

Local Public Health Authority: Multnomah County Health Department
Date: 3/1/2014

LOCAL PUBLIC HEALTH AUTHORITY
FOR
MULTNOMAH COUNTY, OREGON

FY 2014/2015
ANNUAL PLAN



HEALTHY PEOPLE IN HEALTHY COMMUNITIES



Public Health
Prevent. Promote. Protect.

March 1, 2014

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Executive Summary

The Conference of Local Health Officials (CLHO)¹ and Oregon Health Authority 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 provide access to funding to support the functions of local public health authorities.

The FY 2014/2015 Local Public Health Authority Annual Plan for Multnomah County (MCHD) 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 basic public health services:

- 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.

Section I of the plan contains assurance that Essential Public Health services will be provided per OAR 333-014-0050, assurance that the MCHD meets the current Standards for Local Health Departments (ORS 431.345), MCHD current organizational chart, and MCHD current budget information.

Section II of the plan provides a narrative description of MCHD services, Coordinated Care Organization plans, and Early Learning Council plans.

Section III includes a copy of Multnomah County Health Department's Community Health Assessment, strategic plan and annual report.

Section IV includes a copy of the implementation plan for Reproductive Health.

¹ The Conference of Local Health Officials (CLHO) 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. CLHO works in partnership with the Oregon Health Authority to establish the elements of local annual plans, approve a funding formula to ensure the equitable distribution of resources by the Oregon Health Authority, and 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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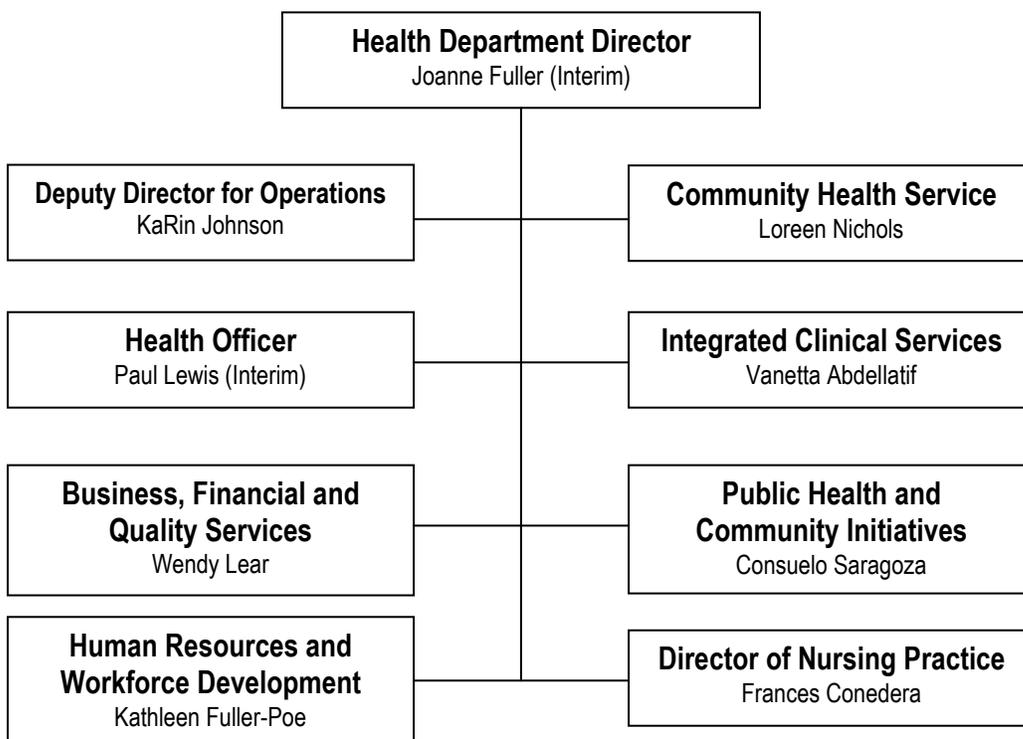
I. Required Elements

a. Community Health Assessment

Please see attached.

b. Organizational Chart

The following organizational chart represents Multnomah County Health Department Leadership as of March 2014.



c. Budget 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

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Portland, OR 97204
Phone: (503) 988-3674, Ext. 27574
Fax: (503) 988-3015
Email: wendy.r.lear@multco.us

The County Chair, Marissa Madrigal, will not submit her final FY 2014/2015 Executive Budget until May 2014. Updates on the Multnomah County FY 2014/2015 budget (which includes the Health Department's budget), as well as the Chair's Executive Budget, can be found at the following web address:

<http://multco.us/budget/fy-2015-budget>

Once available, the 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 in June 2014.

d. Minimum Standards

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.

