. The status of racial and ethnic health disparities in Multnomah County are discussed in a report prepared by the Health Department that 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).

The Department's 2006 report on racial and ethnic health disparities in Multnomah County examines disparities for 17 health status indicators. Using White non-Hispanics as a comparison group, health disparities were calculated for four minority populations groups: African

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Americans, Asians, Native Americans, and Hispanics. The 2006 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 health disparities in the African American community showed improvement over time and some health disparities have been eliminated in recent years. For example, across the 17 health indicators examined for all populations of color, 29 health disparities were identified for the 1990-1994 period. However, by the 2000-2004 time period, six disparities had been 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, 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, as compared to White Non-Hispanics:

- The rate of new cases of gonorrhea infections among African American residents of Multnomah County was six-and-one-half times higher.
- The rate of new Chlamydia cases was five times higher among African American residents, and nearly two-and-one-half times higher among Hispanic residents.
- The rate of new syphilis infections occurred at a rate three times higher among African Americans.

Another area of concern is the rate of births to teenage mothers in communities of color. In the 2001-05 period the percent of live births to Hispanic teens was more than six times higher than for White non-Hispanic teens. For African American 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 when compared to White non-Hispanics.

## **C. Summary of Public Health Services in Multnomah County**

**C.1 Mission & Strategic Goals** - 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.

These strategic goals will be updated during FY 2010.

**C.2 Public Health Services of the Health Department** - The Multnomah County Health Department complies with Oregon statute ORS 431.416 to provide basic public health services.

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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 333-014-0050 (1) of the Oregon Administrative Rules:

*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 OAR 333-014-0050 (2), this section of the Comprehensive Annual Plan for Multnomah County provides a brief description of the programs and services that enable the Health Department to comply with the Oregon Revised Statutes to meet State 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
- Public Health and Regional Health Systems Emergency Preparedness

Each of these requirements are met by the Department through a broad range of public health services, programs, initiatives and activities as described below.

- Control of Reportable Communicable Disease [OAR 333-014-0050 (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 to reduce the morbidity and mortality of reportable communicable disease; assuring the availability of immunizations for 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. See action plans A-1 through A-4 beginning on page 14 in Section III.
- Parent and Child Health [OAR 333-014-0050 (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 (via the Early Childhood Services Program) and Integrated Clinical Services division (via clinical facilities). The Department’s Early Childhood Services Program (ECS) staff utilize a variety of methods to contribute to the health and wellbeing of individuals, families, and communities. Programs include Services for First Time Parents; Services for High Risk Prenatal Program; High Risk

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Infants and Children Program; Family Planning Services; Women, Infants and Children (WIC); and Immunization Services. See action plans beginning on page 22 in Section III.

- Health Statistics [OAR 333-014-0050 (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. See action plan beginning on page 33 in Section III.
- Information and Referral Services [OAR 333-014-0050 (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 Appointment and Information Center. 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. See action plan beginning on page 34 in Section III.
- Environmental Health Services [OAR 333-014-0050 (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 include the Community Environmental Health Program; Lead Poisoning Prevention Health Inspections and Education Program; Vector-borne Disease Prevention and Code Enforcement; and Environmental Health Inspections. See action plan beginning on page 31 in Section III.
- Public Health and Regional Health Systems Emergency Preparedness [OAR 333-014-0050 (3)(b)] - 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.). See action plan beginning on page 36 in Section III.

**C.3 Core Functions to Meet Local Needs (OAR 333-014-0050 (3))** - The Multnomah County Health Department provides a variety of different functions to respond to public health issues

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and special health needs of the community. These functions are organized under the following categories:

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

Specific activities under each of these functions and programs are discussed below.

**General Public Health Functions**

- Coordination/Integration/Leadership – The Department Leadership Team creates and communicates a clear vision and direction for the organization and is responsible for systems-based integration of health services and operations (e.g., 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, etc.). Additional details about the structure, roles and operations of the Department Leadership Team are presented on page 39.
- 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. During 2007, the role of the Health Officer was expanded to serve county jurisdictions in the surrounding Portland metropolitan region in addition to Multnomah County, including Clackamas and Washington Counties.
- Health Planning, Program Evaluation, & Grant Development – The Department provides critical support for public health programs and services through three work units including Health Assessment and Evaluation, Program Design and Evaluation Services, and Grant Development.
- Systems and Quality Support Services Program – The Department's 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).
- Emergency Medical Services – The Department's Emergency Medical Services 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.

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**Specific Public Health Initiatives**

- Initiative to Eliminate Racial and Ethnic Health Disparities - With leadership from the Multnomah County Chair in FY 2008, the Health Department will continue to implement the “Health Equity Initiative” to engage community members and policy makers in an effort to address the root causes of health disparities. The key components of this initiative are policy advocacy training and evaluation and developing a health promotion model that is focused on community engagement and policy change.
- 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 Community Capacitation Center also addresses the social determinants of health by actively promoting health in specific communities, including (but not limited to) the disabled and Latino immigrant communities.
- 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 process requires a systematic and long-term commitment to be successful.
- 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 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 like cancer, diabetes, obesity, heart disease, asthma, and stroke.
- Tobacco Prevention Program - 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 (which is 22% of all deaths), and 23,700 people suffer from a tobacco-related illnesses. The Tobacco Prevention Program’s work is population-based so that large segments of Multnomah County benefit from smoke-free environments.
- 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

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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.

- 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."

**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 38,000 residents were served in 2008). The Department's six clinics are certified through the Joint Commission, and they are recognized as 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. Primary Care Services are overseen by the Multnomah County Community Health Council. The Council includes a majority of members who are consumers of health services at the Health Department; and it is organized to address issues of budget/finance, policy, scope of services, long range planning, diversity, and other issues associated with providing care to the underserved.
- Services for Persons Living with HIV - Since 1981, approximately 4,800 people have been diagnosed with HIV in Multnomah County; over 2,000 persons 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).
- Corrections Health Services - As a part of its health services, the Health Department provides 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.

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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. Corrections Health provided services to 24,447 inmates and provided 75,621 visits.

- 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 who are attending other schools, drop-outs, homeless, in detention, etc.). School-based clinics served 6,500 individuals and provided 21,000 visits.
- 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. It focuses on underserved populations including uninsured, at-risk children, pregnant women, homeless, disabled, minorities, and non-English speaking residents. The Department’s four dental clinics served 19,000 individuals and provided 54,000 clinical visits.
- 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 women and children, uninsured, and mentally ill.

### **III. FY 2010 Action Plans**

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

- A. Epidemiology and Control of Reportable Communicable Diseases [OAR 333-014-0050 (2)(a)]
  - A.1 Communicable Disease Prevention and Control Program (page 14, also see Attachment 1 on page 56 for a copy of the Guidelines for BT/CD Assurances)
  - A.2 STD, HIV and HCV Programs (page 16)
  - A.3 TB Prevention and Control (page 18)
  - A.4 Tobacco Prevention (page 20)
- B. Parent and Child Health Services [OAR 333-014-055 (2)(b)]
  - B.1 Early Childhood Services (page 22)

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- B.2 Babies First! (page 24)
- B.3 Family Planning Services (page 25, see also Attachment 2 on page 60 for the FY 2009-2010 Family Planning Program Annual Plan)
- B.4 Family Planning through School-Based Health (page 26)
- B.5 Women, Infants & Children (page 27, also see Attachment 3 on page 62 for a copy of the FY 2009-2010 WIC Staff Training Plan; Attachment 4 on page 63 for a copy of the Evaluation of the WIC Nutrition Education Plan FY 2008-2009; and Attachment 5 on page 71 for a copy of the FY 2009-2010 WIC Nutrition Education Plan)
- B.6 Community Immunization Program (page 29, also see Attachment 6 on page 75 for a copy of the Immunization Progress Report Plan 2008-2011)

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

- C.1 Environmental Health Services (page 31)

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

- D.1 Health Records Program (page 33)

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

- E.1 Information and Referral Program (page 34)

F. Public Health Emergency Preparedness [OAR 333-014-0050 (3)(b)]

- F.1 Emergency Preparedness Program (page 36)

G. Other Issues (none)

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

**[OAR 333-014-055 (2)(a)]**

**A.1. Communicable Disease Prevention and Control Program (FY 2010 Action Plan)**

- 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 decrease the level of communicable disease in Multnomah County (also see program description on page 8). 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 works 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, EMS Medical Director, and Environmental Health Program staff; as well as with other local health departments in the

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Portland metropolitan region, the Oregon Department of Human Services/Health Services, and public safety responders to improve the reporting, investigation, and implementation of control measures for all communicable diseases occurring in Multnomah County. Program 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; and an on-call system has been created to ensure an appropriate staff response at anytime (i.e., evenings, weekends and holidays).

- b. Goal - The goal of the Communicable Disease Program is to identify, prevent and control epidemics and emerging communicable diseases and environmentally-related 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.
  - 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 - 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 56).
Health Inspections	Number of food service managers who have received County sponsored food safety training.
HIV Care Services Planning and Admin.	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

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<b>Program Area</b>	<b>Measurable Outcome</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 Chlamydia 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.
Other	Number of Tobacco Education & Prevention complaints/ # of initial and follow-up Tobacco Education & Prevention inspections.

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, and others as requested.

**A.2 STD, HIV and HCV Programs (FY 2010 Action Plan)**

- a. Current Condition/Problem - STDs, HIV, and Hepatitis C (HCV) account for over 80% 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 persons 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. Preventing these diseases saves money over the course of a lifetime. For example, each prevented HIV case saves an estimated \$360,000 over a lifetime, and 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 lifetime medical costs of treating a person who is infected.

