

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

**FY 2011/2012  
ANNUAL PLAN**



*HEALTHY PEOPLE IN HEALTHY COMMUNITIES*



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

May 1, 2011

# MULTNOMAH COUNTY HEALTH DEPARTMENT

## LOCAL PUBLIC HEALTH AUTHORITY ANNUAL PLAN

### FY 2011/2012

#### I. EXECUTIVE SUMMARY

*The Conference of Local Health Officials (CLOH)<sup>1</sup> and Oregon State Public Health Division (OPHD) approves the process, scope and due date for all annual plans submitted by local public health authorities in Oregon, including the plan for Multnomah County. These annual plans assure compliance with State requirements for protecting public health, and provides access to funding to support the functions of local public health authorities. Recently announced process changes associated with the development and submission of annual plans after this year, combined with the State's financial uncertainty are key factors that impact the scope and content of all local FY 2011/2012 annual plans.*

The FY 2011/2012 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.

Key recommendations of this plan will continue to provide a variety of programs, services, and initiatives to ensure that 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.
- Programs to address racial and ethnic health disparities and chronic health conditions.
- Emergency preparedness planning, exercises and coordination.
- Health services to support the provision of medical and dental care throughout the county.

Section III of this document contains specific *Action Plans* that identify the (1) significance of specific public health functions, (2) the goals to be achieved, (3) the activities to be implemented, and (4) the processes that will be used to evaluate the outcomes associated with each action plan. The *Attachments* section contains program-specific information, including communicable disease guidelines, family planning program activities for FY 2012, the WIC program plan for FY 2012, the WIC Program evaluation for FY 2011, and the Immunization Program Progress Report for FY 2008 through FY 2011.

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<sup>1</sup> The Conference of Local Health Officials (CLOH) was established to represent the interests of local public health authorities and health officers in decision making, accountability and leadership of Oregon's public health system. CLOH works in partnership with the Public Health Division of the Oregon Department of Human Services to establish the elements of local annual plans, to approve a funding formula to ensure the equitable distribution of resources by the Oregon Public Health Division, and to assure compliance with Oregon Revised Statutes 431.330 through 431.385 and Oregon Administrative Rule 333-014-0040 through 333-014-0070.

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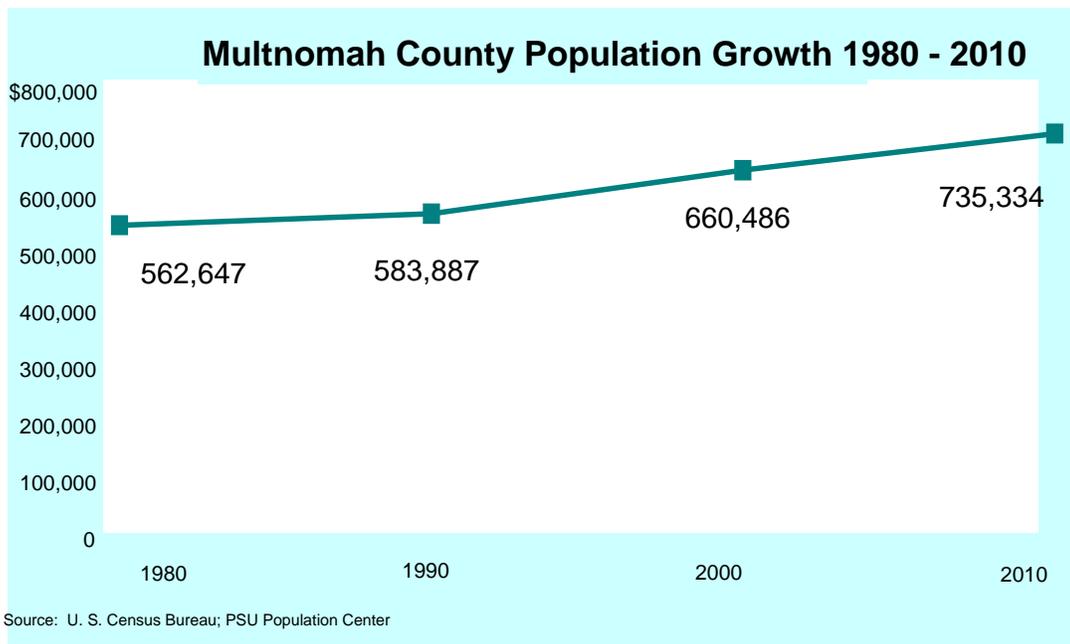
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## II. ASSESSMENT

### A. Multnomah County, Oregon

**A.1 Background and 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, race/ethnicity, income, poverty, and the percentage of individuals without health care coverage are discussed below.

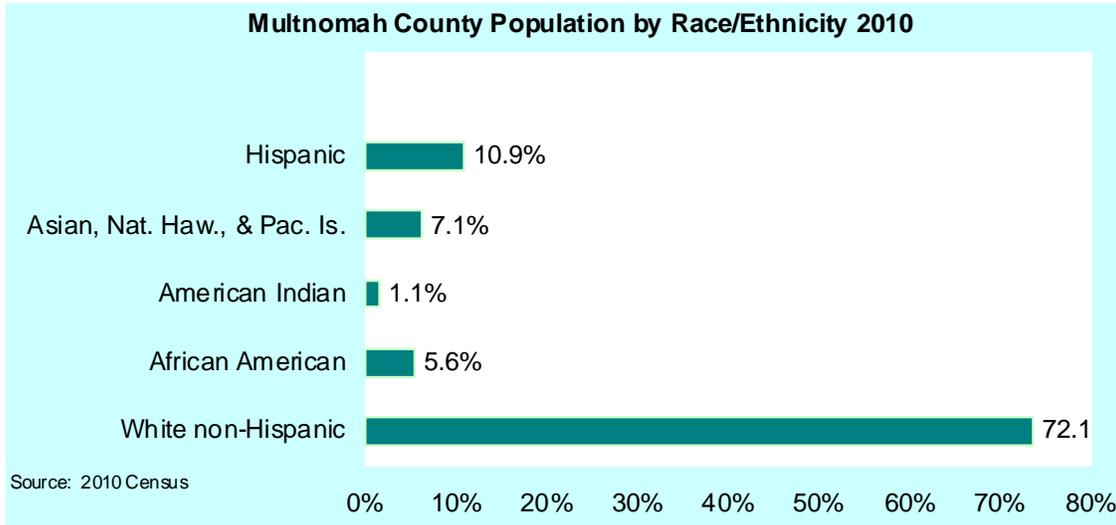
**Population:** Multnomah County continues to be the most populous county in Oregon with 19% of the State's population. Multnomah County grew to 735,334 residents in the year 2010. The population increase from 2000 to 2010 was 11.3%, or 74,848 persons. Over the same period, the population of Oregon increased 11.9%.



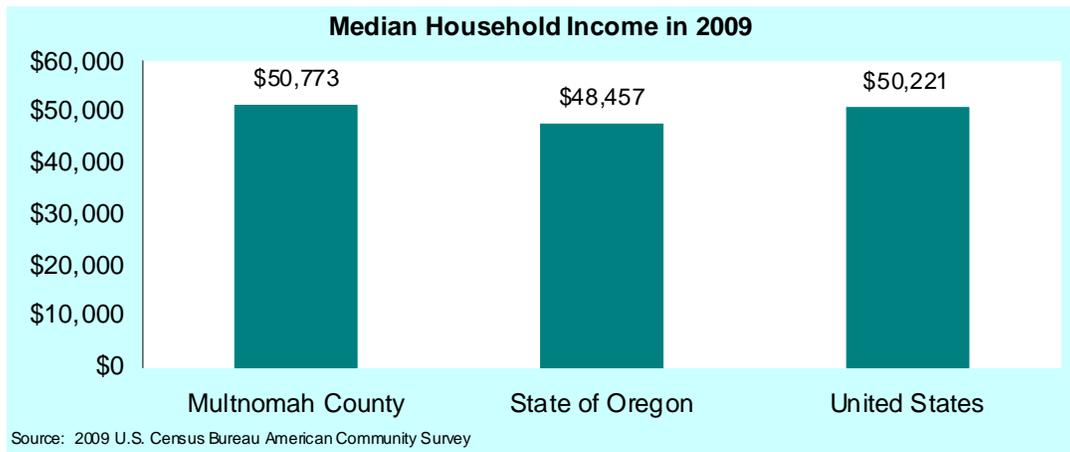
The racial and ethnic mix of the population varies in Multnomah County. North Portland is the most racially diverse geographic area, while the west side of the Willamette River is the least diverse. In 2010, Multnomah County was comprised of 72.1% White non-Hispanics; 5.6% African Americans; 1.1% American Indians; 7.1% Asians, Native Hawaiians and Other Pacific Islanders; and 10.9% Hispanics.

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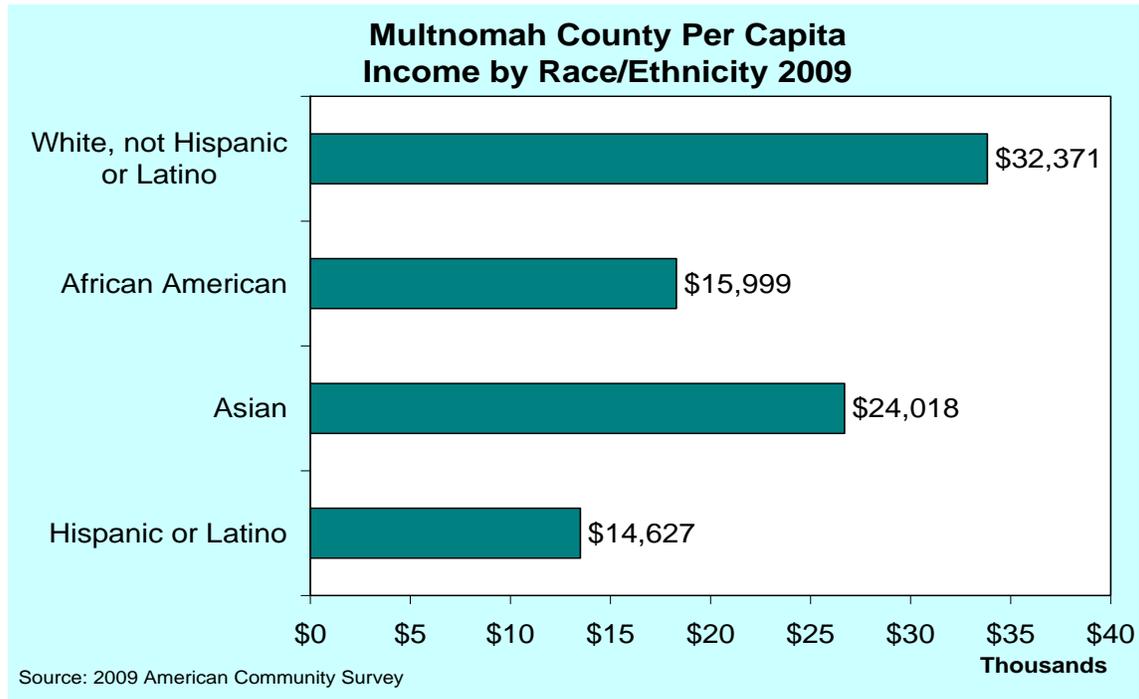


**Income and Poverty:** Median household income for Multnomah County was \$50,773 in 2009. This is slightly higher than the median income for Oregon and the United States.



Approximately 15.1% of Multnomah County residents had incomes below the Federal Poverty Level according to the 2009 Census Bureau's American Community Survey. This is higher than Oregon and the United States (both with 14.3% of their respective populations below the Federal Poverty Level in 2009). The per capita income in Multnomah County was \$32,371 for White non-Hispanic, \$24,018 for Asians, and \$15,999 for African Americans. Hispanic per capita income was \$14,627.

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**Health Care Coverage:** According to the 2009 American Community Survey, 16.8% of Multnomah County residents were without some type of health care coverage in 2009. This is higher than the national rate of 15.1%, and slightly less than the Oregon rate of 17.0%.

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

**B.1 Racial and Ethnic Health Disparities in Multnomah County:** For purposes of this Annual Plan, the assessment of Multnomah County’s health uses health disparities as a key indicator of health across various racial and ethnic groups in the county. The information provided below is based on the Health Department’s most recent “Report Card on Racial and Ethnic Health Disparities” (April 2011). The report can be found at the following Web address:  
[http://web.multco.us/sites/default/files/health/documents/health\\_disparities\\_reportcard3\\_2011.pdf](http://web.multco.us/sites/default/files/health/documents/health_disparities_reportcard3_2011.pdf)

Health disparities are differences in the health status of different segments within the community that are caused by a variety of factors such as poverty, educational status, environmental conditions, individual health behavior choices, and access to health care. Health inequities are the subset of these disparities that are systemic, avoidable, and unjust such as the differences that arise from unequal opportunities for a healthy life based on racial and ethnic bias. It is widely recognized that eliminating health disparities of all types must be a priority in order to achieve optimal health, not only for disadvantaged groups, but also for the community as a whole.

In Multnomah County, the trend regarding the elimination of racial and ethnic health disparities shows improvement. Of the 17 health indicators examined for all populations of color, 29 health disparities were identified for the 1990-1994 period. By the 2000-2004 time period, six

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disparities had been eliminated (three of which were in the African American community) and 14 disparities had been reduced.

While most of the health indicators show either a decrease in rates or stable rates over time for all population groups, one exception to this trend is the diabetes mortality rate for the White non-Hispanic group. This rate has shown a statistically significant increase since the 1994-98 time period. In addition, many of the gaps in rates between non-Whites and their White non-Hispanic counterparts have lessened since 2001-05. However, the gaps themselves have persisted.

The recently released CDC Health Disparities and Inequalities Report—United States, 2011 cautions that health disparities between socioeconomic groups, race/ethnic groups and others will likely continue as a result of the economic downturn. The same populations that experience poorer health outcomes may experience the negative effects of the recession, and this may compound the problem of health disparities. In the face of these challenges it is imperative that the community continue its efforts to address social inequities from all perspectives including access to safety-net services and to targeted programs.