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10. Yes No Written personnel policies and procedures are in compliance with federal and state laws and regulations.

11. Yes No Personnel policies and procedures are available for all employees.

12. Yes No All positions have written job descriptions, including minimum qualifications.

13. Yes No Written performance evaluations are done annually.

14. Yes No Evidence of staff development activities exists.

15. Yes No Personnel records for all terminated employees are retained consistently with State Archives rules.

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 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 No A system to obtain reports of deaths of public health significance is in place.

29. Yes 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 No Health department administration and county medical examiner review collaborative efforts at least annually.

31. Yes No Staff is knowledgeable of and has participated in the development of the county's emergency plan.

32. Yes No Written policies and procedures exist to guide staff in responding to an emergency.

33. Yes No Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.

34. Yes No Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.

35. Yes No Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.

36. Yes No A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes No There is a mechanism for reporting communicable disease cases to the health department.

38. Yes No Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.

39. Yes No Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

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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 analysis 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.

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.

52. Yes No Each drinking water system is monitored for compliance with applicable

53. Yes No Compliance assistance is provided to public water systems that violate requirements.

54. Yes No All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.

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55. Yes No A written plan exists for responding to emergencies involving public water systems.

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

57. Yes No A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.

58. Yes No Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.

59. Yes No School and public facilities food service operations are inspected for health and safety risks.

60. Yes No Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.

61. Yes No A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.

62. Yes No Indoor clean air complaints in licensed facilities are investigated.

63. Yes No Environmental contamination potentially impacting public health or the environment is investigated.

64. Yes No The health and safety of the public is being protected through hazardous incidence investigation and response.

65. Yes No Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.

66. Yes No All license fees collected by the Local Public Health Authority under ORS

Health Education and Health Promotion

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

68. Yes No The health department provides and/or refers to community resources for health education/health promotion.

69. Yes No The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.

70. Yes No Local health department supports healthy behaviors among employees.

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71. Yes No Local health department supports continued education and training of staff to provide effective health education.

72. Yes No All health department facilities are smoke free.

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services.

74. The following health department programs include an assessment of nutritional status:

a. Yes No WIC

b. Yes No Family Planning

c. Yes No Parent and Child Health

d. Yes No Older Adult Health

e. Yes No Corrections Health

75. Yes No Clients identified at 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.

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84. Yes No Comprehensive family planning services are provided directly or by referral.

85. Yes No Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.

86. Yes No Child abuse prevention and treatment services are provided directly or by referral.

87. Yes No There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.

88. Yes No There is a system in place for identifying and following up on high risk infants.

89. Yes No There is a system in place to follow up on all reported SIDS deaths.

90. Yes No Preventive oral health services are provided directly or by referral.

91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.

92. Yes No Injury prevention services are provided within the community.

Primary Health Care

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

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.

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Cultural Competency

99. Yes No The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.

100. Yes No The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.

101. Yes No The local health department assures that advisory groups reflect the population to be served.

102. Yes No The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

The Administrator must have a Bachelor degree plus graduate courses (or equivalents) that align with those recommended by the Council on Education for Public Health. These are: Biostatistics, Epidemiology, Environmental health sciences, Health services administration, and Social and behavioral sciences relevant to public health problems. The Administrator must demonstrate at least 3 years of increasing responsibility and experience in public health or a related field.

Answer the following questions:

Administrator name: _____ Joanne Fuller _____

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.

NOTE: Joanne Fuller currently serves as the Interim Director for Multnomah County Health Department. Ms. Fuller has over 25 years of experience working at Multnomah County and an extensive history in health care, including six years as the director of the Department of County Human Services which provides services to people with mental illness and addictions, senior services, services to people with developmental disabilities, services to youth in schools, anti-poverty services and services to survivors of domestic violence. From 2001 through 2006, Ms.

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Fuller led the Department of Community Justice which provides community corrections, adult probation and parole and juvenile justice services in Multnomah County.