STD, HIV and Hepatitis C (HCV) Programs target and serve newly affected, emerging, and underserved populations impacted by HIV, STDs, and HCV through testing, prevention

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services, treatment of bacterial STDs; notification and referral for partners of those diagnosed with HIV and STDs; 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 six-counties in two states including Multnomah, Washington, Clackamas, Columbia, Yamhill Counties in Oregon, and Clark County in Washington. Nearly 4,000 PLWH/A reside 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, 53% have a mental illness (close to three times the rate found in the general population) and 24% have both a mental illness and substance abuse diagnosis. Among the clients served by this program, 73% have incomes below 100% FPL, 20% lack permanent housing, and 16% 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 goals of the STD, HIV and HCV Community Programs are: 1) to prevent the further spread of STD, HIV and HCV infection, especially among highest risk community members; 2) eliminate African American sexual health disparities through group and community awareness strategies; and 3) effectively manage the Federal Ryan White grant so clients have access to primary health care and support services.
- c. Activities – This program targets high risk populations, including men who have sex with men, injection drug users, partners of persons living with HIV/AIDS; persons living with HIV/AIDS at highest risk of transmitting or acquiring HIV, HCV, or STDs; and low income PLWH/A living the six county area served by the Ryan White-funded Care Services Program. Prevention services include:
- Community testing is provided by staff who visit bars, jails, internet and other "hookup" sites to test, educate, and promote behavior change among the target population.
  - Syringe exchange and disposal is a proven intervention to keep infection rates low among injectors, partners and their infants.
  - Behavior Change/Education and Counseling involves community-based interventions to reduce risky sexual behavior and drug use.
  - STD prevention includes screening and treatment for bacterial STDs, partner notification and referral for partners of those diagnosed with HIV and STDs, and referral into primary care for newly diagnosed PWLH/A.
  - Service locations include community test sites and STD clinics, correctional facilities, drug treatment agencies, and other targeted community venues. Programs directed at African-American youth from 13-24 include the "KnowSex/NoSex" campaign, and the "Male Advocates for Sexual Responsibility" (MARS) evidenced-based intervention to address local racial/ethnic sexual health disparities. Another CDC evidenced-based

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intervention, “Community Promise,” is a tri-county collaborative initiative targeting highest risk men who have sex with men.

- Primary care services in the six county service area include medical care, medications, oral health care, substance abuse treatment, mental health therapy, and health insurance premium/co-pay assistance. Services are provided through contracts with both public and private health systems and community-based organizations.
  - Early Intervention Services targets recently diagnosed and other PLWH/A who have not engaged in primary medical care. Services are provided through the MCHD HIV Community Test site and STD Prevention Program and through a community-based organization that provides HIV prevention and testing services to those at highest risk.
  - 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 individual service plans with each client based on a thorough health and psychosocial assessment of service needs and support systems, and connects clients with health insurance, primary care, housing, and other services critical to remaining in care.
  - Support services for PLWH/A in the six county area promote retention in medical care and assist clients in meeting basic needs. Services provided by public agencies and community-based organizations include housing, psychosocial support, and food/home-delivered meals.
- d. Evaluation - HIV and STD infection rates in Portland are the lowest of all large west coast cities (e.g., syphilis is one-fifth and gonorrhea one-half of the rates they were 15 years ago). Evaluation of programs has demonstrated positive results, including lower HIV mortality (86% drop in 10 years) and better targeted prevention and care services. Staff performed ~5,500 HIV tests and ~12,000 STD clinical encounters in FY 2009. The Department’s expanded access to test results through a phone-based system has increased the number of clients receiving HIV and STD results.

Data collection, data analysis and program evaluation occurs has included the tracking of service provision at the client-level across all service providers in the past two years. Information is reported to the Board of County Commissioners, Oregon Health Services Division, and others as requested.

**A.3 Tuberculosis Prevention and Treatment (FY 2010 Action Plan)**

- 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 2008, Oregon’s TB case rate was 2.0 cases per 100,000 population. The same year Multnomah County reported 3.8 cases per 100,000 population (a decrease in Multnomah County’s 2007 case rate of 3.9 cases per 100,000 population). TB Program staff must continue aggressive efforts in order to maintain current decreasing trends in TB case rates.

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**Tuberculosis Rates By Year, 2005-2008  
Multnomah County & Oregon<sup>a,b</sup>**

Year	Multnomah County	All Oregon
2005	5.8	2.8
2006	4.6	2.2
2007	3.9	2.5
2008	3.8	2.0

<sup>a</sup> Reported data from Oregon DHS TB Program;

<sup>b</sup> Rate per 100,000 population.

- b. Goal - 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, 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) priority assessment is made for each case of TB. DOT is the standard of care for all TB cases. The TB-NCM monitors each of the TB cases' 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.
  - Outreach Prevention Services - The Department's 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 occupants and employees. Screening services include the TB skin test, QuantiFERON-Gold in tube blood test, chest radiography, history and symptom evaluation, sputum collection and testing, and physician assessment as indicated. Bi-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:

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- The number of active cases, types of cases, 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.

The Department's TB Program staff developed and consistently implements a quarterly end of treatment review. Each TB case that has completed treatment is presented by the nurse case manager assigned to the patient. During the review, 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.

Data from TB Program Performance Measures for CY 2008 is unavailable until 2010 due to the length of treatment. Completion of therapy data on infected contacts that initiated treatment for latent TB infection is also unavailable due to the length of treatment.

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, and others upon request.

**A.4 Tobacco Prevention (FY 2010 Action Plan)**

- a. Current Condition or Problem - Tobacco is the leading cause of preventable death in Oregon, and every year in Multnomah County, 1,229 people die from tobacco use (which is 22% of all deaths) and 24,021 people suffer from a tobacco-related illness. Approximately 110,568 Multnomah County residents reported smoking cigarettes. The economic burden of tobacco use amounts to over \$193 million in medical expenses and over \$206 million in lost productivity due to tobacco-related disability and death. In Multnomah County, 20% of adults smoke, compared to 19% statewide. According to the 2007 Oregon Healthy Teens Survey, among 8<sup>th</sup> grade students in Multnomah County, 9% smoke (the same for statewide); and among 11<sup>th</sup> graders, 16% smoke (compared to 17% statewide). While overall cigarette consumption in Oregon is decreasing, smoking prevalence remains higher in some communities. For example, American Indians, the LGBTQ community, and African Americans have a high prevalence of smoking.
- b. Goals - The goals of Multnomah County's 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

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shift social norms around tobacco use and smoking. Primary objectives of the Tobacco Program include:

- Reduce and eliminate exposure to secondhand smoke.
- Counter pro-tobacco influences.
- Promote quitting and increase access to cessation resources, including the Oregon Quit Line.
- Reduce youth access to tobacco and prevent the initiation of tobacco by youth.
- Eliminate disparities in tobacco use.

c. Activities - The Tobacco Program's work is population-based so that large segments of Multnomah County benefit from smoke-free environments. A key function of the program is the enforcement of applicable smoke-free laws, including the Oregon Indoor Clean Air Act. The Tobacco Program's Work Plan consists of multiple best practice objectives in support of tobacco-free childcare centers/head starts, colleges, hospitals, multi-unit housing, outdoor venues, and worksites. These best practice objectives include:

- Multnomah County will fully implement and enforce the Oregon Indoor Clean Air Act in support of smoke-free worksites.
- By June 2010, Multnomah County Board of County Commissioners will consider a smoke-free policy for at least one Multnomah County owned or leased campus.
- By June 2010, Legacy Hospital and Health System will implement a comprehensive smoke-free policy.
- By June 2010, Mount Hood Community College will consider adoption of comprehensive smoke-free or tobacco-free campus policy.
- By June 2010, Portland Community College will implement a tobacco-free campus policy.
- By June 2010, one property management entity, either public or private, will adopt a smoke-free policy.
- By June 2010, six community groups or agencies will better understand and fully comply with the Oregon Indoor Clean Air Act.
- By June 2010, Multnomah County Board of Commissioners will consider policy options to limit tobacco promotions and advertising within defined distances of schools.
- By June 2010, one of four head start districts in Multnomah County will implement a tobacco-free policy.
- By June 2010, one major outdoor venue/event in Multnomah County will adopt a smoke-free policy.

In order to meet these objectives, Tobacco 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 implementation. Much of the work of the program will be carried out through issue-specific coalitions and multidisciplinary partnerships, including the coordination of a broad-based Community Health Advisory Council. The role of the Community Health Advisory Council, comprised of key leaders in the chronic disease prevention, is to provide strategic direction in the development of the program's plans of action related broadly to chronic

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disease prevention and specifically to tobacco prevention. The Tobacco Program coordinates its efforts as much as possible with the statewide culturally-specific tobacco prevention and education networks, such as the African American Tobacco Prevention and Education Network convened by Lifeworks NW and the Asian and Pacific Islander Tobacco Prevention and Education Network convened by the Asian Family Center.

- d. Evaluation - Tobacco 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. 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, and others as requested.

**B. Parent and Child Health Services [OAR 333-014-055 (2)(b)]**

**B.1 Early Childhood Services (FY 2010 Action Plan)**

- a. Current condition or problem - The Community Health Services/Early Childhood Services and Integrated Clinical Services groups contribute to the health of children and their families by serving over 28,000 children and their parents each year. Early Childhood Services consists of community health nurses, community health workers, office assistants, managers and program-specific staff. Staff are in geographically designated offices, project specific teams (NFP, Healthy Start, and HBI), or are out-stationed in various community-based locations such as Head Start programs and Child Care Resource & Referral of Multnomah County as members of multidisciplinary, interagency teams. The ECS staff utilizes a variety of methods to contribute to the health and well being of individuals, families, groups, and communities.