As discussed below, health disparities were calculated for four minority populations groups (African Americans, Asians, Native Americans, and Hispanics) using White non-Hispanics as a comparison group.

**African Americans:** African Americans experienced the largest number of health disparities among racial/ethnic groups in Multnomah County. 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. Data for African Americans show statistically significant disparities for 10 health indicators, for example:

- Health indicators in the African American community requiring intervention include:
  - Teen births.
  - Diabetes mortality.
  - Gonorrhea incidence.
  - Chlamydia incidence.
  - Homicide.
- Health indicators in the African American community with improvement needed include:
  - No first trimester prenatal care.
  - Low birth weight babies.
  - Infant mortality.
  - Stroke mortality.
  - Prostate cancer mortality.
- Relative to their White non-Hispanic counterparts African Americans:
  - Continued to have significantly higher proportions of mothers who did not receive prenatal care in their first trimester.
  - Experienced an infant mortality rate that was almost twice as high.

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- Had a higher stroke mortality rate.
- Had a diabetes mortality rate more than twice as high.
- Were almost two times as likely to die of prostate cancer though there was no disparity in other forms of cancer.
- Experienced incidence of gonorrhea that was 5.7 times greater.
- Experienced incidence of chlamydia that was 4.9 times greater.
- Experienced a homicide mortality rate that was more than 6 times greater.

**Asian/Pacific Islanders:** Asian/Pacific Islanders experienced fewer health disparities than other racial/ethnic groups in Multnomah County. Data shows statistically significant disparities for three of the 18 health indicators for Asian/Pacific Islanders. Unlike disparities in the African American community, there are no health indicators classified as “Requires Intervention.”

- Health indicators with improvement needed include:
  - No first trimester prenatal care.
  - Low birth weight babies.
  - Homicide.
- Relative to their White non-Hispanic counterparts Asian/Pacific Islanders:
  - Continued to have significantly higher proportions of mothers who did not receive prenatal care in their first trimester.
  - Continued to have higher proportions of low birth weight births.
  - Were less likely to die of lung, breast and prostate cancers.
  - Had a lower incidence of gonorrhea.
  - Experienced a higher homicide rate.

**Native Americans:** There are statistically significant disparities in 4 of the 18 health indicators for Native Americans. However, for five of the other health indicators, Native Americans did not have a sufficient number of events to calculate a rate.

- Health indicators requiring intervention include:
  - Teen births.
  - HIV disease mortality.
  - Chlamydia incidence.
- Health indicator needing improvement include:
  - No first trimester prenatal care.
- Relative to their White non-Hispanic counterparts, Native Americans:
  - Had higher rates of teen births.
  - Continued to have significantly higher proportions of mothers who did not receive prenatal care in their first trimester.

**Hispanics:** There are statistically significant disparities in 4 of the 18 health indicators for Hispanics. For example:

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- Health indicators requiring intervention include:
  - No first trimester prenatal care.
  - Teen births.
  - Chlamydia incidence.
- Health indicator needing improvement includes:
  - Gonorrhea incidence.
- Relative to their White non-Hispanic counterparts Hispanics:
  - Continued to have significantly higher proportions of mothers who did not receive prenatal care in their first trimester.
  - Were least likely of all racial/ethnic groups to initiate prenatal care in the first trimester of pregnancy.
  - Were least likely to receive prenatal care in the first trimester, with a rate of approximately 1 in 3 Hispanic women not receiving care in this period. Despite being least likely to get prenatal care in the first trimester, Hispanic women had a comparable rate of low birth weight babies.
  - Experienced a teen birth rate that was 6.7 times higher.
  - Had a Chlamydia incidence that was 2.3 times higher.

Overall, the Health Department has made reducing health inequities a priority, and works to build community capacity to help reduce disparities. Several of the Health Department's programs have collaborated with community partners and other agencies to shape policies and programs that reduce health disparities. Examples include efforts to address sexual and reproductive health disparities, unequal access to healthy food and active transportation choices, and disparities in maternal and child health outcomes. The Department's programs also provide services directly to clients that are designed to address specific health disparities. These include culturally-specific early childhood services in the African American community to address high infant mortality rates, chronic disease screening in specific populations, and community-based testing for sexually transmitted diseases.

Providing health services is only one of the factors contributing to health outcomes. Factors such as education, income, housing, social class, and racism are also contributing factors. Public health alone cannot eliminate health inequities and their root causes; it will require broad efforts at the policy, community, family and individual levels to eliminate health inequities. More broadly, the Health Department is leading efforts to raise awareness of health equity through its Health Equity Initiative which aims to institutionalize a culture of routine and systematic consideration of health equity in program planning activities.

## **C. Adequacy of Public Health Services**

- C.1 Mission of the Health Department:** 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 and achieves this mission through its various public health services, programs and initiatives.

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**C.2 Public Health Services of the Health Department:** The Multnomah County Health Department complies with Oregon Revised Statute 431.416 to provide basic public health services. Public health services are performed in a manner consistent with the *Minimum Standards for Local Health Departments* adopted by the Conference of Local Health Officials. As required under 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 Oregon Administrative Rule 333-014-0050 (2), this section of the Annual Plan for Multnomah County provides a brief description of the programs and services that enable the Health Department to comply with the State's minimum public health requirements, which includes programs to address:

- Control of Reportable Communicable Disease
- Parent and Child Health Services
- Environmental Health Services
- Health Statistics
- Information and Referral Services
- Public Health and Regional Health Systems Emergency Preparedness

These State 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 Control of Reportable Communicable Diseases action plans (A-1 through A-4) beginning on page 18 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 staff utilize a variety of methods to

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contribute to the health and wellbeing of individuals, families, and communities. Programs include Early Childhood Services; Babies First! (services for first time parents and for high risk prenatal cases); Family Planning Services; Family Planning through School-Based Health Centers; Women, Infants and Children; and the Community Immunization Program. See Parent and Child Health action plans (B1 through B6) beginning on page 25 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 Environmental Health Services action plan beginning on page 34 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 Health Statistics action plan beginning on page 37 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 its appointment and information center known as Primary Care Appointments and Referrals. The work unit 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 Information and Referral action plan beginning on page 38 in Section III.
- Public Health 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.,

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hospitals, first responders, elected officials, emergency management, etc.). See Public Health Emergency Preparedness action plan beginning on page 39 in Section III.

**C.3 Core Functions of Local Public Health Services to Meet Needs (OAR 333-014-0050 (3)):** The Multnomah County Health Department provides a variety of different core functions to respond to meet local needs of the community. These functions include the following categories:

- General Public Health Functions
- Specific Public Health Initiatives
- Clinical Health Services and 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., 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, strategic partnerships, etc.). Additional details about the structure, roles and operations of the Department's organizational structure are presented beginning on page 46.
- 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. The Department's Health Officer serves county jurisdictions in the surrounding Portland metropolitan region in addition to Multnomah County, including Clackamas and Washington Counties.
- 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, Environmental Health, Vital Records, Early Childhood Services, and Information and Referral).
- Health and Social Justice (Health Assessment, Program Evaluation, & Grant Development): The Department provides critical support for public health programs and services through the work of three units organized under the Office of Health and Social Justice, including Health Assessment and Evaluation, Program Design and Evaluation Services, and Grant Development.
- Emergency Medical Services: The Department's Emergency Medical Services Program regulates, coordinates, and provides medical supervision and quality assurance for all pre-

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hospital emergency care provided by an exclusive ambulance contractor and fire departments throughout the county.

#### **Specific Public Health Initiatives and Services**

- **Public Health Accreditation:** During FY 2010/2011 the Health Department initiated a process to achieve public health accreditation. Such a process seeks to achieve standards that advance quality and performance within the Health Department in alignment with those across the nation. By meeting standards for accreditation, it is expected that services provided to meet the vision and mission of the organization will be met in a manner that includes improved quality of service, value and accountability. Steps in the process include:
  - A community health assessment, in which a health department assesses the health status and the public health needs in the community. The community health assessment phase is nearly completed as of May 1, 2011.
  - A community health improvement plan, which maps out exactly what the Health Department is doing as it works with partners to improve the health status of its jurisdiction.
  - A strategic plan, which sets forth a Health Department's priorities and how it plans to accomplish its strategic goals.
- **State/Local Health Reform:** The Oregon Health Authority was created by the 2009 Oregon Legislature to bring many of the State's health-related programs into a single agency to maximize purchasing power, containing costs, improve quality and increase access to health care to improve the health of Oregonians (see <http://www.oregon.gov/OHA/docs/hlth-sys-trans/2011>). The Multnomah County Health Department is participating in this effort through the following state and local workgroups to address key issues or concerns:
  - Health Systems Transformation Team
  - Multco Health Care Reform Workgroup
  - Multco Health Care Reform Steering Committee
  - Oregon Education Investment Team
  - Oregon Community Foundation Prevention and Wellness Health Demonstration Project
  - Tri-County Regional Health Authority
  - Multnomah County Health department Coordinated Care Organization Task Force
  - Multnomah, Clackamas, Washington Counties Collaborative Hospital Community Health Needs Assessments
- **Initiative to Eliminate Racial and Ethnic Health Disparities:** 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.
- **Community Capacitation Center:** The Community Capacitation Center assists constituents both internally and externally to develop their capacity to promote health across all levels of

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the socio-ecological model. The Community Capacitation Center also addresses the social determinants of health by actively promoting healthy behaviors among those that are particularly vulnerable to disease and including (but not limited to) racial and ethnic minority 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. The Health Department continues to implement this program with the support of a \$7.5 million ARRA grant through the CDC that was awarded in 2010.
- Climate Change: The Health Department's Environmental Health Services Program is a key stakeholder in the implementation of the local Climate Change Action Plan; and is an appointed member of the National Association of City and County Health Officials' Climate Change Workgroup to develop best practices to address climate change by local health departments nationwide. The Environmental Health Services Program is also a member of a two-year state climate change project that is piloting public health vulnerability adaptation assessment tools at local health departments through a Centers for Disease Control capacity building grant.
- 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 24,000 people suffer from a tobacco-related illnesses.
- Adolescent Health Promotion Program: The Adolescent Health Promotion Program is designed to support academic success of middle school and high school-aged children by breaking down barriers to staying in school. This program gives students the skills and confidence to delay sexual involvement and reduces participation in other risky activities. The program also promotes healthy behaviors, and access to information and resources. More than 11,000 school aged students and their parents in five school districts (49 schools total) in Multnomah County are served by the program each year. The Adolescent Health Promotion Program is also 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

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media influences, correcting misconceptions about teen sexuality, and building assertiveness skills to refuse pressure.

- Hospital Preparedness Program: This program provides planning and collaboration with the goal of preparing northwest Oregon healthcare providers to respond to a large-scale health emergency, and the program serves as the regional lead agency for the Federal-funded Health Preparedness Program.
- Health Reserve Corps: The Health Reserve Corps is responsible for developing and maintaining a voluntary unit of local licensed health care professionals who will be called upon to assist in response to a large-scale emergency.
- Building Better Care Initiative: The Health Department's Integrated Clinical Services unit continues to implement the Building Better Care Initiative 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. The initiative improves timely access to appropriate level of care, cost-effectiveness, continuity and coordination, and quality and safety.

#### **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 (65,818 residents were served in 2010). The Department's seven health centers are certified through the Joint Commission, and they are recognized by the Federal Bureau of Primary Health Care. In 2010, the Department opened the Rockwood Community Health Center. 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 provided by the Health Department. The Council addresses issues of budget/finance, policy, scope of services, long range planning, diversity, and other issues associated with providing care to the underserved.
- 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. Of the 4,000 people living with HIV, 3,740 or 85% of PLWH are gay or bisexual men; and poverty is a common identifier among the population (70% are under 100% of the Federal poverty level). The Health Department's HIV care system consists of the HIV Health

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Services Center, and the HIV Care Services Program to meet the health care needs of this population.

- 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. 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 24,400 inmates and provided 76,000 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 2011/2012, the Department will continue to operate 12 fully equipped school-based medical clinics. Eleven 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 Dental Services Program provided services to 23,791 clients at the Department's five clinics in 2010). 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. In 2010, a new dental clinic was opened as a part of the new Rockwood Community Health Center. Seventy percent of dental services are provided to patients with incomes below 100% of the federal poverty level. In addition, the Department's School and Community Oral Health Program provided screening and sealant services to over 6,500 children and delivered oral health education to over 23,000 children and adults in 2010.
- Clinical Services Infrastructure Group: The Clinical Services Infrastructure Group includes Pharmacy, Laboratory, X-ray, Language Services, 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.

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**III. FY 2011/2012 Action Plans**

Action plans include 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 18, also see Attachment 1 on page 64 for the Guidelines for BT/CD Assurances)
  - A.2 Hepatitis C Surveillance Program (page 19)
  - A.3 TB Prevention and Control (page 21)
  - A.4 STD, HIV and HCV Programs (page 23)
  
- B. Parent and Child Health Services [OAR 333-014-055 (2)(b)]
  - B.1 Early Childhood Services (page 25)
  - B.2 Babies First! (page 27)
  - B.3 Family Planning Services (page 28, see also Attachment 2 on page 68 for the FY 2011/2012 Family Planning Program Annual Plan)
  - B.4 Family Planning through School-Based Health (page 29)
  - B.5 Women, Infants & Children (page 31, also see Attachment 3 on page 70 for the FY 2011/2012 WIC Nutrition Education Plan; Attachment 4 on page 75 for the FY 2011/2012 WIC Staff Training Plan; and Attachment 5 on page 76 for the Evaluation of the WIC Nutrition Education Plan of FY 2010/2011)
  - B.6 Community Immunization Program (page 32, also see Attachment 6 on page 82 for the Immunization Progress Report for FY 2008 – FY 2011)<sup>2</sup>
  
- C. Environmental Health [OAR 333-014-0050 (2)(e)]
  - C.1 Environmental Health Services (page 34)
  
- D. Health Statistics [OAR 333-014-0050 (2)(c)]
  - D.1 Health Records Program (page 37)
  
- E. Information and Referral [OAR 333-014-0050 (2)(d)]
  - E.1 Information and Referral Program (page 38)
  
- F. Public Health Emergency Preparedness [OAR 333-014-0050 (3)(b)]
  - F.1 Emergency Preparedness Program (page 39)
  
- G. Other Issues
  - G.1 Healthy Communities Program (page 42)

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<sup>2</sup> This attachment only includes the annual progress report for the Health Department's Immunization Program (for activities that will be completed from July 1, 2008 through June 30, 2011). The local Immunization Plan will be submitted after the impacts of State budget cuts are announced (after the adoption of Oregon's 2011 – 2013 biennial budget).