Ms. Fuller is a national leader in Juvenile Justice Detention Reform and evidence based practices in community corrections and probation and parole. Before joining Multnomah County in 1988, Joanne worked in the fields of mental health and domestic violence. She served as chair of the Governor's Council on Domestic Violence for six years. She has a master's degree in social work from Portland State University and served as adjunct faculty at PSU from 1990 to 1995.

Ms. Fuller has received many honors including the Oregon Citizens Crime Commission Fred Stickel Award for Public Service and the National Association of Probation Executives Executive of the Year Award, both in 2005. In January 2011 she was honored by the Multnomah County Managers of Color with the Dr. Arthur Flemming Award, in recognition of her work in social justice.

While Ms. Fuller has not completed formal graduate courses in epidemiology or environmental health, her experience in the field of public health and human services more than qualifies her to serve as interim Health Department director. She is fully supported by environmental health and epidemiology experts within Multnomah County Health Department's staff with whom she consults regularly. With Ms. Fuller's expert assistance, Health Department intends to move forward with hiring a new Director during FY14/15.

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;

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.

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

Registration as an environmental health specialist 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.

d. Yes No The local health department Health Officer meets minimum qualifications:

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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.

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.



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II. Optional Elements

a. Narrative Description of LPHA Services

The mission of the Multnomah County Health Department is “In partnership with the communities we serve, the Health Department assures, promotes, and protects the health of the people of Multnomah County.” The Department promotes and achieves this mission through its various public health services, programs, and initiatives.

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 and the Oregon Health Authority. 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.

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 require 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.

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

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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 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. Early Childhood Services includes the Nurse Family Partnership Program, CaCoon, Healthy Families of Multnomah County, Future Generations Collaborative, and the Healthy Birth Initiative. Nurse Family Partnership Program (NFP) is an evidence-based community healthcare program supported by extensive research documented from 25 years of implementation. NFP supports a partnership between low-income, first time mothers with a home-visiting Community Health Nurse to achieve the care and support they need to have a healthy pregnancy, provide competent care for their children, and achieve a better life for themselves and their families. CaCoon is a nurse home visiting program providing care coordination for children birth through four years of age with special health needs and for families identified as high medical and social risk. Healthy Families of Multnomah County (HFMC; formerly Healthy Start) is an evidence-based early childhood home visiting program that is part of the state-wide Healthy Families of Oregon program serving at-risk families. Overall goals include reducing child abuse and neglect, improving school readiness, and promoting healthy growth and development of young children up to age three. The Future Generations Collaborative (FGC) is a coalition among American Indian and Alaska Native community members, Native-serving organizations, and government agencies to increase healthy pregnancies and healthy births and strengthen families in American Indian and Alaska Native communities. The Healthy Birth Initiatives Program (HBI) improves birth outcomes in the African American community using a culturally-specific model that addresses the underlying causes of this problem.

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.

Health Statistics [OAR 333-014-0050 (2)(c)]: The ability to monitor and analyze trends and assess local health conditions is dependent on the availability of accurate and valid health statistics including birth and death reporting, recording, and registration; analysis of health indicators related to morbidity and mortality; and analysis of services provided. The Health Department's capacity to meet the community's need for health statistics is achieved through the Vital Records Program implemented within the Environmental Health Services unit.

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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.

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., hospitals, first responders, elected officials, emergency management, etc.).

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.).

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.

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Community Epidemiology Services: CES provides core public health services to the community. These activities include: epidemiologic surveillance and outbreak response, population health data collection and analysis, application of best and promising evidence-based practices in public health, effective financial management and fiscal accountability, and quality improvement and performance management.

Public Health Community Initiatives: The department provides critical support for public health programs and services through the work of Grants Development, Healthy Columbia Willamette, and Communities Putting Prevention to Work.

Directors Office: The department provides critical support for public health programs and services through the work of Program Development and Evaluation Services and Health Assessment and Evaluation.

Emergency Medical Services: The Department's Emergency Medical Services Program regulates, coordinates, and provides medical supervision and quality assurance for all pre-hospital emergency care provided by an exclusive ambulance contractor and fire departments throughout the county.