Primary Care clinics provide basic medical services, including prevention, diagnosis, and treatment for all ages. Services include family planning/birth control, prenatal care, immunizations, well-child exams, nutrition services, communicable disease screening, drug and alcohol screening, management of low risk TB patients, and care of acute and chronic medical conditions.

- b. Goals - The goal of Parent and Child Services 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 are children and families in Multnomah County. Key activities include:
  - Early Childhood Services Health Teams work to promote wellness, with an emphasis on families with young children. The primary focuses of ECS Teams are to “promote

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healthy pregnancy in populations at risk of not having a healthy pregnancy; and “promote healthy infant/child growth and development in populations at risk of not achieving healthy growth and development.” Services include home visits, coordination with community health providers, groups, classes, and health promotion activities. Services are provided to 11,000 parents and children annually, with priority to teen parents, first-time parents, premature infants, children with special healthcare needs, and high-risk families. Services are delivered through a series of programs, including:

- **Healthy Start:** Healthy Start is a state funded program that provides screening, assessment, referral and home visit services to first time parents in Multnomah County. Health Dept staff visit local hospitals to assess first time parents using the New Baby Questionnaire. Families eligible for home visit services are referred to contracted community agencies and health dept ECS staff for ongoing services of case management and parenting education.
- **Connections:** Connections provides intake, assessment, referral, and support services to first time teens giving birth in the county. Services are focused on teens 17 and under. Connections is integrated into Healthy Start. 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.
- **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:** NFP follows the model developed by David Olds research. MCHD 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 children reach age two. Nurse home-visitors follow the NFP curriculum and guidelines.
- **Community Capacitation Center:** The CCC seeks to improve the health of under-served communities through the training and support of Community Health Workers (CHW’s). The CCC provides professional development, networking opportunities, and training based on popular education.
- **WIC:** The Federally-funded WIC program promotes healthy families through nutrition education, supplemental foods, and community networking. The County program assesses eligibility and provides education, vouchers for specially chosen supplemental foods, referral to healthcare, and breastfeeding support.
- **Primary Care:** Primary Care clinics provide basic medical services, including prevention, diagnosis, and treatment. Services include family planning, prenatal care, immunizations, well-child exams, nutrition services, communicable disease screening, drug and alcohol screening, management of low-risk TB patients, and care of acute and chronic medical conditions.
- **School-Based Health Centers:** The SBHC Program provides preventive and primary health and mental health care, education, and referrals to under-served children and adolescents. Services include physical exams, immunizations, diagnosis and

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treatment of illness/injury, reproductive healthcare, pregnancy testing, contraceptive counseling and services, sexually transmitted disease diagnosis and treatment, HIV counseling/testing, mental health counseling, and health promotion activities such as smoking cessation.

- Healthy Homes Asthma Prevention: Healthy Homes Asthma Prevention program provides assessment by a Certified Asthma Educator, identification of environmental asthma triggers, asthma control status and medical, behavioral and environmental interventions needed to improve control of asthma.
  - School-Based and Community Dental: The Department provides dental evaluations and dental sealants to school age children at school sites including oral health education in the classroom.
- d. Evaluation - The effectiveness of Parent and Child Health services is measured by the following types of outcomes: % of 2-year-olds who are appropriately immunized; % of pregnant women in County clinics who receive prenatal care beginning in first trimester; % of qualifying children who are up to date on well child exams; % of infants breastfed at 6 months and % of women who have been screened for domestic violence. 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, and others upon request.

**B.2 Babies First! (FY 2010 Action Plan)**

- a. Current condition or problem – The Babies First! program 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. Referrals come primarily from prenatal providers, WIC, and hospitals.

Babies First! targets children from birth to age four when 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. Nurses work closely with 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. Goal - 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 – The target population includes high-risk infants and children from birth to four years of age in Multnomah County. Key activities include:
- Outreach
  - Home visits
  - Health assessment and developmental screening
  - Neurological development and growth monitoring

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- Case management and counseling
- Parenting education
- Information and referral
- Advocacy

These activities are performed on an ongoing basis by nurses and other staff of the Department's Early Childhood Services program.

- d. Evaluation - Data is collected per ORCHIDS Babies First! requirements and is electronically transferred to DHS Public Health. Referral sources and risk criteria are reviewed annually. The key performance measure is the percent of infants and children who experience normal growth and development at one year of age. For FY 07-08, 84% of infants participating in Babies First! had normal growth and development at one year. 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, and others as requested.

**B.3 Family Planning (FY 2010 Action Plan)**

- a. Current condition or problem - During FY09, family planning services were provided to 3,479 adolescents, accounting for 41% of the total family planning clients; an estimated 753 adolescent pregnancies were averted; 8,434 total clients were seen, a 6% decrease from the 2007 number; and a system was developed to reduce FPEP and Medicaid billing denials and improved FPEP supply billing. 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 improve the health and well-being of children and families.
- c. Activities - The target population is all Multnomah County residents. Family planning activities are divided among the three areas described below.
- Family planning through Primary Care Clinics:
    - 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
    - STI treatment and follow-up
    - Review of family planning goals, birth control methods education, comprehensive birth control options offered, ongoing BC management, or maintenance provided

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- Preconception health education (prenatal and postnatal care are provided in Primary Care)
  - Miscellaneous family planning activities
    - Community outreach and education
    - New computer-based education in clinics to provide access to high quality websites, guidance and printers to download needed information
    - Technical assistance to teachers and in-class teaching on reproductive health topics
    - Educational displays for school hallways
    - Peer-lead abstinence education
    - Initiation of hormonal contraception by Field Nurses
    - Comprehensive contraceptive counseling by Field Nurses
  - Family Planning Program administrative activities
    - Monitor contraceptive access in School-Based Health Centers.
    - Bill 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; the number of clients evaluated for an abnormal pap smear; maintaining contraceptive access at the same level as FY 2008; and capturing all appropriate Medicaid and FPEP reimbursements for contraceptive visits and supplies. Data collection and analysis occurs at the program level. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and others as requested.

**B.4 Family Planning through School-Based Health (2010 Action Plan)**

- a. Current condition or problem - The vision of the Multnomah County Health Department 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.

Since 1986, MC School-Based Health Centers (SBHC) have provided significant 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.

The program operates 13 fully-equipped medical clinics; twelve clinics are located in schools and one clinic is school linked. Staffing at the clinics includes a Nurse Practitioner, Registered Nurse, medical support staff, and office assistant. Program locations are geographically diverse and all school aged youth are eligible to receive services (including those who may be attending other schools, drop-outs, homeless, detention, etc.). To assure access to care, the clinics are operated beyond regular school hours and at multiple sites open during summer and school breaks.

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SBHC staff's proximity to children creates continuous, 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 encouraged to ensure successful clinical outcomes and 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 insurance coverage and ability to pay;
- Promote healthy lifestyle choices and empower youth to take responsibility for their health and healthcare;
- Encourage parent or guardian involvement to support and sustain successful health outcomes.

c. Activities - The program strives to ensure that basic physical and behavioral health needs of school age youth are met to help them attend, participate, and remain in school. Healthcare for school-age youth, a basic need, is provided in the most readily accessible locations. SBHCs foster academic success by early identification and management of chronic diseases such as asthma and obesity, and preventing teen pregnancy, alcohol/drug use, and other health-related barriers to education.

SBHC services include chronic, acute, and preventive healthcare; age-appropriate reproductive health; and exams, risk assessments, prescriptions, immunizations, fitness and nutrition education/counseling, and referrals. This comprehensive approach enables early identification and intervention, thereby reducing risk behaviors.

e. 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, and others as requested. 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 are overweight or obese who experience a listed health problem.
- Number of patients 5-18 yrs of age diagnosed with persistent asthma who are on appropriate medication.
- Percent of clients receiving healthcare who are from non-SBHC sites.
- Percent of female family planning clients who do not get pregnant.

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**B.5 WIC (FY 2010 Action Plan)**

- 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 4 beginning on page 63 to review the annual evaluation of the Multnomah County WIC Nutrition Education Plan for FY 2008-2009).

This Action Plan represents a summary of the FY 2009-2010 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, 2009, and is appended as Attachment 5 beginning on page 71).

- b. **Goals** - The goal of the County's WIC Program is to provide quality nutrition education that is 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
    - 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 200-2010.
  - 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.

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- 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 2009.
- 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. Results are reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and others as requested.

**B.6 Community Immunization Program (FY 2010 Action Plan)**

- a. **Current condition or problem** - The Community Immunization Program (CIP) 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 6, Immunization Progress Report and Plan 2008-2011 on page 75.
- b. **Goals** - The primary goal of the County's immunization efforts is to promote and provide immunizations to prevent vaccine-preventable disease 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 receive certain services for school, work or in the event of an exposure to a vaccine-preventable disease.
- c. **Activities** - Multnomah County Health Department's 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. The program offers all childhood immunizations and provides blood lead screening for children up through six years of age. Families who have insurance that covers immunization services are encouraged to receive vaccines at their private provider, unless there is a problem with additional costs that makes it

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difficult to do so. CIP also offers adult immunizations and antibody testing to which standard fees apply. Key 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 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, particularly among 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 (7<sup>th</sup> graders) for Tdap in compliance with school requirements.
- 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 injection drug users, men who have sex with men, and persons living with HIV/AIDS and Hepatitis C.
  - Providing antibody testing for Hepatitis B, measles, mumps, rubella, and varicella.
  - Providing TB testing.

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- 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, which 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 MCHD 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 on immunizations; 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, and others upon request.