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G.2 Tobacco Prevention Program (page 44)

**A. EPIDEMIOLOGY AND CONTROL OF COMMUNICABLE DISEASES**

**A.1 Communicable Disease Prevention and Control Program**

- a. **Current condition or problem:** Epidemiology and the control of communicable diseases is addressed through the Communicable Disease Prevention and Control Program (a program of the Communicable Disease Services unit). 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. 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 public health emergency preparedness, this program works closely with community partners to improve the Department's capacity to respond to all possible communicable disease threats. In order to improve the reporting, investigation, and implementation of control measures for all communicable diseases occurring in Multnomah County, CD program staff work collaboratively with Multnomah County's Health Officer, Emergency Preparedness Program, Emergency Medical Services Medical Director, and Environmental Health Program staff, as well as with other local health departments, the State Acute and Communicable Disease Program, and public safety responders in the Portland metropolitan region. Program staff have been trained in the Incident Command System, and routinely participate in multi-agency preparedness response exercises. The Health Department's CD staff are trained to provide surge capacity for large outbreaks or bioterrorism events (e.g., CD staff played a vital role in the local response to the 2009 H1N1 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 exists to ensure that appropriate staff respond on evenings, weekends and holidays.

- b. **Goal:** The goal of the Communicable Disease Prevention and Control Program is to identify, prevent and control epidemics and emerging communicable diseases and environmentally-related threats.
- c. **Activities:** Target population includes all residents of Multnomah County. Significant activities include:
- Providing epidemiologic investigations to report, monitor and control communicable disease and other health hazards.
  - Providing diagnostic and consultative communicable disease services.

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- 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, schools, day cares, nursing homes, and work places 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 the Communicable Disease Prevention and Control Program is evaluated by monitoring the timeframe that cases are reported to the Oregon State Public Health Division. According to the Health Division, 90% of all communicable disease cases must be reported within the standards set forth in OAR Chapter 333, Divisions 1, 12, 24, and 43. Monthly meetings are held with staff in order to review case reports and conduct quality assurance activities. The Clinical Nursing Supervisor reviews cases before case reports are submitted to the State. Client satisfaction surveys are reviewed and findings are distributed. 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 State Public Health Division, and others as requested.

## A.2 Hepatitis C Surveillance Program

- a. **Current condition or problem:** The Control of Communicable Diseases is addressed through the Department's Communicable Disease Services Program (a unit within the Community Health Services Division). Within this program is the Hepatitis C Surveillance Project funded by the Center for Disease Control and Prevention in Atlanta (CDC). The purpose of the project is to perform expanded epidemiologic surveillance of persons in Multnomah County diagnosed with the hepatitis C virus (HCV). Hepatitis C is a reportable condition in Oregon. The Communicable Disease Program maintains a database for individuals with HCV, which enables the Health Department to conduct surveillance on chronic HCV cases to:

1. Better understand the burden of disease and transmission patterns; and
2. Provide education on preventive behaviors to reduce the morbidity and mortality of HCV.

Data collection has recently migrated to the state's ORPHEUS system. Staffing to support the Hepatitis C Surveillance Project includes a research evaluator/analyst with support from a data manager, a program supervisor, and other staff assigned to assure that all data is entered into the database in a timely manner. Program staff are continuing

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efforts to improve coordination with the Health Department's HCV outreach and testing program.

b. **Goal:** Identify descriptive and clinical characteristics and disease burden of persons with confirmed chronic HCV infection reported in Multnomah County.

c. **Activities:** Major activities include:

- Capture data reported by medical laboratories and health care providers.
- Mail health education information and community resource guide to confirmed HCV infected individuals reported by laboratories and providers.
- Interview all individuals aged 18-30 who are newly reported to the HCV CD program with a confirmed or presumptive HCV diagnosis for a more thorough review of their socioeconomic characteristics, medical pathologies, risk factors for HCV and the need for medical and preventive services.
- Analyze surveillance data for demographic and socioeconomic characteristics of persons with HCV infection, estimate the burden of the disease among persons newly-identified with HCV, estimate of the extent of ongoing transmission in Multnomah County, and assess the stage of illness and need for personal preventive services (e.g., history of vaccination against hepatitis A and B).
- Collect and be informed about current research concerning best practices on prevention of hepatitis C infection.
- Disseminate data and findings to health care providers and outreach prevention programs.

A one-page form is faxed to the individual's health care provider requesting information on the patient's race/ethnicity, primary language, reasons for HCV testing, risk factors for HCV infection, referrals made to specialists, vaccination and treatment history. Faxes are not sent to facilities where a provider cannot be identified, such as blood/plasma donation centers and correction facilities.

d. **Evaluation:** The effectiveness of the Hepatitis C Surveillance Program is measured by the following outcomes:

- 90% of hepatitis C cases are reported to Oregon Department of Human Services, Public Health Division within specified time frame.
- 70% of providers responding to the fax surveillance.
- 50% of patients 18-30 years of age participate in an interview.

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 Public Health Division, to funding partners, and upon request.

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**A.3 Tuberculosis Prevention and Treatment (FY 2012 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 2009, Oregon’s TB case rate was 2.3 cases per 100,000 population, compared to Multnomah County’s rate of 4.1 cases per 100,000 population. In 2010, the case rate continued upward, to 4.9 cases per 100,000 population, following behind the curve of increases seen elsewhere on the west coast. TB Program staff must continue aggressive efforts in order to turn back current trends in TB case rates.

<b>Tuberculosis Rates By Year, 2005-2009 Multnomah County and Oregon<sup>a,b</sup></b>		
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
2009	4.1	2.3
2010	4.9	N/A
<sup>a</sup> Reported data from Oregon DHS TB Program. <sup>b</sup> Rate per 100,000 population.		

In the coming year, CD staff will be looking at restructuring our program in order to maintain our aggressive TB prevention activities in the face of several years of reduced state, federal, and local funding for program activities. The effort will move toward becoming part of an integrated Communicable Disease Services Program, while saving on operating costs. Another activity this year is to investigate revenue options for non-mandated services that have experienced deep funding cuts in recent years.

- 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. Also included are short term and long term goals. 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 working to decrease TB cases to a rate that is at or below the Center for Disease Control’s 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.

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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.
- **Smoking Cessation Risk Counseling:** The TB Program plans to develop new methods to address the increased health risk of patients with TB who smoke. The risks include increased progression from latent TB infection to pulmonary disease, the increased probability of disease relapse after TB treatment, and an increase in TB case fatality. Smoking damages the body's ability to fight off infections and increases the severity of TB. The methods the TB Program plans to develop and implement will include a patient information brochure, staff training on how to counsel a patient on TB and smoking risk factors, and revising TB medical history and interviewing forms.

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

- 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

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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 2009 is unavailable until 2011 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.

#### **A.4 STD, HIV and HCV Program (FY 2012 Action Plan)**

- a. **Current Condition or Problem:** STDs, HIV, and Hepatitis C (HCV) account for over 80% of all reportable diseases in the county. Approximately 4,850 people have been diagnosed with HIV in Multnomah County since 1981; over 2,100 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 \$385,000 over a lifetime, and each prevented HCV case saves an estimated \$100,000. Economic studies have determined a \$4,000-\$12,000 syringe exchange program expenditure per HIV infection prevented.

STDs continue to disproportionately affect racial, ethnic and sexual minority communities. In 2009, rates of gonorrhea in Multnomah County were eight times higher among Blacks/African Americans; rates of HIV and Chlamydia were also disproportionately high in the Black/African American community. The majority of new syphilis cases (88%) in 2009 and HIV cases (81%) in 2008 were among gay, bisexual, and other men who have sex with men (MSM). The STD disparities impact African American and Latino adolescents at the highest rates, along with other sexual health disparities such as unplanned teen pregnancy rates.

For the nearly 4,000 people living with HIV/AIDS (PLWH/A) residing in the six-county area served by this program's Ryan White grant, rates of poverty, homelessness, substance abuse, and mental illness are much higher when compared to the general population. Among PLWH/A, 53% have a mental illness (over two times the rate found in the general population) and 25% of these clients have both a mental illness and substance abuse diagnosis. Among the clients served by this program, 68% have incomes below 100% FPL, 18% lack permanent housing, and 13% lack health insurance. The primary care, early intervention, medical case management and supportive services

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funded by this program reduce disparities and result in lower mortality, fewer disease complications, and reduced HIV transmission.

**b. Goals:** The goals of the STD, HIV and HCV Program are:

- To prevent the transmission of STDs, HIV, and hepatitis C.
- To reduce the impact of disease acquisition and drug-related harm on individuals and communities by promoting policies that positively impact physical and sexual health; implementing effective, population-based public health interventions; prioritizing populations that experience the greatest disparities; and engaging in collaborative community partnerships and planning.

**c. Activities:** This program prioritizes efforts for high risk populations at highest risk, including adolescents (as well as their teachers and parents), men who have sex with men, injection drug users, persons living with HIV/AIDS and their partners in Multnomah County; and low income PLWH/A in the additional five counties served by the Ryan White-funded Care Services Program. Services include:

- Community testing is provided in field-based settings such as county jails, alcohol and drug treatment programs, local bars, and community events. Health promotion counseling and referrals to services are standard parts of service provision. Test results are available in person and by phone.
- Syringe exchange and disposal is part of a comprehensive public health approach to prevent the spread of disease among injection drug users, their families, and the larger community. This evidence-based program provides clients with new, sterile, syringes in exchange for used ones, along with safer sex supplies and referrals to medical and social services. Services incorporate harm reduction education, counseling based on readiness for change, and motivational interviewing skills to help guide people to improve individual and community health.
- STD prevention includes testing and treatment for bacterial and viral STDs, behavioral counseling, surveillance of reportable STDs and HIV, partner notification and referral for partners of those diagnosed with HIV and STDs.
- Community collaborations with partnering organizations increase community awareness and education, address social determinants of sexual health disparities, and increase community capacity to advocate for policy and structural change to support sexual health.
- Adolescent and young adult sexual health promotion is prioritized for the African American and Latino communities. Direct school-based education and training for teachers focuses on healthy relationship and decision making skills, comprehensive sexual health education that is developmentally appropriate. Programs are being developed which educate and support parents of middle and high school students to increase their connectedness, increase their confidence and skills to discuss and support sexual health for their youth, and increase youth resiliency, and reduce teen pregnancy. Social media campaigns, peer-educator group interventions, and community discussions reduce stigma, increase awareness, and share health service

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- information. For younger men who have sex with men, a CDC evidenced-based intervention, “MPOWERment,” is an initiative focusing on HIV prevention.
- Primary care services in the six county service area funded and coordinated by the STD,HIV,HCV Program 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 people living with HIV 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 (there has been an 86% decrease in mortality between 1994 and 2004), and prevention and care services are better targeted. Staff performed ~5,500 HIV tests and ~12,000 STD clinical encounters in FY 2010.

Data collection, data analysis and program evaluation of subcontracting service providers for HIV care activities includes tracking service provision and performance outcomes at the client-level. Information is reported to the Board of County Commissioners, Oregon State Public Health Division, community partners and to others as requested.

## **B. PARENT AND CHILD HEALTH SERVICES [OAR 333-014-055 (2)(B)]**

### **B.1 Early Childhood Services (FY 2012 Action Plan)**

- a. **Current condition or problem:** The Early Childhood Services Program provides services to reduce the health disparities in the population of childbearing women and their families. Priority groups include pregnant and parenting teens, first time parents , African American women, premature infants and children with special health care needs. Staff include community health nurses, community health workers, office assistants, program supervisors and managers, and program-specific staff. Staff are located in

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geographically designated offices and assigned to project-specific teams (e.g., Nurse Family Partnership, Healthy Start and Healthy Birth Initiative) or staff may be out-stationed as members of multidisciplinary, interagency teams in various community-based locations such as Early Head Start and Healthy Start programs. Approximately 9,500 clients received over 30,000 visits through Early Childhood Services in the past year.

- b. **Goal:** The goal of the Early Childhood Services Program is to improve the overall health of women, infants, children, and families at risk through preventive health programs and services that build on the strengths of specific populations and community partnerships.
- c. **Activities:** Key activities for all Early Childhood Services include:
- Health screening and assessment of pregnant women and children including developmental screening, and screening for domestic violence and depression.
  - Health promotion and health education in the home and group settings.
  - Referrals and community linkages.
  - Parenting education and support.
  - Breast feeding education and support.

Services are delivered through several programs, including:

- Healthy Start is a State funded program that provides screening, assessment, referral and home visit services to first time parents in Multnomah County. Health Department staff visit local hospitals to assess first time parents using the New Baby Questionnaire. Families eligible for home visit services are referred to contracted community agencies, and Health Department ECS staff for ongoing services of case management and parenting education. The Immigrant and Refugee Community Organization, Impact NW and Insights Teen Parent Program are contracted to provide Healthy Start home visiting services.
  - Healthy Birth Initiative addresses disparities in perinatal health among African American women residing in specific zip codes, which reflect high infant mortality rates. 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 is an evidenced-based best practice model of home visiting designed for first time parents. The Health Department is an official NFP site contracted by the National NFP Service Office. Services are provided to first time pregnant women beginning early in their pregnancy until children reach age two. Nurse home-visitors follow the NFP curriculum and guidelines.
- d. **Evaluation:** The effectiveness of the Early Childhood Services Program will be measured by the following types of outputs/outcomes:

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- Percent of mothers who are breastfeeding at six months postpartum.
- Percent Healthy Start enrolled parents reporting reading to/with their child at least three times per week.
- Percent of infants 0-12 months with developmental screening.
- Percent of clients completing survey who are satisfied/very satisfied with services.