Specific Public Health Initiatives and Services

Public Health Accreditation:

Multnomah County Health Department has submitted a Public Health Accreditation statement of intent in February 2014. The Department is participating in the Healthy Columbia Willamette collaborative comprised of public health, hospital, and coordinated care organizations to complete the Community Health Assessment and Community Health Improvement Plan prerequisites. MCHD is currently developing the third prerequisite, an organizational strategic plan. Department leadership supports pursuing Public Health Accreditation and an Accreditation Coordinator is in place to facilitate the work.

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 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, 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.

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The resulting Health Promotion Framework process requires a systematic and long-term commitment to be successful.

Chronic Disease Prevention: The vision of the Community Wellness & Prevention Program continues to be 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 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, including the county's community wide A Healthy Active Multnomah County It Starts Here media campaign.

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.

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.

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 (65,000+ residents are provided with medical, dental, behavioral health, substance abuse and enabling services annually). The Department's seven health centers are certified

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through the Joint Commission, and they are recognized by the Federal Bureau of Primary Health Care. Each of the Department's clinics provides culturally competent services, which include primary healthcare, well child care, family planning, and immunizations; health services for homeless children and adults; mental health services; outreach services; drug and alcohol assessment services; and appropriate referrals for specialty care. Primary care services are overseen by the Multnomah County Community Health Council. The Council includes a majority of members who are consumers of health services 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: The Health Department's HIV care system consists of the HIV Health Services Center and the HIV Care Services Program. These programs aim to address unmet health needs of low-income persons living with HIV disease in the Portland metropolitan area. The HIV Health Services Center serves people living with HIV by providing comprehensive and compassionate medical treatment, nursing care and social services. In addition to HIV care, the Services Center provides: on-site primary health care, medical case management, mental health, nutrition, and clinical pharmacy. The Services Center provides care via medical teams which include a provider, nurse, medical assistant and medical case manager.

Corrections Health Services: As a part of its health services, the Department provides health care for adult and juvenile inmates housed at Multnomah County's Justice Center, Inverness Jail, Restitution Center, 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 annually provides services to 24,000+ inmates.

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 2014/2015, the Department will continue to operate 13 fully equipped school-based medical clinics. 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.).

Dental Services: The 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 23,000+ clients annually at the Department's five clinics). The 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.

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

Local Public Health Authority: Multnomah County Health Department

Date: 3/1/2014

clients of the Department's care clinics, which include a large percentage who are women and children, uninsured, and mentally ill.

b. Health Care Reform/CCO Plans

MCHD continues to participate in activities related to state and local health care reform. The Department is a member of the regional Coordinated Care Organization (CCO), Health Share of Oregon, and has a seat on its Board of Directors. In partnership with Clackamas and Washington Counties, MCHD has engaged in solidifying the partnership with local CCOs and the local LPHAs in the form of an agreement with the Health Share of Oregon and FamilyCare CCOs. Two Health Department staff currently service in the Non-traditional Health Worker Steering Committee housed in the State's Office of Equity and Inclusion. As CCOs move forward, this group continues to inform decisions related to the integration of Community Health Workers, Peer Wellness Specialist, Patient Navigators and other similar workers into clinical and community programs supporting CCO members.

MCHD is a key partner in the Health Commons grant awarded to Health Share of Oregon, to kick start transformation of our regional system to enhance support for people on Medicaid. MCHD involvement in grant activities includes:

- CareOregon employed outreach workers sited at MCHD clinics who work with patients who experience potentially avoidable hospital and emergency room use.
- Licensed Clinical Social Workers employed by the MCHD Emergency Medical Services (EMS) program who work with community members who are frequent users of EMS.
- Participation in the creation of a standardized process and consistent reporting for hospital discharge between area hospitals and primary care.
- Development and delivery of a customized curriculum for CCO outreach workers by MCHD's Community Capacitation Center.

c. Early Learning Council Plans

Oregon's future starts with nurturing all children on a path to kindergarten readiness. The recruitment and certification of Community-based Coordinators of Early Learning Services (Hubs) will provide system architecture for achieving this goal. Children at the highest risk will be the focus. Success will result from a determined concentration on outcomes and the integration of services at state and community levels. Individual, service and system measurements will be tracked with a willingness to change approaches that do not deliver success. Multnomah County Health Department continues to work alongside community partners to ensure these outcomes are achieved.