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

**C.1 Environmental Health Services (FY 2010 Action Plan)**

- a. Current condition or problem - The Environmental Health Services unit is responsible for assuring the public of safe food; controlling diseases that can be acquired from food and water; managing vector populations (i.e., rats and mosquitoes); certifying County birth and death records (see Vital Statistics below); regulating selected businesses and accommodations; and enforcing State and local environmental health laws and rules. Environmental Health Services staff work in cooperation with other programs in the Department to achieve and assure community health, for example:

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- The Communicable Disease Prevention Program to refine procedures for responding to communicable disease.
  - Emergency Preparedness Program to refine responses to a broad range of disasters and emergencies that can threaten the health of the community (e.g., floods, vectors, earthquakes, intentional contamination of food and other mass casualty events).
  - The Health Equity Initiative to further refine strategies designed to overcome health disparities.
- b. Goals - The goals of Environmental Health Services are to (1) analyze local environmental health issues from a public health perspective; (2) regulate specified businesses and accommodations; (3) enforce State and local environmental health laws and rules; (4) engage and empower the community to identify and remediate identified environmental public health issues; and (5) develop policy recommendations that address environmental public health issues.
- c. Activities – The 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.
  - Emergency preparedness.
  - Vector and nuisance control.
  - Lead poisoning prevention.
  - Inspection, licensure, consultation, and compliance investigation of food services, tourist facilities, institutions, public swimming and spa pools, and drinking water systems to assure conformance with public health standards.
  - Community education about environmental health risks and hazards including asthma, housing, 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 the Environmental Health Services program as a mechanism to support disease control and prevention is measured by the types of data listed in the table below. Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, Oregon DHS, and others upon request.

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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 total food program complaints received
	Number food borne illness complaints received
	Number food borne illness outbreaks investigated
	Number 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 [OAR 333-014-0050 (2)(c)]**

**D.1 Health Records Program (FY 2010 Action Plan)**

- a. Current condition or problem - The purpose of maintaining vital records is to 1) assure that birth and death certifications are complete and accurate; 2) maintain data to enable the analysis of statistical information to monitor trends in public health conditions; and 3) identify populations at risk for poor health outcomes and support the delivery of intervention services.
  
- b. Goals - Short term goals assure accurate, timely and confidential certification of birth and death events, thereby, minimizing the opportunity for misuse of personal information (i.e., identity theft). Populations at risk for poor health outcomes can be identified for the provision of proactive interventions. Ongoing and long term goals provide an opportunity

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for comprehensive and longitudinal analysis of health on a population through analysis of public health information consistently gathered on birth and death certificates.

- c. Activities - Birth attendants initiate the birth certification process. Funeral directors and physicians initiate the death certification process. County Registrars complete the certification process by assuring the completeness, accuracy, confidentiality, and proper certification of births and deaths for the first six months after the event. Analytical capacity exists at the County and State levels to evaluate vital statistics information to identify at-risk populations and assess trends over time. The State Vital Records Program converted to electronic records. This conversion has resulted in difficulty in acquiring local data. The County Vital Records Program is committed to supporting correction of this issue. Examples of uses for the data include: provision of data that allows for public health interventions like proactive services to new mothers who have given birth to infants identified to be at-risk for poor health outcomes; identification of birth and death statistics to evaluate clinic and county health programs and the population in general; and analysis of fetal and infant demise to support analysis of the perinatal system to promote healthier birth outcomes. These efforts are overseen by Early Childhood Services and Epidemiology.

Key activities related to the Health Records Program include:

- Data collection and analysis.
  - Birth and death reporting, recording, and registration.
  - Analysis of health indicators related to morbidity and mortality.
  - Analysis of services provided.
- 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, Oregon DHS, and others upon request.

**E. Information and Referral [OAR 333-014-055 (2)(d)]**

**E.1 Information and Referral Services Program (FY 2010 Action Plan)**

- 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. During FY 2008/2009 I&R services were improved to reflect the goals of the Department's Building Better Care Initiative (see description on page 12).
- c. Activities - The Information and Referral Program will continue to provide services in FY 2009/2010. The I&R program was enhanced during 2008 to include a new system know as "Primary Care Access and Referrals" (PCAR) in response to the Department's Building Better Care Initiative. PCAR strives to provide access to primary care services for *new* low income, uninsured individuals seeking primary care services. PCAR includes the following components:
- Focuses on appointing new patients into the system, so that resources for uninsured Multnomah County residents are optimized by providing one-time referrals to assign individuals to a primary care medical home.
  - Collaboration 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.
  - Access to comprehensive, collaborative planning processes that are patient centered, respectful and attentive to resource stewardship.
  - Patients assigned a primary care "home" are now able to call their medical home for appointments, cancellations and advice during hours of operations.
  - WIC appointments are now decentralized to the WIC Programs service sites: East County Health Center, Northeast Health Center and Mid-County Health Center.
  - Health Department Information and Referral continues to be provided from a centralized location, using a new, updated and streamlined database.
  - Eventually all new primary care patients will be appointed by PCAR team members and the Primary Care Appointments and Referrals Referral Coordinator, and a there is a new phone number for new patient appointments.
  - The new processes was phased in during the fall 2008; and all outside agencies, new CareOregon patients, Corrections Health patients and uninsured Multnomah County residents are now appointed by the Primary Care Appointments and Referrals Team.

The new Primary Care Appointments and Referrals system is operational, and the current I&R phone number (503-988-3816) continues to be the central resource for individuals needing services.

- 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, Oregon DHS, and others upon request.

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**F. Public Health Emergency Preparedness**

**F.1 Emergency Preparedness Program (FY 2010 Action Plan)**

a. Current Condition or Problem - Emergency preparedness has been institutionalized as Goal 3 of the Department's FY05-09 strategic plan, and the program's objectives are drivers of emergency preparedness activities in conjunction with Federal/State grant requirements. The following missions and their supporting authorities are the foundation of public health emergency preparedness activities through the Health Department:

1. Ensure a coordinated and effective emergency medical system through paramedics, medical technicians, and hospitals.
2. Monitor, evaluate, and respond to disease and environmental threats when manifested as a public health emergency.

Emergency preparedness activities must ultimately develop the capacity to mobilize all Department resources and leverage public and private partner organizations to appropriately respond to the public health impacts of any scale of emergency. Oversight and evaluation of the Emergency Preparedness Program is scheduled to be reorganized from the Department's Community Health Services unit to the Director's Office on July 1, 2009. The program's organizational structure includes the following:

- The Public Health Officer, Deputy Department Director, 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's Office in consultation with the Department's Leadership Team determines Department-wide investment for emergency preparedness activities.
- The Deputy Director, Emergency Preparedness Manager, and/or 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 Emergency Preparedness Manager is responsible for maintaining an Incident Management Team and Response Plans. Performance is measured by the number of Incident Management Team members (90 persons authorized), training/experience, and evaluation of exercises/operations/plans.
- 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.

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- Health Preparedness Organization is a MCHD-based regional initiative to build response capacity and collaboration in a six county medical/hospital community and their partner public health departments.
  - Business Continuity is the responsibility of the Department's Deputy Director and is delegated to a Project Manager. Performance is measured by periodic reviews of adequacy.
- b. Goal – The goal of the emergency preparedness program is to prevent and mitigate the public health impacts of natural and human-caused disasters. A series of program objectives support the Department's effort to attain this goal, including the following:
- Objective 1 - Improve internal capacity to respond to bioterrorism, major communicable disease outbreaks, and environmental health hazards through the following steps:
    - Maintain a Regional Health Preparedness Organization and a County Public Health Emergency Response Plan that is aligned with regional partners' efforts.
    - Maintain an internal staff and an Incident Management Team as a focal point for emergency preparedness training and responsibility.
    - Build emergency management experience and competence.
    - Develop, maintain and test emergency response protocols/plans.
    - Improve and maintain a notification, alert, decision and activation framework for emergency response, including the FY 2009-2010 Department-wide implementation of the automated Health Alert Notification system.
    - Improve emergency communications within the Department and externally.
    - Develop active surveillance in coordination with the State (e.g., bring CD database into compliance with BT/CD guidelines; develop depth in CD nurse epidemiology investigators; develop and test emergency response CD protocols).
  - Objective 2 - Assure business continuity during an emergency. Shift from a several year old business continuity plan to a software-based continuity of operations plan by bold solutions in coordination with an initiative led by Multnomah County Emergency Management.
  - Objective 3 - Assure that diverse communities' needs for emergency preparedness and response are recognized and effectively addressed.
    - Further develop and exercise Community Connector concept.
    - Planning and operational links to community-based organizations including expansion of Push Partner Registry partners who agree to distribute medication during emergencies and participation in several initiatives aimed at supporting special populations.

Objective 4 - Integrate public health response to emergencies across Health Department programs, County Emergency Management, other County Departments, and with external partner organizations (e.g., local hospitals, community groups, etc.). Know, plan, and

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exercise with partner organizations by conducting a major annual exercise involving staff from many partner organizations.

Objective 5 - Plan and exercise for managing population responses to events involving mass casualties/exposures and develop techniques to respond to such events.

- d. Evaluation - Data collection, data analysis, and program evaluation occur at program, division, department and regional levels. Program performance is measured by assessing the outcomes associated with specific program activities, including the following:
- Progress made leading and cultivating regional collaborative efforts within public health and emergency medical organizations and in the general communities with respect to emergency preparedness.
  - Investments made to support emergency preparedness (equipment, training, etc.).
  - Identification of public health priorities and projects that represent progress toward meeting program goals and objectives.
  - Evaluation of exercises/operations/plans conducted under the direction of the Emergency Preparedness Manager in conjunction with the Incident Management Team and Department's Response Plans (performance is measured by the number of Incident Management Team numbers, training/experience, etc.).
  - Performance of staff during major annual exercises to develop emergency response leadership and technical expertise using the Incident Command System.
  - Participation on the regional Health Preparedness Organization as an effective initiative to build response capacity and collaboration in a six-county medical/hospital community and their partner local public health departments.
  - Periodic reviews of the adequacy of the Department's Business Continuity Plan.