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 State Public Health Division, and to others upon request.

**B.2 Babies First! (FY 2012 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! serves children from birth to age five 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, developmental and emotional health of high risk infants and children ages birth to five years.
- c. **Activities:** The target population includes high-risk infants and children from birth to five years of age in Multnomah County. Key activities include:
  - Outreach
  - Home visits
  - Health assessment and developmental screening
  - Monitoring neurological development and growth
  - 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 Health Department's Early Childhood Services program.

- d. **Evaluation:** Data is collected per ORCHIDS Babies First! requirements and is electronically transferred to the Oregon State Public Health Division. Referral sources and risk criteria are reviewed annually. The key performance measure is the percent of

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infants birth to 12 months who had developmental screening. Data collection, data analysis, and program evaluation occur at the program, division and department levels. Information is reported to the Board of County Commissioners, Oregon State Public Health Division, and to others as requested.

**B.3 Family Planning Services (FY 2012 Action Plan)**

- a. **Current condition or problem:** During FY 2010, family planning services were provided to 3,145 adolescents, accounting for 412% of the total family planning clients; an estimated 604 adolescent pregnancies were averted; 7,379 total clients were seen, a 6% decrease from the 2009 number. Family planning services are offered through Primary Care Clinics, School-Based Health Centers, and other community based sites.
- b. **Goal:** 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 each client's family planning goals and their need for individualized contraceptive education.
    - Offer a comprehensive array of contraceptive methods.
    - Provide individualized contraceptive management.
    - Pregnancy options counseling.
    - 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 school based 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 nurses in Early Childhood Services.
    - Comprehensive contraceptive counseling by nurses in Early Childhood Services.
    - Pregnancy options counseling by nurses in Early Childhood Services.

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- Family Planning Program administrative activities:
  - Monitor contraceptive access.
  - Bill all appropriate Medicaid and FPEP contraceptive visits and supplies.

**d. Evaluation:** Data collection and analysis occurs at the program level. Information is reported to the Board of County Commissioners, the Oregon State Public Health Division, and others as requested. Family planning outcome measures include the following:

- Number of clients receiving Family Planning services.
- Number of adolescent clients receiving Family Planning services.
- Percent of 15 to 20-year-old female family planning clients who do not get pregnant during the year.
- Number of clients treated for an STI.
- Number of clients evaluated for an abnormal pap smear.
- Capturing all appropriate Medicaid and FPEP reimbursements for contraceptive visits and supplies.

#### **B.4 Family Planning through School-Based Health (FY 2012 Action Plan)**

**a. Current condition or problem:** Since 1986, the Department's 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 vision of the Health Department's SBHC 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. During FY 2010 these clinics served 5,445 students (a total of 17,709 visits).

The Health Department operates 11 school-based health clinics and one school-linked health clinic. SBHC are located in close proximity to children in order to create continuous, trusting relationships to encourage high-risk youth to seek help and make better life choices, including staying in school and avoiding at-risk behaviors. 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. Through this program, the Health Department maintains strong working relations with Portland Public Schools (nine clinics are located in this school district); the Parkrose School District (one clinic); and the David Douglas School District (one clinic). The school-linked health clinic is located in the East County Service Center, and its aim is to provide better access to health care for students in the Centennial School District and the Gresham-Barlow School District. All 12 SBHCs are connected to the Department Community Health Center Program in terms of administration, funding, quality of care, Electronic Health Records, and continuity of services.

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Staffing at SBHCs include a Nurse Practitioner, Registered Nurse, Medical Assistant, 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 one site is open during summer and school breaks.

b. **Goals:** In partnership with schools, families, healthcare providers, and community agencies, the Multnomah County School-Based Health Center Program strives to:

- 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 SBHC program ensures 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 by 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.

In addition to providing services to school-aged children, key activities to support the SBHC program that were implemented during FY 2010/2011, and some activities that will continue into FY 2011/2012, include the following:

- Lincoln Park Elementary SBHC has been moved to the David Douglas High School, expanding services to five days per week (up from three) and including students K-12 (the former site served only students K-8). This improvement was made possible by Federal funding through the American Recovery and Reinvestment Act.
- Portland Public Schools completed a high school re-design that resulted in a decision to close Marshall High School. The SBHC located at Marshall High School will be moved to Franklin High School during September 2011.
- Federal Health Care Reform legislation includes funding for SBHCs, including capital improvements and new SBHC sites. The Health Department has submitted grant requests for capital improvement projects at five SBHC, and another application

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- was submitted to open a new SBHC at Centennial High School (if Federal funding is awarded to the Health Department through the Health Resources and Service Administration).
- Partnering with Multnomah Youth Commission to start youth advisory boards at all high school SBHC locations. This activity was successful during FY 2010-2011, and ongoing funding for this project is being sought to support this effort into FY 2011-2012.

**d. Evaluation:** Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon State Public Health Division, 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 that 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.

#### **B.5 WIC (FY 2012 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, Gateway, and Northeast), and during FY 2010 the Health Department provided WIC services to 32,000 individuals (83,842 encounters). WIC is a prevention-oriented, behavioral change 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; frequent growth monitoring, nutrition education and referrals to health care and other family support services (see Attachment 3 beginning on page 70 to review the annual evaluation of the Multnomah County WIC Nutrition Education Plan for FY 2010).

This Action Plan represents a summary of the FY 2011-2012 WIC Nutrition Education Plan for Multnomah County (the WIC Nutrition Education Plan will be submitted to the Oregon Department of Human Services/Health Services WIC Coordinator on or before May 1, 2011, and this plan is appended as Attachment 4 beginning on page 75).

**b. Goals:** The goals of the County's WIC Program are to provide quality nutrition education and access to other health and family support services appropriate to the clients' needs; to improve the health outcomes through nutritional behavioral change; and to improve breastfeeding initiation and duration rates of WIC clients.

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- c. **Activities:** - Key activities of the WIC Program for this fiscal year are specified in the WIC Nutrition Plan and WIC Training Plan presented in the attachments of this document (see Attachment 3 on page 70 and Attachment 4 on page 75).
- d. **Evaluation:** The effectiveness of WIC is measured by the average number of participants on the program, improved birth outcomes, improved immunization rates, less prevalence of childhood anemia and improved nutrient intake. 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 2012 Action Plan)**

- a. **Current condition or problem:** The Community Immunization Program promotes and provides immunizations throughout Multnomah County for uninsured and underinsured children. The program oversees the immunization school law process for vaccine requirements for children and students in day care facilities; preschools; Head Start programs; and for those attending private, alternative and public schools. Blood lead level screening for children six years of age and younger, adult immunization services, and antibody testing are also provided. There is difficulty in reaching primary and middle school populations who may not have completed their immunizations, and there are a growing number of families who seek the State's religious exemption to avoid having their children vaccinated. 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 Health Department's walk-in clinic serves as a safety net for those children who cannot access immunization services elsewhere.

In the coming year the Health Department's Community Immunization Program will be proactively looking at restructuring the program in order to maintain our immunization program activities in the face of expected state and federal budget cuts. The program will continue to work toward becoming part of a truly integrated Communicable Disease Services Program, combining with Tuberculosis Prevention and the Communicable Disease programs to reduce operating costs, and will be investigating revenue options for non-mandated services.

- 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

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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 for children and students up through 18 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 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 reporting 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 upgrades with MESD and Oregon Health Authority Immunization Program staff to comply with State-established school requirements.
- 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.
- Collaborating with STD/HIV/HCV Prevention Program to offer vaccines to high risk youth seen at STD Clinic and/or community youth-based organizations.
- 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.

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- 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.
- 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 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.
  - Technical assistance on online vaccine ordering and online monthly vaccine reporting.
  - 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.
  - Assisting with training for ICS staff which includes vaccine coding and basics of vaccine forecasting.
  - 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 vaccine storage and handling.

**d. Evaluation:** Performance of the Community Immunization Program is measured by output and outcome measures of the number of immunizations directly provided to keep children in school; number of schools and other facilities assisted with immunization school law requirements; and of facilities assisted, those successful in meeting immunization school law requirements. 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 State Public Health Division, and others upon request. The most recent evaluation for the Community Immunization Program is presented in Attachment 6 of this document beginning on page 82.

### **C.1 Environmental Health Services (FY 2012 Action Plan)**

**a. Current condition or problem:** The Environmental Health Services unit is responsible for assuring safe food and water for the public by regulating selected businesses and accommodations, enforcing State and local environmental health laws and rules conducting surveillance for food, water and vector borne disease, and conducting

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investigations to curtail food, water and vector borne disease outbreaks. Housing inspections are conducted to assure rental housing complies with housing codes. The Healthy Homes, AIR and CAIR programs all work to remediate unhealthy housing conditions and support health care providers with critical information about the living situations of asthmatic children and/or children exposed to lead. The unit certifies County birth and death records (see Vital Statistics below). Environmental Health Services staff work in cooperation with other programs in the Department to achieve and assure healthy people in healthy communities and improve health equity, for example:

- The Communicable Disease Prevention Program to refine procedures for responding to and preventing 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 refine strategies designed to overcome health inequities.
- The Chronic Disease Program to improve obesity through menu labeling, the built environment, and tobacco prevention.
- State and national initiatives on climate change as it impacts the overall health of the population and the environment.
- State initiatives and policy collaborative on air quality, environmental justice and toxic exposure.

**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 but often impacts Oregon residents as well. The following activities are implemented on an ongoing basis:

- Environmental health assessment, planning and policy development.
- 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.
- Inspection and remediation of housing issues, education and training for landlords and tenants, convening of community partners to impact policy change.

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- Community education about environmental health risks and hazards including asthma, housing, poor indoor air quality, lead poisoning, food borne illness, bedbugs, climate change, and vectors.
- Data analysis to identify environmental health trends and future service needs.

Environmental Health will continue to support public policy change that reflects the interface between health and the environment through an environmental justice and health equity lens. The unit will also work to educate and empower diverse communities about environmental health risks, hazards and mitigation to protect public health and reduce health inequities.

- 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 State Public Health Division, and to others upon request.

<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.

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**D. HEALTH STATISTICS**

**D.1 Health Statistics (FY 2012 Action Plan)**

- a. **Current condition or problem:** The purpose of maintaining Vital Records at the government level is to:
- Assure that birth and death certification is complete and accurate.
  - Analyze public health statistics to analyze the status of health in the county.
  - Identify populations at risk for the provision of intervention services.
- b. **Goals:** Short term goals are to assure accurate, timely and confidential certification of birth and death events minimizing the opportunity for 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 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 level to evaluate vital statistics information to identify at-risk populations and assess trends over time. The state Vital Records program has been converted to electronic records. This conversion has resulted in difficulty in acquiring local data. The local 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 staff in Early Childhood Services and Communicable Disease programs.

Key activities related to Health Statistics 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, the Oregon State Public Health Division, and to others as requested.

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

**E.1 Information and Referral Services Program (FY 2011-2012 Action Plan)**

- a. **Current condition or problem:** The Health Department's Health information and referral program (Primary Care Access and Referrals or PCAR) provides information and referrals for individuals seeking access to health services in Multnomah County. During FY 2008-2009, PCAR services were improved to reflect the goals of the Department's Building Better Care Initiative. PCAR uses a telephone-based information and education program serving residents of Multnomah County. The program'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. Staff includes Health Information Specialists who are bilingual in Spanish, Vietnamese, and Russian.
- b. **Goal:** The goal of the Primary Care Access and Referrals Program is to provide information and referral services to the public regarding Health Department services and referrals.
- c. **Activities:** The Information and Referral Program will continue to provide services in FY 2011/2012. PCAR strives to provide access to primary care services for *new* low income, uninsured individuals seeking primary care services, and 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 process that is 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 Program's service sites: East County Health Center, Northeast Health Center and Mid-County Health Center.
  - PCAR continues to be provided from a centralized location, using a new, updated and streamlined database.
- 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.
  - Number of prequalification appointments for financial assistance programming including SCHIP, FPEP, Oregon Health Plan, etc.

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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 State Public Health Division, and to others upon request.

## F. Public Health Emergency Preparedness

### F.1 Emergency Preparedness Program (FY 2012 Action Plan)

a. **Current Condition or Problem:** The basis of the Health Department's emergency preparedness activities are established in the following missions and their supporting authorities:

- Ensure a coordinated and effective emergency medical system through paramedics, medical technicians, and hospitals.
- 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 emergency regardless of its scale. The core of the Emergency Preparedness Program resides in the Directors office, and it is related to many formal and informal organizational structures that advance its goals and objectives including:

- The Tri-County Public Health Officer, Deputy Department Director, Emergency Medical Director, Emergency Preparedness Manager, and NW Oregon Health Preparedness Organization Manager lead and cultivate regional collaborative efforts within public health, emergency medical, and healthcare system communities. Performance is measured in the results of those efforts.
- The Director's Office in consultation with the Department's Leadership Team (DLT) determines Department-wide investment for emergency preparedness activities.
- The Director represents the Department on a Regional Public Health Leadership Group of public health administrators (UASI region) and health officers.
- The Deputy Director represents the Department on the County's Emergency Management Policy Team.
- The Emergency Preparedness Manager performs numerous functions to assure that the Emergency Preparedness program is coordinated and functional. For example, the Emergency Preparedness Manager:
  - Represents the Department on the Regional Public Health Emergency Preparedness Coordinator's Working Group, and the Regional Public Health Leadership Group. The Leadership Group provides strategic and policy direction, and carries forward regional public health emergency preparedness priorities and projects. Performance is measured by progress toward accepted goals, objectives, and deliverables.

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- Is responsible for maintaining an Incident Management Team (IMT) and Response Plans. Performance is measured by the number of Incident Management Team numbers (in April 2011, DLT designated ~300 persons for a restructured IMT, an increase from the previous ~85 persons), training/experience, and evaluation of exercises/operations/plans.
  - Directs and is on an Advisory and Oversight Committee for a National Association of County and City Health Officials Advanced Practice Center (APC). The APC is developing national benchmarks for just-in-time training of surge personnel for large-scale disease investigation and mass prophylaxis operations.
  - Serves on various national project teams such as a NACCHO Project Public Health Ready Committee, a U. S. Department of Human Services Medical/Public Health Resource Typing Committee, and the National Alliance for Radiation Readiness Steering Committee.
  - 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. Multnomah County Health Department serves as Regional Lead Agency for Healthcare Preparedness Region 1 (Clackamas, Clatsop, Columbia, Multnomah, Tillamook and Washington Counties in Oregon). The Department staffs the NW Oregon Health Preparedness Organization (HPO), a regional planning collaboration of hospitals, public health and related healthcare and governmental organizations working to ensure that Northwest Oregon is prepared and responds effectively and efficiently to large-scale health emergencies that have impacts across institutional and jurisdictional lines.
  - The Department's Deputy Director is responsible for the continuity of operations.
- b. Goal:** The goal of the emergency preparedness program is to prevent and mitigate the public health impacts of natural and human-caused disasters.
- c. Activities:** Activities that will be conducted to achieve and maintain this goal include the following:
- Objective 1 - Improve internal capacity to respond to bioterrorism, major communicable disease outbreaks, and environmental health hazards through the following steps:
    - Implement an Emergency Preparedness Quality Improvement Initiative that was approved by the Department Leadership Team in early 2011.
    - Maintain the NW Oregon Health Preparedness Organization and a County Public Health Emergency Response Plan that is aligned with the efforts of regional partners.

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- Maintain an internal staff and an Incident Management Team as a focal point for emergency preparedness training and responsibility.
  - Build emergency management experience and competencies.
  - Develop, maintain and test emergency response protocols/plans.
  - Improve and maintain a notification, alert, decision and activation framework for emergency response, including continued implementation of the Department-wide automated Health Alert Notification system.
  - Improve emergency communications within the Department and externally throughout the community.
  - 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; and develop and test emergency response CD protocols).
- Objective 2 - Assure business continuity during an emergency.
    - Maintain workable business continuity plans and processes.
  - Objective 3 - Assure that diverse communities' needs for emergency preparedness and response are recognized and effectively addressed.
    - Continue to develop and exercise Community Connector concepts in coordination with County Emergency Management.
    - Planning and operational links to community-based organizations including expansion of Push Partner Registry (PPR) partners who agree to distribute medication during emergencies, expanding PPR to include administering vaccine.
  - Objective 4 - Integrate public health response to address 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 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 the program's goal and objectives.

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- 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 NW Oregon Health Preparedness Organization Steering Committee to understand and contribute to the Region 1 strategic priorities and direction.
- Periodic reviews of the adequacy of the Department's Continuity of Operations Plan.

**G. OTHER HEALTH ISSUES**

**G.1 Healthy Communities (FY 2012 Action Plan)**

- a. **Current Condition or Problem:** It is estimated that 75% of healthcare dollars are spent treating chronic diseases, making this the number one driver of healthcare costs. When combined, heart disease, stroke, diabetes, cancers, and chronic lower respiratory diseases account for more than three out of five deaths in Oregon. Nearly 90% of Oregonians have a risk factor for chronic disease such as tobacco smoking, being overweight or obese, consuming too few fruits and vegetables and/or being physically inactive. In Oregon, 69% of adults have a chronic disease or hypertension or high cholesterol. In Multnomah County more than 1/2 of adults are considered overweight or obese. More than 40% of adults are not meeting the Centers for Disease Control's standards for physical activity. Tobacco use 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). In addition, 24,000 people suffer from a tobacco-related illness. The economic burden of tobacco use amounts to \$193 million in medical expenses and \$206 million in lost productivity each year in Multnomah County alone. While chronic conditions impact a large number of people in Multnomah County, some communities are disproportionately impacted by some chronic conditions. For example, African Americans had the highest heart disease, stroke, lung cancer and diabetes mortality rates, and Non-Hispanic Whites and Native Americans had the highest lung cancer rates.
- b. **Goal:** The goal of Multnomah County's Healthy Communities Program is to develop and implement strategies that are grounded in CDC best and promising practices for prevention, early detection and self-management of chronic diseases. The program implements local population based initiatives that reduce the burden of chronic diseases most linked to tobacco use, physical inactivity and poor nutrition. The Healthy Communities Program developed a three-year Community Action Plan (CAP) based on assessment findings, review of best practices and guidance from a multi-disciplinary and diverse Community Health Advisory Council (CHAC). The plan seeks to make sustainable environmental change, such as the adoption of new policies or activities that help to shift social norms in a variety of settings where people live, work, play and learn. Primary objectives of the Healthy Communities Program include:

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- Reduce youth access to tobacco.
- Counter pro-tobacco influences.
- Promote quitting.
- Increase access to evidence-based self management programs.
- Increase availability of healthful foods.
- Decrease availability of unhealthy foods.
- Decrease advertising and promotion of unhealthy foods.
- Promote appropriate population-based early detection screenings.

**c. Activities:** The Healthy Communities Program's work is population-based so that large segments of Multnomah County benefit from increased opportunities for physical activity, healthy food options and chronic disease self-management. A key function of the program is the development and implementation of a Community Action Plan (CAP). The Healthy Communities Program's Work Plan consists of multiple best practice objectives in support of tobacco free lifestyles, easy access to healthy foods, easy and safe access to physical activity, early detection services and chronic disease self-management programs for people living with chronic diseases. Multnomah County Healthy Communities Program's best practice objectives for FY12 include:

- Multnomah County will identify and recruit 2-3 organizations to offer Chronic Disease Self-Management Programs.
- Multnomah County will adopt and implement nutrition guidelines for food and beverages purchased with county funds.
- Multnomah County will recruit and establish voluntary agreements with five retail locations aimed at increasing access to healthy food.

In order to meet these objectives, Healthy Communities 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 disease prevention and specifically to the Healthy Community Program's planned activities. The Healthy Communities Program coordinates its efforts as much as possible with the diverse coalitions, such as the Community Health Action Response Team (CHART), convened as part of the National Association of Chronic Disease Directors ACHIEVE grant to address root causes of chronic diseases disproportionately impacting African Americans, Africans and Blacks in Multnomah County.

**d. Evaluation:** Healthy Communities Program effectiveness is tracked by the Oregon Health Promotion and Chronic Disease Prevention Program (HPCDP) as a part of its statewide evaluation activities. The HPCDP program will embark on a participatory evaluation of county programs and the state programs that support them. Behavior Risk

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Factor Surveillance (BRFSS) and Healthy Teens Survey data will be reviewed yearly to identify nutrition and physical activity trends among adults and youth. Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Multnomah County's activities will also be evaluated as a part of its Communities Putting Prevention to Work Initiative, which includes an extensive qualitative evaluation. As a part of this program, Multnomah County is participating as one of fifteen case study sites by the CDC. Information is reported to the Board of County Commissioners, Oregon State Public Health Division, and others as requested.

## G.2 Tobacco Prevention (FY 2012 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 (38.3% of adults), the LGBTQ community (22.4% of bisexual adults), and African Americans (29.9% of adults) 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 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.
  - Limit the availability and marketing of tobacco products
  - Build capacity for prevention, early detection and self management of tobacco-related chronic diseases.
  - Eliminate disparities in tobacco use and exposure.
- c. **Activities:** The Tobacco Program's work is population-based so that large segments of Multnomah County benefit from smoke-free environments and limited access to the availability and marketing of tobacco products. A key function of the program is the enforcement of applicable smoke-free laws, including the Oregon Indoor Clean Air Act.

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The Tobacco Program's Work Plan consists of multiple best practice objectives in support of tobacco-free multi-unit housing, outdoor venues, and worksites; population-wide health promotion campaigns; as well as working towards the adoption of regulations such as tobacco retailer licensing and marketing restrictions. The work plan also includes activities to link tobacco prevention efforts to chronic disease prevention, early detection, and self-management, activities to promote healthy eating, increase access to healthy food and beverages, promote physical activity, and increase opportunities for active living. The best practice objectives for FY12 include:

- One to two Multnomah County Health Department community health centers will develop systems for referring clients with chronic conditions into Chronic Disease Self-Management Programs.
- Multnomah County will implement a tobacco-free policy at all health department-owned facilities and campuses.
- Multnomah County TPEP will work with two additional worksites to adopt tobacco free worksite policies.
- Multnomah County will receive and respond to all complaints of the Oregon Indoor Clean Air Act throughout the county.
- Multnomah County will conduct all needed site visits, follow-up visits, and subsequent visits per OAR 333-015-0030.
- Multnomah County will respond to all ICAA related calls and requests for assistance from businesses and the public.
- Multnomah County will work with three to five property management entities to adopt new or expanded no-smoking policies.
- Multnomah County will present a policy recommendation to implement tobacco licensure to the appropriate local policy making authority.
- Multnomah County will develop a counter-marketing strategy that builds on its "*It Starts Here*" campaign.

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 disease prevention and specifically to tobacco prevention. The Tobacco Program coordinates its efforts, and receives guidance from diverse coalitions such as the Community Health Action Response Team (CHART), convened as part of the National Association of Chronic Disease Directors ACHIEVE grant to address root causes of chronic diseases disproportionately impacting African Americans, Africans and Blacks in Multnomah County.

- 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

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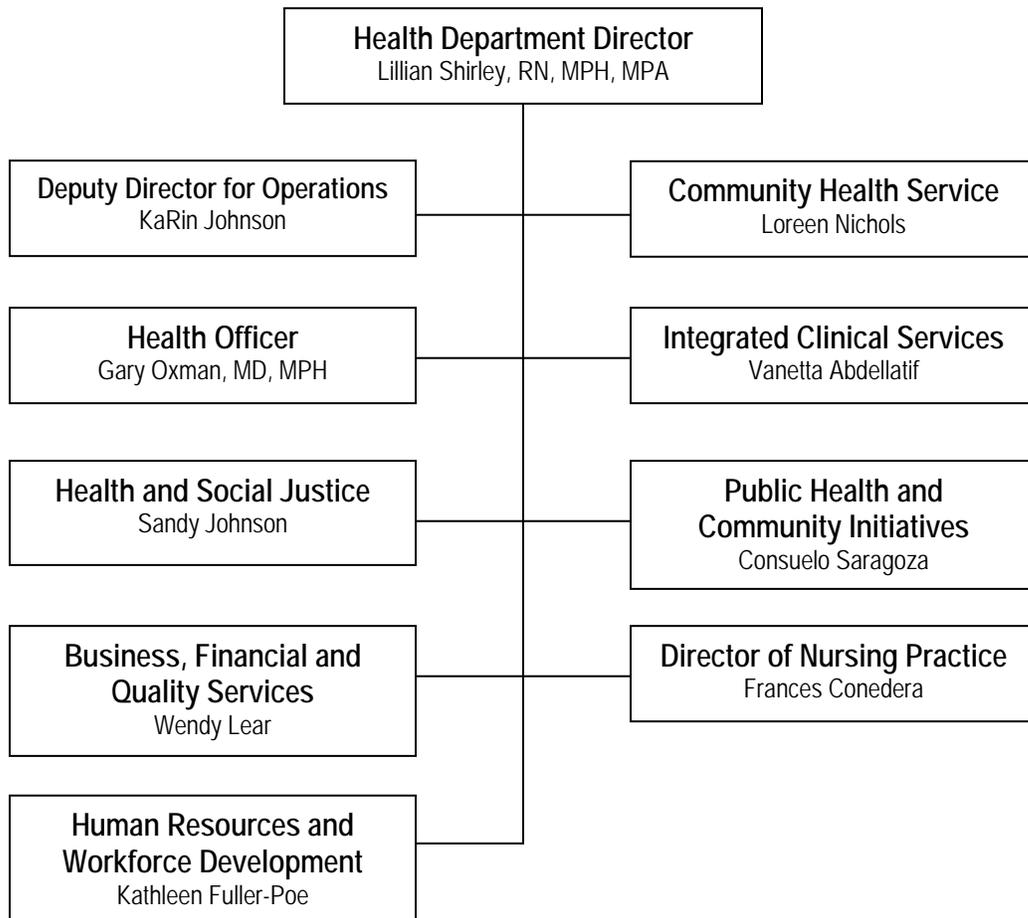
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smoking rates were reduced by 59% between 1996 when the program started and 2006. There was a 46% drop among 11<sup>th</sup> graders during the same time period, as well as a 41% decline in cigarette consumption and a 21% decrease in adult smoking. The Multnomah County Tobacco program routinely evaluates its effectiveness and responsiveness in enforcing Oregon’s Indoor Clean Air Act: The Smokefree workplace law. 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 State Public Health Division, and to others as requested.

#### IV. ADDITIONAL REQUIREMENTS

**Organizational Chart:** The following organizational chart reflects the Health Department’s leadership structure as of April 1, 2011.



**A description of the Department’s organizational structure is presented below.**

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

- Jeff Cogan, County Chair  
Term ends: December 31, 2014  
Phone: (503) 988-3308, fax (503) 988-3093  
E-mail: [mult.chair@multco.us](mailto:mult.chair@multco.us)  
Web: <http://web.multco.us/chair>
- Deborah Kafoury, Commissioner for District 1  
Term ends: December 31, 2012  
Phone: (503) 988-4435, fax (503) 988-5440  
E-mail: [district1@multco.us](mailto:district1@multco.us)  
Web: <http://web.multco.us/ds1>
- Loretta Smith, Commissioner for District 2  
Term ends: December 31, 2014  
Phone: (503) 988-5219, fax (503) 988-5440  
E-mail: [district2@multco.us](mailto:district2@multco.us)  
Web: <http://web.multco.us/ds2>
- Judy Shiprack, Commissioner for District 3  
Term ends: December 31, 2012  
Phone: (503) 988-5217, fax (503) 988-5262  
E-mail: [district3@multco.us](mailto:district3@multco.us)  
Web: <http://web.multco.us/ds3>
- Diane McKeel, Commissioner for District 4  
Term ends: December 31, 2012  
Phone: 503.988-5213, fax (503) 988-5262  
Web: <http://web.multco.us/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 Boulevard). Except for executive sessions, all meetings are open to the public. The Board's mailing address is 501 SE Hawthorne Boulevard, Suite 600, Portland, Oregon 97214-3587.