**G. Other Health Issues**

None.

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**IV. ADDITIONAL REQUIREMENTS**

**Board of Health** - The Multnomah County Board of County Commissioners constitutes the Multnomah County Board of Health under ORS 431.410 and 431.415. Members of the Board include:

Ted Wheeler, Chair  
Position term ends: December 31, 2010  
Phone: (503) 988-3308, fax (503) 988-3093  
E-mail: [mult.chair@co.multnomah.or.us](mailto:mult.chair@co.multnomah.or.us)  
Web: <http://www.co.multnomah.or.us/cc/chair>

Deborah Kafoury, District 1  
Position term ends: December 31, 2012  
Phone: (503) 988-5220, fax (503) 988-5440  
E-mail: [district1@co.multnomah.or.us](mailto:district1@co.multnomah.or.us)  
Web: <http://www.co.multnomah.or.us/cc/ds1/>

Jeff Cogen, District 2  
Position term ends: December 31, 2010  
Phone: (503) 988-5219, fax (503) 988-5440  
E-mail: [district2@co.multnomah.or.us](mailto:district2@co.multnomah.or.us)  
Web: <http://www.co.multnomah.or.us/cc/ds2>

Judy Shiprack, District 3  
Position term ends: December 31, 2012  
Phone: (503) 988-5217, fax (503) 988-5262  
E-mail: [district3@co.multnomah.or.us](mailto:district3@co.multnomah.or.us)  
Web: <http://www.co.multnomah.or.us/cc/ds3/>

Diane McKeel, District 4  
Position term ends: December 31, 2012  
Phone: 503.988-5213, fax (503) 988-5262  
E-mail: [district4@co.multnomah.or.us](mailto:district4@co.multnomah.or.us)  
Web: <http://www.co.multnomah.or.us/cc/ds4/>

The Multnomah County Board of Commissioners meets as the County Board of Health periodically to consider matters of public health. Meetings are held in the first floor Boardroom of the Multnomah Building (501 SE Hawthorne Blvd.). Except for executive sessions, all meetings are open to the public. The Board's mailing address is 501 SE Hawthorne Blvd, Suite 600, Portland, Oregon 97214-3587.

**Organizational structure** - The Health Department employs the largest number of staff among Multnomah County's seven departments with more than 870 FTEs working in the Health Department's seven distinct divisions, including the Director's Office, Health Officer, three service divisions, and two support divisions.

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- 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.

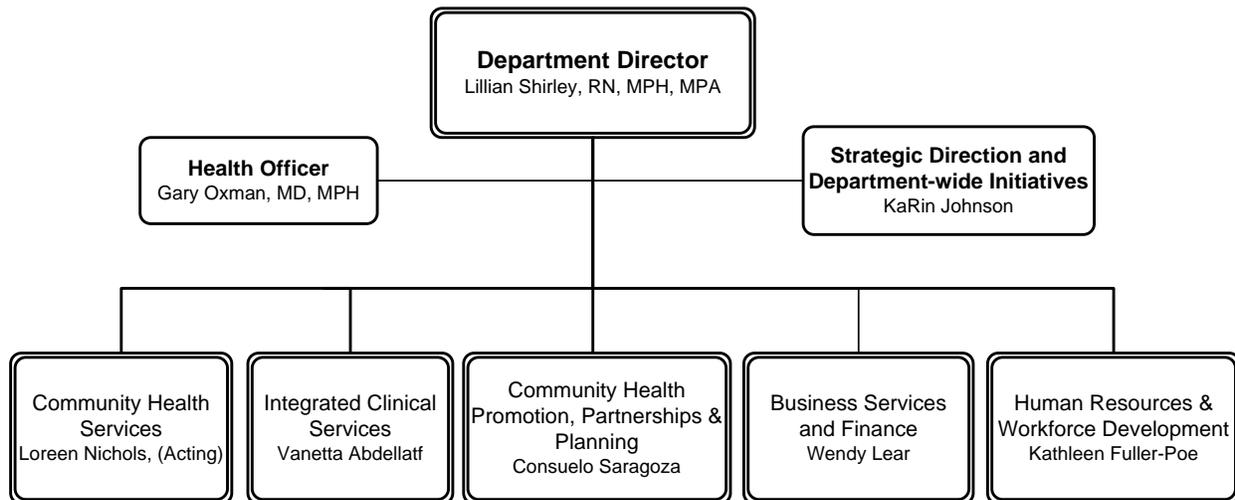
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- Support Divisions - The Department's financial and administrative functions are supported by the *Business Services and Finance* division and the *Human Resources and Workforce Development* division. The Business Services and Finance division is 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 05/01/2009



**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 2009, 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 Services 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**

Multnomah County faces severe budget constraints in the next fiscal year due to the economic decline that began in September 2008. The County has projected that it will have a revenue shortfall of \$35 million over the next 12 months, which will translate into a 1.26% reduction in local funds to support public health functions. The overall significance of the budget cuts for public health programming are discussed below (the discussion of these programs is not presented in any particular priority, nor do they incorporate any reductions in State funding that may occur):

- HIV/Hepatitis C/STD Prevention Programs – Budget impacts to these programs in FY 2010 from both the County General Fund and State grants resulted in plans to merge HIV/HCV Community Programs with the STD Prevention Program. This merger will enable a 1.35 FTE cut in management positions, and overall, combined program cuts of 5.4 FTEs (14% of program staff), and more than \$100,000 in contract services. Program impacts of these funding cuts will include:
  - Reduced HIV counseling and testing services, limiting our ability to identify undiagnosed HIV infection and link HIV-positive individuals to medical care and prevention services.
  - Reduced STD screening, treatment, and contact follow-up, resulting in further disease spread, longer infection periods, and more severe medical complications.
  - Reduced syringe exchange services, impacting our ability to maintain our low rate of HIV infection and to reduce HCV infection among injection drug users.
  - Reduced ability to address health disparities in communities disproportionately affected by these diseases: gay and bisexual men affected by HIV, syphilis, and gonorrhea; African Americans affected by HIV and gonorrhea, and Latinos affected by Chlamydia.
  - Reduced capacity to deliver effective research-based prevention interventions. Each prevented HIV case saves more than \$360,000 in lifetime care and treatment costs and each prevented HCV case saves \$66,000 in care and treatment costs.
- Early Childhood Services – Programs that address Parent and Child Health Services are provided through the Department’s Early Childhood Services program. This program will suffer a 20% reduction of support from the County General Fund, which results in the loss of 19.4 FTE spread across all classifications. The major reductions were in Community Health Nurses with loss of 8.8 FTE. This results in the loss of maternity case management services to 700 pregnant women and Babies First! services to 600 infants. Remaining services will be focused on higher risk pregnancies and newborns. The cuts will force the program to eliminate services for “lower risk” families in order to maintain services for those considered to be “high risk” families.
- School-Based Health Center Program - The SBHC program completed a thorough program evaluation resulting in a major program redesign that was operationalized in FY 2008-2009. Further reductions of County General Fund dollars warranted additional program changes in the proposed FY 2010 budget. Program changes include reducing summer services from two summer teams (providing SBHC service at three locations) down to one summer team

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(providing service at two summer locations). This represents a 40% reduction of summer services, and will mean that clients will face delays in services and some must travel further to access care through the program. Systems are being developed to link SBHC clients to other primary care clinics especially for those with acute needs. Additional changes included reducing Community Health Nurse positions by 1.6 FTE, reducing Community Health Specialist time by 0.3 FTE, and increasing Community Medical Assistant positions by 2.4 FTE. Services will continue to be provided at all 13 existing SBHC locations during the school year.

- Environmental Services – Although the majority of revenue to support Environmental Health Services is fee-based, loss of General Fund revenue will directly impact the Vector Control Program. Consequently, it is necessary to reduce the overall plan for vector surveillance and abatement (i.e., mosquitoes and rodents). For example, budget cuts will cause the elimination of reduction of the following vector control services and related expenses:
  - Adult and immature mosquito prevention/control/surveillance capacity for Multnomah County schools, Portland Parks and Recreation, and at the Cities of Gresham, Fairview, Wood Village, Troutdale, and Maywood Park.
  - Aerial larviciding capacity for mosquito prevention/control.
  - Rodent surveillance capacity and testing at Oregon State University.
  - Sentinel chicken flocks for mosquito disease surveillance.
  - Code enforcement uniform replacement.
  - Janitorial services.
  - Fleet vehicles for seasonal staff.
  - Temporary/on-call staff from 2,088 hours to 1,044 hours.
  
- Emergency Preparedness – The Health Department’s core Emergency Preparedness staff is funded by a federal grant that has steadily declined since 2002, and is not directly supported by County General funds. Core staff was reduced from three to two persons last year, and the number of FTE’s may have to be reduced further or be backstopped by other revenues at some point. Actual management of emergencies is leveraged through a trained, appointed 90-person Incident Management Team and, in a worst case scenario, through the whole Department and partner organizations. The availability of Incident Management Team members for training and exercises is profoundly impacted by the demands of their normal work, much of which comes from General Funds or is affiliated with revenue generating activities. From an impact perspective, staff with less training equates to lower levels of experience, and, therefore, organizational capacity to respond to large, complex emergencies will be tested.

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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 Multnomah County Chair's proposed FY 2009/2010 budget (which includes the Health Department's budget) can be found at the following web address:

<http://www2.co.multnomah.or.us/Public/EntryPoint?ch=af1b7c1f3c7fc110VgnVCM1000003bc614acRCRD>

This budget is proposed, and changes may be made before it becomes final upon adoption by the Multnomah County Board of Commissioners during June 2009.

**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.

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3. Yes X 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 X No \_\_\_ Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes X No \_\_\_ Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes X No \_\_\_ Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes X No \_\_\_ Local health officials develop and manage an annual operating budget.
8. Yes X No \_\_\_ Generally accepted public accounting practices are used for managing funds.
9. Yes X No \_\_\_ All revenues generated from public health services are allocated to public health programs.
10. Yes X No \_\_\_ Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes X No \_\_\_ Personnel policies and procedures are available for all employees.
12. Yes X No \_\_\_ All positions have written job descriptions, including minimum qualifications.
13. Yes X No \_\_\_ Written performance evaluations are done annually.
14. Yes X No \_\_\_ Evidence of staff development activities exists.
15. Yes X No \_\_\_ Personnel records for all terminated employees are retained consistently with State Archives rules.
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.

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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.
31. Yes X No \_\_\_ Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes X No \_\_\_ Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes X No \_\_\_ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.

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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.
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.

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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.
56. Yes  No  Information for developing a safe water supply is available to people using on-site individual wells and springs.

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57. Yes \_\_\_ No X 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 X No \_\_\_ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes X No \_\_\_ School and public facilities food service operations are inspected for health and safety risks.
60. Yes X 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 X 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 X No \_\_\_ Indoor clean air complaints in licensed facilities are investigated.
63. Yes \_\_\_ No X 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 X 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 X 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 X 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**

67. Yes X No \_\_\_ Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.

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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**

Local health department Health Administrator minimum qualifications:

The Administrator must have a Bachelor degree plus graduate courses (or equivalents) that align with those recommended by the Council on Education for Public Health. These are: Biostatistics, Epidemiology, Environmental health sciences, Health services administration, and Social and behavioral sciences relevant to public health problems. The Administrator must demonstrate at least three years of increasing responsibility and experience in public health or a related field.

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Answer the following questions:

Administrator name: Lillian Shirley, RN, MPH, MPA

- Does the Administrator have a Bachelor degree?      Yes X No \_\_\_
- Does the Administrator have at least 3 years experience in public health or a related field?      Yes X No \_\_\_
- Has the Administrator taken a graduate level course in biostatistics?      Yes X No \_\_\_
- Has the Administrator taken a graduate level course in epidemiology?      Yes X No \_\_\_
- Has the Administrator taken a graduate level course in environmental health?      Yes X No \_\_\_
- Has the Administrator taken a graduate level course in health services administration?      Yes X No \_\_\_
- Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems?      Yes X No \_\_\_

- a.    Yes X No \_\_\_ The local health department Health Administrator meets minimum qualifications:

If the answer is "No", submit an attachment that describes your plan to meet the minimum qualifications.

- b.    Yes X 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;

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.

If the answer is "No", submit an attachment that describes your plan to meet the minimum qualifications.

- c.    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

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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.

If the answer is "No", submit an attachment that describes your plan to meet the minimum qualifications.

- d. Yes  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.

If the answer is "No", submit an attachment that describes your plan to meet the 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.

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Agencies are **required** to 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*

Local Public Health Authority

Multnomah  
County

May 1, 2009  
Date

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**ATTACHMENT 1  
GUIDELINES FOR BT/CD ASSURANCES**

**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.

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2. Disease Investigation and Management
  - a. 100% of cases will have case investigation and contact identification initiated 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	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.

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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>
Rubella	1 working day		Within 24 hours	Initiate control measures within 24 hours and complete within 72 hours.
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  
FAMILY PLANNING PROGRAM ANNUAL PLAN FOR  
MULTNOMAH COUNTY HEALTH DEPARTMENT  
FY 2009-2010**

As a condition of Title X, funding agencies are required to have a plan for their Family Planning Program, which includes objectives that meet SMART requirements (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-Bound). In order to address State goals in the Title X grant application, each agency must identify how they will address each of the following two goals:

- Goal 1:** Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.
- Goal 2:** Assure ongoing access to a broad range of effective family planning methods and related preventive health services.

Please include the following four components in addressing these goals:

1. **Problem Statement** – For each goal, briefly describe the current situation in your county that will be addressed by that particular goal. The data provided may be helpful with this.
2. **Objective(s)** – Write one or more objectives for each goal. The objective(s) should be realistic for the resources you have available and measurable in some way. Please use the attached “Writing Objectives” for each goal in order to assure your agency objectives are **SMART**.
3. **Planned Activities** – Briefly describe one or more activities you plan to conduct in order to achieve your objective(s).
4. **Evaluation** – Briefly describe how you will evaluate the success of your activities and objectives, including data collection and sources.

**Agency: Multnomah County Health Department**

**Contact: Margo Salisbury**

**Goal 1: Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.**

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Chlamydia is the leading cause of infertility in young women. Last year, 25.5% of the Chlamydia tests were submitted to the State did not meet high risk criteria, which is a waste of resources.	Decrease the percentage of inappropriate Chlamydia screening to 18%.	Issue Chlamydia screening guidelines for providers. Periodically monitor our screening performance, and counsel providers as indicated.	IPP data on the percentage of tests not meeting IPP screening criteria.

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**Goal 2: Assure ongoing access to a broad range of effective family planning methods and related preventive health services.**

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Over half of all pregnancies are unintended.	Increase the percentage of clients who receive Plan B for future from 12.2% to 20%	Inform providers that it is an expectation that all women of reproductive age will be offered Plan B for future use. Develop a history question on the EPIC family planning smart set that asks the client about emergency contraceptive interest. Periodically monitor our EC for future use data. Focus on emergency contraception at the annual family planning educational update.	Ahlers data on EC for future use.

Objectives checklist:

- Does the objective relate to the goal and needs assessment findings?
- Is the objective clear in terms of what, how, when and where the situation will be changed?
- Are the targets measurable?
- Is the objective feasible within the stated time frame and appropriately limited in scope?

**Progress on Goals/Activities for FY 09 (Currently in Progress)**

<b>Goal/Objective</b>	<b>Progress on Activities</b>
Serve adolescent reproductive needs.	We saw 3,479 adolescents, which was 41% of our total Family Planning clients. This is the largest percentage of adolescents served in the State. We averted an estimated 753 adolescent pregnancies.
Capture all appropriate Medicaid and FPEP reimbursements for contraceptive visits and supplies.	We have developed systems to reduce our FPEP and Medicaid billing denials and have improved our FPEP supply billing process.

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**ATTACHMENT 3  
WIC NUTRITION EDUCATION PLAN FORM FY 2009-2010**

**County/Agency:** Multnomah County Health Department

**Person Completing Form:** Joy McNeal, Mary Kay Diloreto, Elizabeth Berol Rinder

**Date:** 4/10/2009

**Phone Number:** 503 988-3663 x 24647

**Email Address:** [joy.k.mcneal@co.multnomah.or.us](mailto:joy.k.mcneal@co.multnomah.or.us)

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

**Year 3 Objective:** During planning period, staff will be able to work with participants to select the food package that is the most appropriate for their individual needs.

**Activity 1:** Staff will complete the appropriate sections of the new Food Package Assignment Module by December 31, 2009.

**Resources:** Food Package Assignment Module to be released summer 2009.

**Implementation Plan and Timeline:** At the Statewide meeting in June the TWIST special users may attend the break out session offered. All staff will be allowed time to complete Food Package Assignment Module at their clinic site. All staff will have completed the module by December 31, 2009.

**Activity 2:** Staff will receive training in the basics of interpreting infant feeding cues in order to better support participants with infant feeding, breastfeeding education and to provide anticipatory guidance when implementing the new WIC food packages by December 31, 2009.

**Resources:** Sessions on Infant Feeding Cues at the WIC Statewide Meeting June 22-23, 2009.

**Implementation Plan and Timeline:** All CPA staff, including RD's, will be required to attend the session provided at the statewide meeting.

**Activity 3:** Each local agency will review and revise as necessary their nutrition education lesson plans and written education materials to assure consistency with the Key Nutrition Messages and changes with the new WIC food packages by August 1, 2009.

**Example:** Pregnant women will no longer be able to routinely purchase whole milk with their WIC FIs. If the nutrition education materials your agency uses indicates all pregnant women should drink whole milk, those materials would need to be revised.

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**Implementation Plan and Timeline:** The Fresh Choices class will be presented at Statewide Meeting and implemented by August 1, 2009. All classes offered after August 1, 2009 will be reviewed and revised before being implemented to ensure consistency with new food packages and key nutrition messages.

**Activity 4:** Identify your agency training supervisor(s) and projected staff in service training dates and topics for FY 2009-2010. Complete and return Attachment A by May 1, 2009.

**Implementation Plan and Timeline:** Agency training supervisors are Mary Kay Diloreto, Joy McNeal and Elizabeth Berol Rinder, Heidi Suess, RD, Suzanne Bruels, RD.

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

**Year 3 Objective:** During planning, each agency will develop a plan for incorporating participant centered services in their daily clinic activities.

**Activity 1:** Each agency will identify the core components of participant centered services that are being consistently utilized by staff and which components need further developing by October 31, 2009.

**Examples:** Use state provided resources such as the Counseling Observation Guide to identify participant centered skills staff are using on a regular basis. Use state provided resources such as self evaluation activities done during Oregon WIC Listens onsite visits to identify skills staff are working on and want to improve on.

**Implementation Plan and Timeline:** We will email Sara Sloan to identify participant centered skills that staff are using and those skills that need to be improved. There will be a total of four site visits by the State which should give us information on needed training.