### **Organizational structure**

With 972 employees, the Health Department employs the largest number of staff among Multnomah County's seven departments. The Health Department organizational structure

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includes the Director's Office,<sup>3</sup> Health Officer, Integrated Clinical Services, and Community Health Services. The Department's organization structure also includes two administrative support units (Business, Financial and Quality Services; and Human Resources and Workforce Development).

- Director's Office: The Department Director is responsible for overseeing the development of policies regarding all aspects of public health and clinical services; presenting the Department's annual budget to the Board of County Commissioners; and for overseeing the implementation of various plans, policies and initiatives regarding public health issues. The Director also oversees the Department Leadership Team, which is comprised of the senior managers representing the nine units within the organizational structure (see organizational chart). The Director's Office includes several essential organizational units of the Health Department, including the Department Operations, Nursing Practice, the Office of Health and Social Justice, and the Office of Public Health and Community Initiatives. Each of these units' includes a senior manager that is represented on the Department Leadership Team.
- Health Officer: The Health Officer is the County's legal authority for local administration of laws that govern public health. The Health Officer also provides consultation on issues of public health importance to elected officials, County staff, the medical community, community agencies, and the public. The role of the Health Officer includes monitoring health and disease occurrences in the community; analyzing health and disease trends; participating in agency and community planning for surveillance, analysis, and control and evaluation of public health problems. The Health Officer is responsible for implementing public health policies developed to monitor and respond to communicable disease issues. The Health Officer oversees the work of the Health Department's Medical Director (the Medical Director recruits and oversees clinic providers; assures clinical quality improvement; and implements special initiatives that enhance access to health care). The Health Officer also supervises the Emergency Medical Services Administrator; and participates in policy, legal and regulatory analysis, planning of the EMS system's operation.
- Service Units: The Department's two service units include the following:
  - *Community Health Services (CHS)* is dedicated to improving the health of the community through a variety of public health services and programs (environmental health services, TB prevention and treatment, Early Childhood Services, Immunization Program, STD Prevention and Treatment, HIV Prevention, and Communicable Disease Prevention and Control). The division also implements health promotion initiatives (e.g., tobacco prevention, adolescent health, and chronic disease prevention).
  - *Integrated Clinical Services (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, corrections health, HIV care, healthcare for

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<sup>3</sup> The Director's Office includes four essential organizational units of the Health Department, including the Department Operations, Nursing Practice, the Office of Health and Social Justice, and the Office of Public Health and Community Initiatives.

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the homeless, teen health care, school-based health, and WIC) and assures the availability of related support systems (e.g., electronic health records, information and referral, X-ray, pharmacy, laboratory and language services).

- **Support Units:** The Department's financial and administrative functions are supported by the *Business, Financial and Quality Services* unit, and the *Human Resources and Workforce Development* unit. The Business, Financial and Quality Services unit is responsible for implementing financial management policies (grants management, AR/AP, contracts, and supporting auditing procedures, etc.); and overseeing the Department's budget development process; quality improvement initiatives, and IT support and training. The Human Resources and Workforce Development unit is responsible for implementing County-specific HR policies; overseeing collective bargaining processes; and implementing workforce development programs. Both divisions work with the County's Central Budget Office and Central Human Resources Office to ensure that Department's operations are appropriately coordinated and consistently applied across all County government departments.

**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 2011, the Commission started the process by reviewing existing community plans that address children and youth issues (approximately 30 plans of various types). In order to coordinate the Annual Planning process with the SB 555 Comprehensive Plan, Health Department staff participated in several community meetings that involved staff from the Early Childhood Services Program and the School-Based Health Center Program. In addition, Health Department staff currently participate as members on the Commission's ongoing Early Childhood Council and the School Age Youth Council, these individuals provide input into the planning process as members of these councils.

## V. **UNMET NEEDS**

The Health Department's ability to implement public health services and address unmet needs is directly aligned with the availability of financial resources. Multnomah County has experienced successive years of declining revenues, which has resulting in severe budget constraints for all County departments. As of March 2011, the County Budget Office has projected a FY 2011-2012 budget deficit of \$4.4 million when compared to the FY 2010-2011 budget (this projection represents a slight improvement over last year's project budget shortfall of \$5.3 million that was forecasted in October 2010). Even with the slight improvement in revenue losses over last year there is a projected revenue gap of \$3 million to \$4.2 million per year between 2013 and 2016.

Preparation of the County budget for FY 2011-2012 consists of a complex and time consuming process involving Department staff, County elected leaders, local communities and the public. County Chair, Jeff Cogan, will submit his final Executive Budget on May 13, 2011, and it is not yet possible to fully report the impact of the County's projected budget deficit in terms of its impact on public health services.

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In recognition of the fiscal impacts associated with the costs of government operations given the current economic climate, an assessment of County administrative services has been conducted with the intent of identifying specific areas in which reductions in costs could be achieved without having to impact direct community services. The output of this work focuses on tangible opportunities the County could enact during the FY 2012 and the FY 2013 budget cycles. As part of the Board's FY 2012 budget work, the County will implement selected recommendations to improve efficiency. The focus of these recommendations is on administrative services within the County that support, but do not provide, direct services to the community. Functions that were analyzed as part of this work included budget, finance, accounting, human resources, contracting, facilities, fleet, motor pool, records, distribution/mail, and stores/purchasing. Based on a countywide analysis of administrative functions, there are five specific areas of focus that will result in both savings to the County (some include the administration of services through the Health Department), and a more effective ongoing operating model, including:

- Structural improvements to ensure more efficient and accountable management of County administrative functions.
- Improved budget system and planning process to create more transparency in budgeting and to enable better alignment of spending throughout all departments to stated County priorities.
- Increased management span of control within administrative functions, resulting in the need for fewer managers and a more efficient organization.
- Utilization of warehousing and distribution functions already included in vendor pricing (for office supplies, medical supplies and computer equipment) and increased focus on a central strategic sourcing strategy to reduce the total costs associated with the acquisition of goods and professional services.
- More efficient operating models in the way that the County manages its Fleet and Motor Pool, specifically including reducing the number of fleet vehicles and increasing utilization of each vehicle, utilizing external service relationships for fleet maintenance/repairs and significantly reducing its motor pool operations.

**Specific Unmet Public Health Needs:** Anticipated unmet needs specific to public health activities, which include potential impacts resulting from budget deficits, have been assessed by various public health programs, and the conclusions of these assessments are summarized below (this discussion is not presented in any particular priority).

The cumulative local, state and federal budget cuts continue to challenge the Health Department to maintain necessary direct clinical and surveillance services and to focus upstream, with community partners, to change conditions that contribute to health disparities. Even though improvements continue to be made in this area, racial and ethnic health disparities continue to be a challenging unmet need.

In the area of more routine communicable disease work, CD staff are reviewing the Department's approach to Hepatitis prevention and control in light of the recent Institute of Medicine report on this topic. This includes methods for expanding outreach, and improving coordination of activities with programs that exist for high risk populations, like refugees.

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In the coming year the Health Department will proactively restructure the CD program in order to maintain communicable disease prevention activities in the face of expected state and federal budget cuts. Of particular focus will be to become an integrated Communicable Disease Services Program, combining the Tuberculosis Prevention Program with the Immunizations Program to reduce operating costs; and investigating revenue opportunities for non-mandated services.

An unmet need among a specific population is to address the significant increase in the rate of syphilis among men who have sex with men, which has recently emerged in west coast urban centers including Multnomah County. This is especially important for individuals living with HIV.

Recent funding losses have resulted in the reorganization of the Adolescent Sexual Health Promotion Program. This situation has impacted middle school and high school students throughout Multnomah County, and it has required the Health Department to focus its resources on reproductive health promotion activities in minority communities at highest risk. The STD/HIV/HCV Program is leveraging its work with high school students and young adults in these communities in order to compensate for the loss of capacity to deliver services.

The Department's Environmental Health Program is working to address new and emerging issues by expanding the scope of services to further address inequities associated with environmental health and personal health outcomes. To this end, there is an unmet need in terms of capacity to address policy and program development, advocacy, and education with a focus on environmental health issues.

## **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)

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The County Chair, Jeff Cogan, will not submit his final Executive Budget until May 5, 2011. The Multnomah County Chair's proposed FY 2011-2012 budget (which includes the Health Department's budget) will be presented at the following web address (after May 5, 2011):

<http://web.multco.us/budget/budget-information-fy-2012>

Once available, this proposed budget will be presented for local public review, and, therefore, changes may be made before it becomes final upon adoption by the Multnomah County Board of Commissioners on June 9, 2011.

**VII. MINIMUM STANDARDS**

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

**Organization**

1. Yes  No  A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes  No  The Local Health Authority meets at least annually to address public health concerns.
3. Yes  No  A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes  No  Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes  No  Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes  No  Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes  No  Local health officials develop and manage an annual operating budget.
8. Yes  No  Generally accepted public accounting practices are used for managing funds.
9. Yes  No  All revenues generated from public health services are allocated to public health programs.
10. Yes  No  Written personnel policies and procedures are in compliance with federal and state laws and regulations.

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11. Yes  No  Personnel policies and procedures are available for all employees.
12. Yes  No  All positions have written job descriptions, including minimum qualifications.
13. Yes  No  Written performance evaluations are done annually.
14. Yes  No  Evidence of staff development activities exists.
15. Yes  No  Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes  No  Records include minimum information required by each program.
17. Yes  No  A records manual of all forms used is reviewed annually.
18. Yes  No  There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes  No  Filing and retrieval of health records follow written procedures.
20. Yes  No  Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes  No  Local health department telephone numbers and facilities' addresses are publicized.
22. Yes  No  Health information and referral services are available during regular business hours.
23. Yes  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  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  No  To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes  No  Certified copies of registered birth and death certificates are issued within one working day of request.

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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.
34. Yes X No \_\_\_ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes X 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 X 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 X No \_\_\_ There is a mechanism for reporting communicable disease cases to the health department.
38. Yes X 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.

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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.
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.)*

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52. Yes \_\_\_ No X 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 X 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 X 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 X No \_\_\_ A written plan exists for responding to emergencies involving public water systems.
56. Yes X No \_\_\_ Information for developing a safe water supply is available to people using on-site individual wells and springs.
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*

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*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.
68. Yes X No \_\_\_ The health department provides and/or refers to community resources for health education/health promotion.
69. Yes X No \_\_\_ The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes X No \_\_\_ Local health department supports healthy behaviors among employees.
71. Yes X No \_\_\_ Local health department supports continued education and training of staff to provide effective health education.
72. Yes X No \_\_\_ All health department facilities are smoke free.

**Nutrition**

73. Yes X 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 X No \_\_\_ WIC
  - b. Yes X No \_\_\_ Family Planning
  - c. Yes X No \_\_\_ Parent and Child Health

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- 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.
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.

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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.
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.

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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.

Answer the following questions:

Administrator name: Lillian Shirley, RN, MPH, MPA

Does the Administrator have a Bachelor degree? Yes  No

Does the Administrator have at least 3 years experience in public health or a related field? Yes  No

Has the Administrator taken a graduate level course in biostatistics? Yes  No

Has the Administrator taken a graduate level course in epidemiology? Yes  No

Has the Administrator taken a graduate level course in environmental health? Yes  No

Has the Administrator taken a graduate level course in health services administration? Yes  No

Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems? Yes  No

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

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

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AND

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

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

- c. Yes  No  The local health department Environmental Health Supervisor meets minimum qualifications:

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

OR

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

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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**Assurance by Local Public Health Authority**

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.



Local Public Health Authority

Multnomah

County

May, 1, 2011

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 the Oregon State Public Health Division within 24 hours of receipt of report.
  - c. Reports on 100% of investigations will be forwarded to Oregon State Public Health Division 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 Oregon State Public Health Division 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 Oregon State Public Health Division 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 one working day of report.
  - b.  $\geq 95\%$  of confirmed or presumptive cases will be reported to Oregon State Public Health Division within one 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 Oregon State Public Health Division 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 two working days of report.
  - b. 100% of confirmed case investigations will be completed within seven 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 Oregon State Public Health Division within one 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.
			*EOCW = End of calendar week	

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**ATTACHMENT 2  
FAMILY PLANNING PROGRAM ANNUAL PLAN FOR  
MULTNOMAH COUNTY HEALTH DEPARTMENT  
FY 2011/2012**

**(this plan may be updated after May 1, 2011)**

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 (Specific, Measurable, Achievable, Realistic, and Time-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.**

Problem Statement	Objective(s)	Planned Activities	Evaluation
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 2010-2011 (Currently in Progress)**

Goal/Objective	Progress on Activities
Serve adolescent reproductive needs.	
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  
FY 2011/2012 WIC Nutrition Education Plan Form**

**County/Agency:** Multnomah County WIC Program

**Person Completing Form:** David Brown

**Date:** 04/04/2011

**Phone Number:** 503 572-1123

**Email Address:** david.t.brown@multco.us

Return this form electronically (attached to email) to: [sara.e.sloan@state.or.us](mailto:sara.e.sloan@state.or.us)  
by May 1, 2011  
Sara Sloan, 971-673-0043

**Goal 1: Oregon WIC Staff will continue to develop their knowledge, skills and abilities for providing quality participant centered services.**

**Year 2 Objective:** During planning period, staff will incorporate participant centered education skills and strategies into group settings.

**Activity 1:** Local agency staff will attend a regional Group Participant Centered training focusing on content design to be held in the fall of 2011.