**Activity 2:** Each agency will implement at least two strategies to promote growth of staff's ability to continue to provide participant centered services by December 31, 2009.

**Examples:** Using the information from Goal 2, Activity 1, schedule quarterly staff meeting time to review Oregon WIC Listens Continuing Education activities related to participant centered skills staff identified they want to improve on. Schedule time for peer to peer observations to focus on enhancing participant centered services.

**Implementation Plan and Timeline:**

Strategy #1: In order to create opportunity for peer to peer observations, CPA and clerical staff will go to Washington County to observe for half a day each.

Strategy #2: Include Oregon WIC Listens continuing education at forums and clerical meetings.

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

**Year 3 Objective:** During planning period, each agency will develop a plan to consistently promote the Key Nutrition Messages related to Fresh Choices thereby supporting the foundation for health and nutrition of all WIC families.

- *Breastfeeding is a gift of love.*
- *Focus on fruit.*
- *Vary your veggies.*
- *Make half your grains whole.*
- *Serve low-fat milk to adults and children over the age of 2.*

**Activity 1:** Each agency will implement strategies for promoting the positive changes with Fresh Choices with community partners by October 31, 2009.

**Example:** Determine which partners in your community are the highest priority to contact such as medical providers, food pantries, breastfeeding coalitions, and/or Head Start programs. Provide a staff in-service, written materials or presentation to those partners regarding Fresh Choices.

**Implementation Plan and Timeline:** Head Start, Field team and County medical providers will be contacted and schedule a time to share Fresh Choices information by October 31, 2009.

**Activity 2:** Each agency will collaborate with the state WIC Research Analysts for Fresh Choices evaluation by April 30, 2010.

**Example:** Your agency is a cooperative partner in a state led evaluation of Fresh Choices such as hosting focus groups or administering questionnaires with participants.

**Implementation Plan and Timeline:** Multnomah County Health Department WIC will cooperate in state led evaluation of Fresh Choices. Timeline is unknown at this time.

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

**Year 3 Objective:** During planning period, each agency will develop a plan to promote breastfeeding exclusivity and duration thereby supporting the foundation for health and nutrition of all WIC families.

**Activity 1:** Using state provided resources, each agency will assess their breastfeeding promotion and support activities to identify strengths and weaknesses and identify possible strategies for improving their support for breastfeeding exclusivity and duration by December 31, 2009.

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**Resources:** State provided Oregon WIC Breastfeeding Study data, the breastfeeding promotion assessment tool and technical assistance for using the tool. Technical assistance will be provided as needed from the agency's assigned nutrition consultant and/or the State Breastfeeding Coordinator.

**Implementation Plan and Timeline:** Using state provided resources and technical assistance we will assess the strengths and weaknesses of our breastfeeding promotion and support activities and then identify possible strategies for improvement by December 31, 2009.

**Activity 2:** Each agency will implement at least one identified strategy from Goal 4, Activity 1 in their agency by April 30, 2010.

**Implementation Plan and Timeline:** Implement one identified strategy from Goal 4, Activity 1 by April 30, 2010.

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**ATTACHMENT 4  
MULTNOMAH COUNTY WIC STAFF TRAINING PLAN  
7/1/2009 THROUGH 6/30/2010**

Agency: Multnomah County

Training Supervisor(s) and Credentials: Joy McNeal, MS RD, Mary Kay DiLoreto, MS RD, Elizabeth Berol-Rinder, MS RD.

**Staff Development Planned** - Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), program goals or identified staff needs, quarterly in-services and or continuing education planned for existing staff. In-services and program objective for quarterly in-services for July 1, 2009 – June 30, 2010. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	August, 2009	<ol style="list-style-type: none"> <li>1. OWLS</li> <li>2. Present new group education class incorporating key nutrition messages.</li> <li>3. Food package issues</li> </ol>	<ol style="list-style-type: none"> <li>1. Practice OWLS</li> <li>2. Learn/review a participant centered education way to teach a class.</li> <li>3. Review food package assignment issues</li> </ol>
2	October, 2009	<ol style="list-style-type: none"> <li>1. OWLS</li> <li>2. Review strengths &amp; weaknesses of BF program. Disc possible strategies</li> <li>3. Present new class.</li> </ol>	<ol style="list-style-type: none"> <li>1. Enc using OWLS</li> <li>2. To find strategy to improve bf outcomes of clients and staff.</li> <li>3. Staff can teach class in pce way.</li> </ol>
3	January 2010	<ol style="list-style-type: none"> <li>1. OWLS</li> <li>2. Implement breastfeeding strategy.</li> <li>3. Present new class</li> </ol>	<ol style="list-style-type: none"> <li>1. Discuss problems -OWLS.</li> <li>2. To begin implementation of bf strategy by everyone.</li> <li>3. Staff can teach in pce way</li> </ol>
4	May 2010	<ol style="list-style-type: none"> <li>1. OWLS</li> <li>2. Present new class to staff.</li> <li>3. Review &amp; evaluate bf strategy.</li> </ol>	<ol style="list-style-type: none"> <li>1. OWLS/ classes</li> <li>2. To train staff in presenting this participant centered class.</li> <li>3. Make adjustment to strategy as needed.</li> </ol>

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**ATTACHMENT 5  
EVALUATION OF WIC NUTRITION EDUCATION PLAN  
FY 2008-2009**

WIC Agency: Multnomah County Health Department

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

Date: 04/22/2009 Phone: 503-988-3663 x24354

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2009

Please use the outcome evaluation criteria to assess the activities your agencies did for each Year Two 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 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 WIC Program's Key Nutrition Messages and identify which ones they need additional training on.*

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

- How were the WIC Program's Key Nutrition Messages shared with staff in your agency?
- Which messages did staff identify as needing additional training on?
- How did this training occur?

Response: On August 28, 2008 Multnomah County WIC had an all staff meeting at which the key nutrition messages were identified. Each staff person identified messages for which they would like additional training in order to use most effectively. The key messages most frequently identified by staff are:

- Pregnant Women: Oral health and physical activity needs.
- Breastfeeding: Early signs of hunger
- Postpartum women: physical activity and folic acid needs
- Infants: care for baby's gums
- Children: Influence of parental role modeling and physical activity.
- General: Family meal time.

The original 2008-2009 plan did not require training on key nutrition messages that staff identified for further training. We have completed training on key messages as related to Fresh Choices using state provided in-service, key nutrition messages, and food package information.

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*Activity 2: By March 31, 2009, staff will review the 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*
- *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 change.*

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

- How did staff review the proposed food package changes?
- Which nutrition education messages were identified that need to be modified?
- How will these messages be shared with participants?

Response:

- January 29, 2009: We provided in-service training on overall food package changes and completed the low fat dairy training for certifiers and dietitians using the state provided in-service materials, to train on food package changes, key nutrition messages, and how to present to clients.
- February 11, 2009: We provided the same in service for office assistants.
- March 11, 2009 We completed the required in-service on infant and postpartum women food package changes for all Multnomah County WIC staff. All food package modifications in these categories were discussed along with the reason behind them. Covered topics included: how the food package changes and how we talk about them to promote breastfeeding as the standard. Language was introduced to help staff discuss changes with clients in a positive and encouraging manner. Use of state provided in-service materials to train on food package changes, key nutrition messages, and how to share with clients.
- In April, the required Medical Documentation in-service will be completed at each clinic site.

*Activity 3: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2008-2009.*

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?

Response: Completed staff in-services as identified. See details below.

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

**Goal 1, Activity 3**

**WIC Staff Training Plan – 7/1/2008 through 6/30/2009**

Agency: Multnomah County Health Department

Training Supervisor(s) and Credentials: Mary Kay DiLoreto, MS, RD; Elizabeth Berol-Rinder, MPH, RD, Joy McNeal, MS, RD, Heidi Suess, RD

**Staff Development Planned**

Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2008 – June 30, 2009. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective	Core CPA Competency
1	August 28, 2008	<ul style="list-style-type: none"> <li>Oregon Key Nutrition Messages</li> <li>Wellness Program Resources</li> </ul>	<p>Staff will review Oregon Key Nutrition Messages and identify which ones for which they need additional training</p> <p>Identify healthy eating and physical activity strategies we can implement.</p>	Objectives met per Goal 1, Activity 1 (see above). CPA competencies: PPM 660: Principles of Life Cycle Nutrition
2	October, 2008	<ul style="list-style-type: none"> <li>Diet Assessment</li> <li>Nutrition Risk Module Follow-up</li> </ul>	<ul style="list-style-type: none"> <li>Review the diet assessment steps from the Dietary Risk Module and identify which ones for which they need additional training.</li> <li>Staff will evaluate how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.</li> <li>Review Nutrition Risk errors that came up during chart audits</li> <li>Vitamin D update</li> </ul>	<p>Core Competency: PPM 660: Nutrition Assessment Process</p> <p>Communication</p> <p>Nutrition Assessment Process</p> <p>Lifecycle Nutrition</p>
3	January 29, 2009	<ul style="list-style-type: none"> <li>Food Package Changes</li> </ul>	<ul style="list-style-type: none"> <li>Reviewed the overall food package changes, rationale for changes, and</li> </ul>	CPA competencies: PPM 660: Principles of Life Cycle Nutrition and

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Quarter	Month	In-Service Topic	In-Service Objective	Core CPA Competency
		<ul style="list-style-type: none"> <li>Diet Assessment Module Follow-up</li> </ul>	timeline and training plan <ul style="list-style-type: none"> <li>Provided state provided low fat milk in-service training</li> <li>Trained CPA staff to teach <i>Get the Skinny on Milk</i></li> </ul>	WIC Program Overview
4	March 11, 2009	<ul style="list-style-type: none"> <li>Infant Feeding/Post Partum In-Service</li> </ul>	<ul style="list-style-type: none"> <li>Used state provided in-service materials</li> </ul>	Life cycle nutrition Appropriate food package selections
5	May 21, 2009	<ul style="list-style-type: none"> <li>Whole grain staff in-service</li> <li>Training on teaching Whole grain class</li> <li>Nutrition Risk module update and referral guide</li> <li>OWLS practice</li> </ul>	<ul style="list-style-type: none"> <li>Used state provided in-service materials</li> <li>Use state whole grain class outline.</li> <li>Reinforce referral guidelines</li> <li>Use state provided CE activity</li> </ul>	Appropriate food package selection  Nutrition Assessment Process Critical Thinking  Communication Critical Thinking

**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 assessment steps from the Dietary Risk Module and identify which ones they need additional training on.*

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

- Did staff review the assessment steps from the Dietary Risk Module?
- Which steps did staff identify as needing additional training on?
- How did this training occur?

Response: On October 23, 2008 and January 29, 2009, the Nutrition Supervisors reviewed the diet assessment steps from the Dietary Risk Module and also covered the findings from the State Review. Staff did not identify any training needed for specific diet assessment steps. See Activity 2 for training needs identified.

*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.*

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

- How have staff modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules?

Response: We completed state-provided assessment at the October 23 in-service. Staff identified the following key topics for more training: listening more, asking more open-ended questions, and providing more participant-centered education. The State provided Oregon WIC Listens training met staff identified training needs.

Many of the team had not had the original Oregon WIC Listens training until after November 30, 2009. However, at the October 2008 Nutrition Forum, the East County Staff and those who had had the training, lead a discussion and answered questions about the how to proceed with the Oregon WIC Listens campaign/counseling style. From the discussion a lot of concern was voiced and training opportunities identified. With the implementation of Oregon WIC Listens, each site and at county wide training we continue to discuss and build participant centered education skills.

**Goal 3: Improve the health outcomes of WIC clients and WIC 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 objective and strategy to facilitate healthy behavior change for WIC staff.*

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

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

Response:

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.

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We wanted to explore our county Wellness Program resources and identify ways we could promote exercise and healthy eating among staff. We chose this objective because our county has a wellness program, and we would like to access its resources more fully. We wanted to continue to encourage healthy eating and physical activity among staff in a new way.

**Implementation and Evaluation**

At the August and March All Staff training, we used our County Wellness Letter to do a group participation activities. Topics included: Ways to improve heart health, identifying plastics to use/avoid in food containers, reducing skin cancer risk, healthy snack choices.

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

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

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

Response:

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.

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

Promoting physical activity has been an on-going campaign to promote health and reduce obesity. We continued promoting physical activity by providing the following classes throughout the county on a monthly or quarterly basis: Moms on the Move, Indoor Activities, Exercise in Autumn, Exercise in Winter, Active Kids, Family Fitness, Turn off the TV, Kids Club. Classes promoting physical activity were offered in English, Spanish, and Russian.

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

Year 2 Objective: During plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one objective and implement at least on strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Activity 1: Identify your objective and strategy to improve breastfeeding outcomes for WIC clients.

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

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

Response:

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.

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 and Evaluation:

1. Offer World Breastfeeding week celebration in August 2008. Each clinic site sponsored a World Breastfeeding Week celebration in English and Spanish.
2. We did 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}. Accomplishments to date include: Developing a key messages framework to be used across program lines for promoting a supporting breastfeeding, drafting new breastfeeding policy to be implemented across county programs, pursuing the Breastfeeding Friendly designation at McCoy and N. Portland Health Center Buildings, and drafting some training materials.

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**ATTACHMENT 6**

**MULTNOMAH COUNTY IMMUNIZATIONS PROGRESS REPORT AND PLAN 2008 – 2011**

**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.

<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>1</sup></b>	<b>Progress Notes<sup>2</sup></b>
<p>A. 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>Integrated Clinical Services (ICS) run monthly lists, by clinic, off EPIC of children that are missing their 4<sup>th</sup> DTaP. Each clinic follows up with clients in their own way but, primarily, clients are called once and if no response, a reminder notice is sent asking them to come in. Children re-appear on the list from month/month if they do not come in for the immunizations.</p> <p>Five trainings were held in the spring and summer for 58 staff on the basics of forecasting and the other principles of immunizations (i.e. reducing missed opportunities, utilizing minimal spacing, etc.) In addition, a training was held at the semi-annual Skills Fair on adult immunizations to 12 participants.</p> <p>The January 2009 UTD immunization rate shows a slight decrease of 3% from January 2008. However, the Missed Shot rate decreased by 1.3% and the Late Start rate decreased by 1.4% in this same time period.</p> <p>Met with WIC staff to review screening and referral process for immunizations. Many WIC clients have</p>	<p>There appears to be some discrepancy in the data received from OHS and that generated in EPIC regarding the 4<sup>th</sup> DTaP. The data from OHS indicates a much higher rate of children who are missing the 4<sup>th</sup> DTaP than EPIC. Possibly, this could be related to the fact that OHS takes into account any child who has ever received at least one shot at a clinic, then they are forever that clinic's client, even if they have moved on to a different medical home. EPIC only takes into account children that are established clients and whom are seen regularly. More discussion on this topic and the different systems and methodologies used may be warranted in the future.</p> <p>Integrated Clinical Services have continued to roll out the Building Better Care (BBC) model. As such, they have decentralized their services and, rather than have one vaccine lead at each clinic, more staff at every clinic are tasked with giving both childhood and adult immunizations. Therefore, during this transition period, we will</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 met 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>1</sup></b>	<b>Progress Notes<sup>2</sup></b>
			established medical homes where they receive immunizations.	have to continue focusing on training on immunization-specific information. Thus, we don't project there will be an increase in immunization rates of more than 1% in the foreseeable future.
B. Develop and implement a sustainable vaccine education training program over three years.	<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>Throughout the year, 11 trainings were conducted on vaccine coding and use of IRIS/ALERT databases to 102 staff members.</p> <p>To prepare for the new Tdap school requirement, MCHD collaborated with MESD and OHS to provide two large trainings for 125 MESD and MCHD staff. Evaluations from the trainings indicated they were an overall success with staff understanding the new school law requirement more thoroughly.</p> <p>The CIP worked with schools of nursing to provide opportunities during fall, winter and spring clinics for over 50 student nurses to learn more about immunizations, forecasting and vaccine storage/handling as well as giving injections.</p> <p>An online program was developed to train staff on understanding the screening questions on the Vaccine Administration Record (VAR) in order to mitigate giving vaccines to clients for which contraindications exist.</p>	<p>We learned that attendance at trainings is more assured when the clinics request them rather than have them prescheduled.</p> <p>The coding data quality remains about the same as last year as a result of the trainings based on monthly data quality checks. The transition from Locally Owned hepatitis and PPV23 vaccine to State-supplied, in particular, has been somewhat difficult. That, along with periodic additions to 317 guidelines make coding an ongoing challenge.</p> <p>As more Medical Assistants are working in the Primary Care clinics and need more background in immunization basics, two online trainings on immunizations have been posted in the web-based MCHD Immunization Manual. These include the CDC's self-study program and the Vaccine Healthcare Centers Network's Immune Readiness Course. These are in addition to the recently-developed VAR training. Additional online trainings will be added to the website as suitable ones become identified and available.</p>

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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>3</sup></b>	<b>Progress Notes<sup>4</sup></b>
A. Increase the up-to-date rate (4:3:1:3:3:1) for 2-year-olds seen at MCHD by 1% a year over the next two years.	Continue providing training for clinical staff on: <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> Reassess current plan and modify as needed.	Improved immunization rates by 1% and decreased missed shot rate based on quarterly assessment reports from OHS.  Evaluate by: <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>	To be completed for the FY 2010 report	To be completed for the FY 2010 report
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 planning and implementation of online training. Pilot the training with a particular clinic staff.	Evaluated 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.  Evaluate by surveying participants in pilot of online training program.	To be completed for the FY 2010 Report	To be completed for the FY 2010 Report

<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 met 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>5</sup></b>	<b>Progress Notes<sup>6</sup></b>
A. Increase the up-to-date rate (4:3:1:3:3:1) for 2-year-olds seen at MCHD by 1% a year over the next two years.	Continue providing training for clinical staff on: - reducing missed opportunities by giving every shot due at each visit - deferring shots only when medically appropriate - utilizing minimal spacing  Reassess current plan and modify as needed.	Improved immunization rates by 1% and decreased missed shot rate based on quarterly assessment reports from OHS.  Evaluate by: - number and dates of trainings - number of staff trained - results of pre/post tests or by qualitative method	To be completed for the FY 2011 Report	To be completed for the FY 2011 Report
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.	Evaluated 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>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 met these objectives in the future.

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**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>7</sup></b>	<b>Progress Notes<sup>8</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.	Conducted training for 15 State certifier staff on new school law requirements. Other groups trained include: - two groups of 15 providers in the Childcare Provider Network; - three trainings to 34 staff at 29 different agencies/schools.  Evaluations indicate trainings were very useful and informative. Submissions from these staff were generally very complete and required minimal, if any, follow-up.	State certifier staff are becoming more aware of the importance of discussing with prospective certified childcare providers, the requirement to report immunization status on children in their care each year.

**Activity 2**

<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>9</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.	Conducted training for staff from all delegate agencies on importance of appropriate vaccine management services. Notification of when temperature excursions occur has increased as awareness has increased.	Re-certification of all delegate agencies is due in FY 09-10 which also provides training opportunities and double checks for compliance.

<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 met 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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