**Note:** Specific training logistics and registration information will be sent out prior to the trainings.

**Implementation Plan and Timeline including possible staff who will attend a regional training:**

*All WIC certifying staff will attend a Group Participant Centered training focusing on content design in the fall of 2011.*

**Activity 2:** Each agency will modify at least one nutrition education group lesson plan from each category of core classes and at least one local agency staff in-service to include PCE skills and strategies by March 31, 2012. Specific PCE

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skills and strategies were presented during the PCE Groups trainings held Fall 2010 and Spring 2011.

**Implementation Plan and Timeline:**

*By March 31, 2012 Multnomah County WIC will modify at least one nutrition education group lesson plan from each main category of core WIC classes and at least one staff in-service focusing on PCE skills and strategies by March 31, 2012.*

**Activity 3:** Each agency will develop and implement a plan to familiarize all staff with the content and design of 2<sup>nd</sup> Nutrition Education options in order to assist participants in selecting the nutrition education experience that would best meet their needs.

**Implementation Plan and Timeline:**

*Multnomah County WIC will develop and implement an in-service training to orient all staff with content and design of all 2<sup>nd</sup> Nutrition Education opportunities we offer clients and how best to match with the client's needs.*

**Goal 2: Oregon WIC staff will improve breastfeeding support for women in the prenatal and post partum time period.**

**Year 2 Objective:** During planning period, each agency will incorporate participant centered skills and strategies into their group settings to enhance their breastfeeding education, promotion and support.

**Activity 1:** Each agency will modify at least one prenatal breastfeeding class to include PCE skills and strategies by March 31, 2012. Specific PCE skills and strategies were presented during the PCE Groups trainings held in the Fall of 2010 and Spring of 2011.

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**Implementation Plan and Timeline:**

*Multnomah County WIC will modify its prenatal Breastfeeding class to include PCE skills and strategies by March 31, 2012.*

**Activity 2:** Each agency's Breastfeeding Coordinator will work with the agency's Training Supervisor to provide an in-service to staff incorporating participant centered skills to support breastfeeding counseling.

**Note:** In-service content could include concepts from Biological Nurturing, Breastfeeding Peer Counseling Program – Group Prenatal Series Guide and/or Breastfeeding Basics – Grow and Glow Curriculum. An in-service outline and supporting resource materials developed by state WIC staff will be sent by July 1, 2011.

**Implementation Plan and Timeline:**

*Multnomah County's Breastfeeding Coordinator will provide an in-service to certifying staff incorporating PCE skills to support breastfeeding counseling. Content will include concepts from the Breastfeeding Peer Counseling Program.*

**Goal 3: Strengthen partnerships with organization that serve WIC populations and provide nutrition and/or breastfeeding education.**

**Year 2 Objective:** During planning period, each agency will continue to develop strategies to enhance partnerships with organizations in their community that serve WIC participants by offering opportunities to strengthen their nutrition and/or breastfeeding education.

**Activity 1:** Each agency will invite at least one partner that serves WIC participants and provides nutrition education to attend a regional Group Participant Centered Education training focusing on content design to be held fall of 2011.

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**Note:** Specific training logistics and registration information will be sent out prior to the trainings.

**Implementation Plan and Timeline:**

*Multnomah County WIC will invite a community partner that serves WIC participants and provides nutrition education to the State sponsored Group Participant Centered Education training focusing on content design to be held in the fall of 2011.*

**Activity 2:** Each agency will invite at least one community partner that provides breastfeeding education to WIC participants to attend a Breastfeeding Basics – Grow and Glow Training complete the Oregon WIC Breastfeeding Module and/or complete the new online Oregon WIC Breastfeeding Course.

**Note:** Specific Breastfeeding Basics - Grow and Glow training logistics and registration information will be sent out prior to the trainings. Information about accessing the online Breastfeeding Course will be sent out as soon as it is available.

**Implementation Plan and Timeline:**

*Multnomah County WIC will invite at least one community partner that provides breastfeeding information to WIC participants to breastfeeding education that will include Breastfeeding Basics Grow & Glow training, complete the Oregon WIC Breastfeeding Module and/or complete the new on-line Oregon WIC Breastfeeding course.*

**Goal 4:** Oregon WIC staff will increase their understanding of the factors influencing health outcomes in order to provide quality nutrition education.

**Year 2 Objective:** During planning period, each agency will continue to increase staff understanding of the factors influencing health outcomes.

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**Activity 1:** Each agency will conduct a Health Outcomes staff in-service by March 31, 2012.

**Note:** An in-service outline and supporting resource materials developed by state WIC staff will be sent by July 1, 2011.

**Implementation Plan and Timeline:**

*Multnomah County WIC will conduct a Health Outcomes staff in-service by March 31, 2012 using State WIC supplied in-service outline and supporting resource materials.*

**Activity 2:** Local agency staff will complete the new online Postpartum Nutrition Course by March 31, 2012.

**Implementation Plan and Timeline:**

*All Multnomah County local agency staff will complete the new online Postpartum Nutrition Course by March 31, 2012.*

**Activity 3:** Identify your agency training supervisor(s) and projected staff quarterly in-service training dates and topics for FY 2011-2012. Complete and return Attachment A by May 1, 2011.

**Agency Training Supervisor(s):**

*Multnomah County training supervisors are Joy McNeal, Mary Kay Diloreto and Elizabeth Berol-Render.*

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**ATTACHMENT 4  
FY 2011/2012 WIC NUTRITION EDUCATION PLAN  
WIC STAFF TRAINING PLAN – 7/1/2011 THROUGH 6/30/2012**

**Agency: Multnomah County Health Department**

**Training Supervisor(s) and Credentials: Staff Development Planned**

Based on planned program initiatives, 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, 2011 – June 30, 2012. State provided in-services, trainings and meetings can be included as appropriate.

1	Estimated October 2011 (State sponsored event)	Regional Group Centered Training.	Improve Group Centered education by focusing on content design.
2	By March 2012	2 <sup>nd</sup> Nutrition Education opportunities.	Orient all MC WIC staff on 2 <sup>nd</sup> Nutrition Education opportunities offered and how best to match with client's needs.
3	By June 2012	Incorporating PCE skills in breastfeeding counseling.	Support the use of PCE skills for certifiers in breastfeeding counseling.
4	March 31, 2012	Health Outcomes training.	Re-orient staff to associate Health Outcomes counseling with assigned nutrition risks using State supplied outline and training materials.

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**ATTACHMENT 5  
EVALUATION OF WIC NUTRITION EDUCATION PLAN  
FY 2010/2011**

WIC Agency: Multnomah County WIC Program

Person Completing Form: David Brown

Date: 3/16/2011 Phone: 503 572-1123

Return this form, attached to email to: [sara.e.sloan@state.or.us](mailto:sara.e.sloan@state.or.us) by May 1, 2011

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

**Goal 1: Oregon WIC staff will continue to develop their knowledge, skills and abilities for providing quality participant centered services.**

Year 1 Objective: During planning period, staff will learn and utilize participant centered education skills and strategies in group settings.

*Activity 1: WIC Training Supervisors will complete the online Participant Centered Education Module by July 31, 2010.*

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

- Did your WIC Training Supervisor complete the module by December July 31, 2010?
- Was the completion date entered into TWIST?

Response: Yes, the training supervisor completed the PCE module.  
Completion date is entered into TWIST.

*Activity 2: WIC certifiers who participated in Oregon WIC Listens training 2008-2009 will pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010.*

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

- Did all certifiers who participated in Oregon WIC Listens training 2008-2009 pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010?

Response: Yes, all certifiers who participated in Oregon WIC Listens training 2008-2009 passed the PCE post-test.

*Activity 3: Local agency staff will attend a regional Group Participant Centered training in the fall of 2010. The training will be especially valuable for WIC staff who led group nutrition education activities.*

Evaluation criteria: Please address the following question in your response.

- Which staff from your agency attended a regional Group Participant Centered Education in the fall of 2010?
- How have those staff used the information they received at the training?

Response: All staff attended PCE education in the fall of 2010. Staff has reflected that they are talking less and listening more while gently guiding the discussion. Staff state clients like this style more and are willing to participate in the discussion and their own nutrition behavior change.

**Goal 2: Oregon WIC staff will improve breastfeeding support for women in the prenatal and post partum time period.**

Year 1 Objective: During planning period, each agency will identify strategies to enhance their breastfeeding education, promotion and support.

*Activity1: Each agency will continue to implement strategies identified on the checklist entitled "Supporting Breastfeeding through Oregon WIC Listens" by December 31, 2010.*

Evaluation criteria: Please address the following questions in your response:

- What strengths and weaknesses were identified from your assessment?

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- What strategies were identified to improve the support for breastfeeding exclusivity and duration in your agency?

Response: All staff has or is scheduled to take an advanced BF course. 17 of our staff have also had some continuing education in BF through the college nutrition course they are currently taking. One weakness is that BF duration has not improved substantially. This is why Multnomah County WIC has also launched its Breast Feeding Peer Counseling Program under the supervision of Mary Wachsmuth IBCLC with the hopes that group counseling techniques will support increased duration. WIC has also started a Love'n Weigh postnatal group where moms can come in and weight their infant and discuss BF problems/concerns and infant feeding questions.

*Activity 2: Each local agency will implement components of the Prenatal Breastfeeding Class (currently in development by state staff) in their breastfeeding education activities by March 31, 2011.*

No response needed. The Prenatal Breastfeeding Class is still in development.

**Goal 3: Strengthen partnerships with organizations that serve WIC populations and provide nutrition and/or breastfeeding education.**

Year 1 Objective: During planning period, each agency will identify organizations in their community that serve WIC participants and develop strategies to strengthen partnerships with these organizations by offering opportunities for nutrition and/or breastfeeding education.

*Activity 1: Each agency will invite partners that serve WIC participants and provide nutrition education to attend a regional group Participant Centered Education training fall 2010.*

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

- Which community partners did your agency invite to attend the Group PCE training fall of 2010?
- How do you feel partnerships with those agencies were enhanced?

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- What went well and what would you do differently?

Response: Various Head Start agencies were invited and attended the regional group PCE training that occurred in the fall of 2010. Mt. Hood Head Start/WIC have teamed up to provide 2<sup>nd</sup> ed. contact for mutual clients. They have used us to screen their nutrition education materials for some of their classes. The partnerships are going well and WIC is constantly looking to mutual benefits for both programs that will enhance our business relationship.

*Activity 2: Each agency will invite community partners that provide breastfeeding education to WIC participants to attend a Breastfeeding Basics training and/or complete the online WIC Breastfeeding Module.*

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

Which community partners did your agency invite to attend a Breastfeeding Basics training and/or complete the online WIC Breastfeeding Module?

- How do you feel partnerships with those agencies were enhanced?
- What went well and what would you do differently?

Response only if you invited community partners to attend a Breastfeeding Basics training. The online WIC Breastfeeding Course is still in development.

WIC invited ICTC to the BF Basics classes and our BFPC Coordinator also taught a BF class to ICTC enrollees. Teaching the class at ICTC greatly enhanced our relationship with them. WIC IBCLC has also been meeting with IBCLC's at ECS (Early Childhood Services) on a regular basis.

**Goal 4: Oregon WIC staff will increase their understanding of the factors influencing health outcomes in order to provide quality nutrition education.**

Year 1 Objective: During planning period, each agency will increase staff understanding of the factors influencing health outcomes.

Activity 1: Local agency staff will complete the new online Child Nutrition Module by June 30, 2011.

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

- Did/will the appropriate staff complete the new online Child Nutrition Module by June 30, 2011?
- Are the completion dates entered into TWIST?

Response: Yes, all staff completed the Child Nutrition Module and completion dates are entered into TWIST. All WIC certifiers (exclusive of RD's) attended a MCH college level nutrition class through the University of Alaska On-Line education program. The class was specifically tailored for WIC staff.

Activity 2: Identify your agency training supervisor(s) and projected staff in-service dates and topics for FY 2010-2011. Complete and return attachment A by May 1, 2011. **Joy McNeal, Mary Kay DiLoreto & Elizabeth Berol-Render.**

Evaluation criteria: Please use the table below to address the following question in your response.

- How did your staff in-services address the core areas of the CPA Competency Model (Policy 660, Appendix A)?
- What was the desired outcome of each in-service?

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**FY 2010/2011 WIC Staff In-Services**

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
All nutrition supervisors, program manager and OA2 senior staff have completed all State e-learning modules by July 31, 2010.	Participant Centered e-learning modules.	Managerial staff staying current in e-learning modules.
All Multnomah County WIC staff attended a Participant Centered Education training event scheduled for Fall 2010.	Participant Centered Counseling Training	Continued skill development in PCE.
All WIC staff have successfully completed all the State e-learning modules and posttests by December 31, 2010 (except the ones not currently developed).	Participant Centered e-learning Modules	WIC staff staying current in all e-learning modules.
All non-RD certifier staff will have successfully completed a college level nutrition basics course by June 30, 2011.	A more complete and thorough knowledge base of MCH Nutrition.	Wanted non-RD certifier staff to have a sound, core understanding of maternal and child nutrition to benefit their PCE counseling skills.

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**ATTACHMENT 6**

**FY 2008 - FY 2011  
IMMUNIZATION COMPREHENSIVE TRIENNIAL PLAN (CPT)  
AND  
YEARLY PROGRESS REPORT**

The following table only includes the triennial progress report for the Health Department's Immunization Program (for activities completed July 1, 2008 through June 30, 2011). The local Immunization Plan (CPT) will be submitted after the impacts of State budget cuts are announced (i.e., after the adoption of Oregon's 2011–2013 biennial budget).

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**ATTACHMENT 6, continued  
MULTNOMAH COUNTY IMMUNIZATIONS PROGRESS REPORT  
FY 2008 – FY 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#</b>	<b>Progress Notes#</b>
<p><b>A.</b> Meet the HRSA immunization rate goal of 85% among 24-month-olds according to the 4:3:1:3:3:1 measure over three years.</p> <p>January 2008 rate among primary care clinics is 74% so ideal rate increase will be 3.66% or higher each year to meet goal.</p>	<p>Develop and implement a reminder/recall system for children aged 15-24 m/o missing the fourth dose of DTaP.</p> <p>Provide training for clinical staff on:</p> <ul style="list-style-type: none"> <li>• Reducing missed opportunities by giving every shot due at each visit</li> <li>• Deferring shots only when medically appropriate</li> <li>• Utilizing minimal spacing</li> <li>• Work with WIC</li> </ul>	<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) runs monthly lists, by clinic, from 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.</p> <p>- Children re-appear on the list from month/month if they do not come in for their 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>- There appears to be some discrepancy in the data received from OHS and that generated in EPIC regarding the 4<sup>th</sup> DTaP.</p> <p>- 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 to a different medical home.</p> <p>- EPIC only takes into account children that are established clients and who are seen regularly.</p> <p>-More discussion on this topic and the different systems and methodologies used may be warranted in the future.</p> <p>- ICS has continued to roll out the</p>

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	staff to ensure understanding of immunization screening and referral.		<ul style="list-style-type: none"> <li>- 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.</li> <li>- Met with WIC staff to review screening and referral process for immunizations. Many WIC clients have established medical homes where they receive immunizations.</li> </ul>	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 have to continue to focus on training on immunization-specific information. We don't project there will be an increase in immunization rates of more than 1% in the foreseeable future.
<b>B. Develop and implement a sustainable vaccine education training program over three years.</b>	<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-</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</p>	<ul style="list-style-type: none"> <li>- Throughout the year, 11 trainings were conducted on vaccine coding and use of IRIS/ALERT databases to 102 staff members.</li> <li>- 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.</li> <li>- The CIP worked with schools of nursing to provide opportunities during fall, winter and spring</li> </ul>	<ul style="list-style-type: none"> <li>- We learned that attendance at trainings is more assured when the clinics request them rather than have them prescheduled.</li> <li>- 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 makes coding an ongoing challenge.</li> <li>- As more Medical Assistants are working in the Primary Care clinics and need more background in immunization basics, two online</li> </ul>

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	<p>existing online resources.</p>	<p>training within the Department.</p>	<p>clinics for over 50 student nurses to learn more about immunizations, forecasting and vaccine storage/handling as well as giving injections. - 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>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#</b>	<b>Progress Notes#</b>
<p><b>A.</b> 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.</p>	<p>Continue providing training for clinical staff on:</p> <ul style="list-style-type: none"> <li>• Reducing missed opportunities by giving every shot due at each visit</li> <li>• Deferring shots only when medically appropriate</li> <li>• Utilizing minimal spacing</li> <li>• Reassess current plan and modify as needed</li> </ul>	<p>Improved immunization rates by 1% and decreased missed shot rate based on quarterly assessment reports from OHS.</p> <p>Evaluate by:</p> <ul style="list-style-type: none"> <li>• Number of trainings</li> <li>• Number of staff trained</li> <li>• Results of pre/post tests or by qualitative method</li> </ul>	<p>- Based on the assessment reports, the UTD rate fell several percentage points midway through the fiscal year but have started moving back up to rates of one year ago for 2-year-olds. These include rates of missed shots and late starts. The rates for 35-month-olds <u>has</u> increased by 1% over last year, to 67%.</p> <p>- Overall, the 4<sup>th</sup> DTaP rates stayed relatively stable. However, the Hib vaccine shortage had a large impact and lowered our overall rates.</p> <p>- Other contributing factors to the immunization rates include new staff getting oriented to childhood immunization schedules (see Section B below) and the impact that the H1N1 pandemic had on our clinics.</p> <p>- Integrated Clinical Services (ICS) continues to run monthly lists, by clinic, from 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</p>	<p>- For the past few years, ICS has been implementing continuous quality improvement in an effort to work more efficiently with fewer resources. As such, they have moved to the Building Better Care (BBC) model to improve quality of systems, flow and productivity.</p> <p>- Staff at each clinic are now organized in teams comprised of a provider, RN in some cases and an LPN or CMA (or both). As a result, responsibility for vaccinations have been decentralized with a staff member from each team (an LPN and/or CMA) giving the immunizations for their assigned clients. (Prior to this, immunizations were administered by one staff member, primarily, per clinic.)</p> <p>- ICS will be developing internal outcome measures that will be included in next year's report.</p> <p>- They will also be working on more proactive outreach to families of late-start children. This will be done by respective team members who have come to know their families, thereby</p>

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			in. Children re-appear on the list from month/month if they do not come in for the immunizations.	building on established trust and familiarity.
<b>B.</b> Continue implementation of a sustainable vaccine education training program over three years.	<p>Continue in-person trainings for new hires and current staff.</p> <p>Conduct various activities related to planning and implementation of online training. Pilot the training with a particular clinic staff.</p>	<p>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.</p>	<p>- In FY'09-'10, approximately 15 trainings were conducted on vaccine coding, use of IRIS/ALERT databases and vaccine forecasting for 50 staff members. A large group of new Certified Medical Assistants (CMA) came on board last summer to work in the various primary care clinics. CIP coordinated with Integrated Clinical Services (ICS) to develop a comprehensive training on immunizations over a period of several days.</p> <p>- Evaluation and feedback from the trainings were rated high to very high (3-5 on a scale of 1-5). In addition to more formal group trainings, the majority took place at the clinics in one-on-one settings.</p> <p>- Periodic QA checks of coding errors found a low percentage of mistakes, particularly given the high number of immunizations given per month at each clinic.</p> <p>- A planned pilot of online training did not occur due to numerous activities that led to the pandemic H1N1 response. However, the online trainings</p>	<p>- We learned that attendance at trainings is more assured when the clinics request them rather than have them prescheduled. The summer trainings worked well.</p> <p>- We have found that one-on-one teaching and interaction often works better and is more effective in the long run. With individualized attention, staff are more focused, less intimidated and understand the content and steps involved better.</p> <p>- Immunizations rates, discussed above, is remaining relatively stable with a slight uptick beginning towards the end of 2009. Due to the submission deadline of this report (April), the rates for first quarter 2010 are not yet available.</p> <p>- In looking ahead, a Health Educator may be hired to work in the Community Health Services service group of the Health Department.</p> <p>- This individual would work with a number of different programs, Immunizations being one. Having someone expressly focused on vaccine information,</p>

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			have been parked in the Immunization Manual site for staff to access.	education and services management etc. would be a key addition to the group.
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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#</b>	<b>Progress Notes#</b>
<p><b>A.</b> 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.</p>	<p>Continue providing training for clinical staff on:</p> <ul style="list-style-type: none"> <li>• Reducing missed opportunities by giving every shot due at each visit</li> <li>• Proactive management of late start children</li> <li>• Outreach to clients who are not up-to-date at 15 months of age</li> </ul> <p>Reassess current plan and modify as needed.</p>	<p>Improved immunization rates by 1% and decreased missed shot rate based on quarterly assessment reports from OHS.</p> <p>Evaluate by:</p> <ul style="list-style-type: none"> <li>• The number of children receiving outreach</li> <li>• Up-to-date rates</li> </ul>	<p>The 4:3:1:3:3:1 immunization rate improved by 15% over the past year, from 55% on the 1/1/2010 assessment to 70% as documented on the 1/1/2011 report.* This significant increase in rate over the past year is the result of the primary care clinics' immunization improvement pilot. The objectives of this pilot has been: performing a careful analysis of current immunization workflows; developing a standardized workflow for forecasting the immunization needs of scheduled, same day and walk-in patients aged 15-36 months; and building reporting tools that allow the teams to track their immunization rates in the target population (15-36 month olds.) During the pilot, the teams</p>	<p>*The State Immunization Program runs an assessment report of immunization rates on a quarterly basis for MCHD from their database. This report contains only the primary care clinics that provide immunizations to 15-36 month olds in a medical home setting.</p> <p>In October 2011, the primary care sites started the "Pre-visit Preparation Process". The goal is for the Panel Manager at each clinic to look at all the clients' charts before the appointment time (called scrubbing) and documenting in EPIC/EMR what is outstanding. This information is used to prepare for the "huddle" where (at the very least), the provider, support staff (CMA/LPN) and CHN plan</p>

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			<p>have been utilizing an UTD EPIC/ EMR report looking at all pediatric patients who are not up-to-date on immunizations and actively doing outreach. A process was created to meet the goals but with the implementation of the new ALERT IIS, the pilot has been put on hold until the two-way ALERT IIS is implemented as it will have an impact on the workflow. In the meantime, the pilot teams are still using the UTD report and creating ways to continue increasing their immunization rates.</p>	<p>for the visit. This allows the team to proactively plan for the visit, which includes administering outstanding immunizations for all patients as needed.</p>
<p><b>B.</b> Submit application for grant to NACCHO to improve capacity to better characterize and respond to vaccine safety concerns in two community sub-populations that can influence the rate of child vaccine uptake:</p> <p>1. Parents of children attending schools where there is a high percentage of religious exemptions to mandatory daycare/school vaccinations (including administrators of these schools); and parents of</p>	<p>If received:</p> <ul style="list-style-type: none"> <li>• Work with NACCHO staff to review project goals, process, outcomes</li> <li>• Gather data and convene project stakeholders</li> <li>• Work with project stakeholders &amp; reps of target subpopulations to develop outreach and</li> </ul>	<p>Outcomes include:</p> <ul style="list-style-type: none"> <li>• Relationship-building with NACCHO and other grantees</li> <li>• Identify baseline rates and priority actions to address concerns among target populations</li> <li>• Greater understanding of issues related to vaccine safety among target sub-populations;</li> </ul>	<p>In Fall, 2011, MCHD was notified of receiving one of four \$20,000 grant awards from NACCHO. A meeting was held in Washington DC in November to officially kick off the project and meet the other grantees.</p> <p>In addition to discussion/focus groups that are planned with participants, a survey tool (in Spanish and English) was developed for initial contact. The survey questions being used are similar to those tested and</p>	<p>Implementation of grant activities has proceeded slower than anticipated, but it is proceeding, nevertheless. Due to reluctance or inability of some schools to participate in the study, several alternate schools have had to be identified and contacted. Additionally, clinic staff at the two identified pediatric collaborative groups in primary care have been involved in ongoing process improvement activities and transitioning to the new</p>

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<p>children who access primary care services at the Health Department where parents decide not to have their children vaccinated despite physician recommendations and the availability of low-cost or free vaccinations.</p>	<p>communications strategies</p> <ul style="list-style-type: none"> <li>• Conduct an evaluation, prepare final report</li> </ul>	<p>development of communications strategies</p> <ul style="list-style-type: none"> <li>• Lessons-learned are shared; strengths and weaknesses assessed; knowledge sharing among LHDs leading to better communication and information for vulnerable populations</li> </ul>	<p>used by the Vaccine Safety study done by the State Immunization Program a few years ago.</p> <p>Meetings were set up with staff from MCHD primary care quality improvement and Multnomah Education Service District to develop plans for outreach to primary care clinic patients/parents and two schools (one public, one private.) A report issued by the State of the exemption rates in Multnomah County public and private schools was used to identify those schools with high exemption rates.</p> <p>Outreach to and surveys at the various sub population groups are beginning to take place.</p>	<p>ALERT IIS. As such, they have been dealing with an already increased workload, so adding outreach to parents about vaccine safety concerns has been difficult.</p> <p>Once survey responses are collected, the focus groups will be formed to discuss further and gain a better understanding of issues related to vaccine safety and hesitancy.</p> <p>Following this, communication strategies on how best to disseminate information and lessons-learned will be shared.</p> <p>While the grant officially ends in August, 2011, MCHD will continue work towards completion of the objectives to get a better understanding of vaccine hesitancy among two subpopulations in Multnomah County.</p>
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<b>Outreach Activities: July 2008 – June 2011</b>				
<b>Activity 1 (July 2010 – June 2011)</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results#</b>	<b>Progress Notes#</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.	<p>Increase knowledge and understanding of school law purpose and process.</p> <p>Evaluate by:</p> <ul style="list-style-type: none"> <li>• Number of trainings held</li> <li>• Number of staff attending</li> <li>• Results of pre/post tests (or other method of evaluation)</li> <li>• Quality of reports submitted</li> </ul>	<ul style="list-style-type: none"> <li>- Conducted five school law trainings for 55 staff from 26 certified childcare facilities/ private schools and 18 registered care facilities.</li> <li>- Two of the five trainings were done for providers (an English-speaking group and a Vietnamese-speaking group w/ interpreter) signed up with the Multnomah County Child Care Resource &amp; Referral (CCRR) Program. Also gave two presentations for 30 Head Start staff regarding school immunization reporting.</li> <li>- Evaluations indicate the trainings and presentations were very useful and informative.</li> <li>- Submissions of immunization reports from these facilities were generally very complete and required minimal to no follow-up. Staff at these facilities were very proactive in getting questions answered before submitting their reports.</li> </ul>	<p>CCRR conducts continuing education trainings of all types year-round for the providers. They will put immunization school law reporting in their fall calendar of trainings beginning October/November 2011. This will provide us with another avenue for disseminating information to child care providers.</p> <p>Last summer, OHS sent another list of certified home care providers in Multnomah County of which over 50 were not on our list. When contacting these new (to us) sites, many were unaware of this requirement. Therefore, it would be helpful for the State certifier staff to be better educated about the immunization reporting requirement so they can advise and discuss this requirement with prospective certified childcare providers.</p>

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<b>Activity 2 (July 2010 – June 2011)</b>				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results#</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.	Met with staff from two delegate agencies on appropriate vaccine management and reporting requirements.  Delegate agency clinic staff have become very cognizant of the implications of poor vaccine storage and handling. They promptly notify us of when they experience a temperature excursion. Most sites have upgraded their vaccine storage equipment.	Re-certification of all delegate agencies is due in 2011. Education and updates on vaccine storage and handling is always reviewed at this time along with discussion and information on next steps in areas that need improvement..

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