In October of 2013, Multnomah County and United Way took the lead in submitting the Early Learning Multnomah (ELM) grant to the State to begin moving forward with the creation of an Early Learning Hub. The grant was revised and resubmitted in January 2014 and contracting for the ELM is now moving forward. Finalization of the governance structure of the ELM is currently underway and Multnomah County and its partners on the Early Learning Council continue to evaluate funding opportunities to advance this work. Multiple levels of MCHD leadership are invested in making sure the ELM is implemented effectively. Multnomah County

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Health Department Director Joanne Fuller will sit on ELM investors council and Healthy Birth Initiative Program Director Rachael Banks will sit on the community accountability council.

III. Attachments

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- b. Multnomah County Health Department Strategic Plan FY2010 – FY2014.....51
- c. Multnomah County 2012 Annual Report57

IV. Public Health Program Implementation Plans

As requested by Oregon Health Authority, attached is the implementation plan and budget projection for Reproduction Health Services for FY 2015.

Multnomah County Community Health Assessment Mobilizing for Action through Planning and Partnerships (MAPP) To Identify Health-Related Priorities

Summary Report



Prepared for:
The Multnomah County Health Department Leadership Team

Prepared by:
Christine Sorvari, MS
Erin Mowlds, MPH
Health Assessment and Evaluation
Multnomah County Health Department

August 2011

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Multnomah County Community Health Assessment Advisory Group and Stakeholders

Managers, Organizations, and Participants of the Community Assessments and Engagement
Projects Included in this Project

Participants of the Multnomah County Focus Groups

Respondents to the Multnomah County Community Health Survey

Participants of the Local Public Health and Forces of Change Assessment Interviews

Innovative Housing, Inc

Human Solutions

Wood Village Baptist Church

Multnomah County Health Department Diversity and Quality Team

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Nancy White/Flickr

heac photos/Flickr

public domain

public domain

Multnomah County Community Health Assessment Advisory Group and Stakeholders¹

Sonali Balajee, Multnomah County Health Department Health Equity Initiative

Liz Baxter, We Can Do Better (formerly The Archimedes Movement)

Rachel Burdon, Public Health Institute

Polo Catalani, Office of Human Relations City of Portland New Portlander Programs

Molly Franks, Multnomah County Health Department HIV/Hep C Prevention Operations

Rujuta Gaonkar, Multnomah County Health Department Community Capacitation Center

Mariotta Gary Smith, Multnomah County Health Department HIV/Hep C Prevention Operations

Jonathan Harker, City of Gresham Comprehensive Plan

Nancy Harvey, Mt Hood Community College Child Development and Family Support Services

Brian Hoop, Office of Neighborhood Involvement Neighborhood Resource Center

Michelle Kunec, Portland Bureau of Planning and Sustainability

Lai-Lani Ovalles, Native American Youth and Family Center Development and Community Engagement

Sandra Meucci, African American Health Coalition

Midge Purcell, Urban League of Portland Advocacy and Civic Engagement

Alejandro Queral, Multnomah County Health Department Communities Putting Prevention to Work

David Rebanal, Northwest Health Foundation

Teresa Rios-Campos, Multnomah County Health Department Community Capacitation Center

Consuelo Saragoza, Multnomah County Health Department Public Health and Community Initiatives

Pei-ru Wang, Immigrant and Refugee Community Organization Community Health

Staff:

Erin Mowlds, Multnomah County Health Department Health Assessment and Evaluation

Christine Sorvari, Multnomah County Health Department Health Assessment and Evaluation

¹ Some of the individuals listed above did not participate as advisory group members, but they did provide feedback at different points of the project through individual meetings, e-mail, and phone conversations. These stakeholders are included in this list to acknowledge their contribution.

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I. INTRODUCTION

This report presents the 11 “key health-related issues” identified by the Multnomah County Community Health Assessment Advisory Group. These key issues were identified through the findings from four assessments conducted between July 2010 and July 2011. This process was based on the National Association of County and City Health Officials’ (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) model.

MAPP is a community planning process developed to identify health issues and recommendations to improve public health through the involvement of community members and stakeholders from community-based organizations, advocacy organizations and government. The process is facilitated by public health leaders and is intended to increase the efficiency, effectiveness, and, ultimately, the performance of local public health systems.

Mobilizing for Action through Planning and Partnerships (MAPP)

The standard NACCHO MAPP process includes the following four assessments:

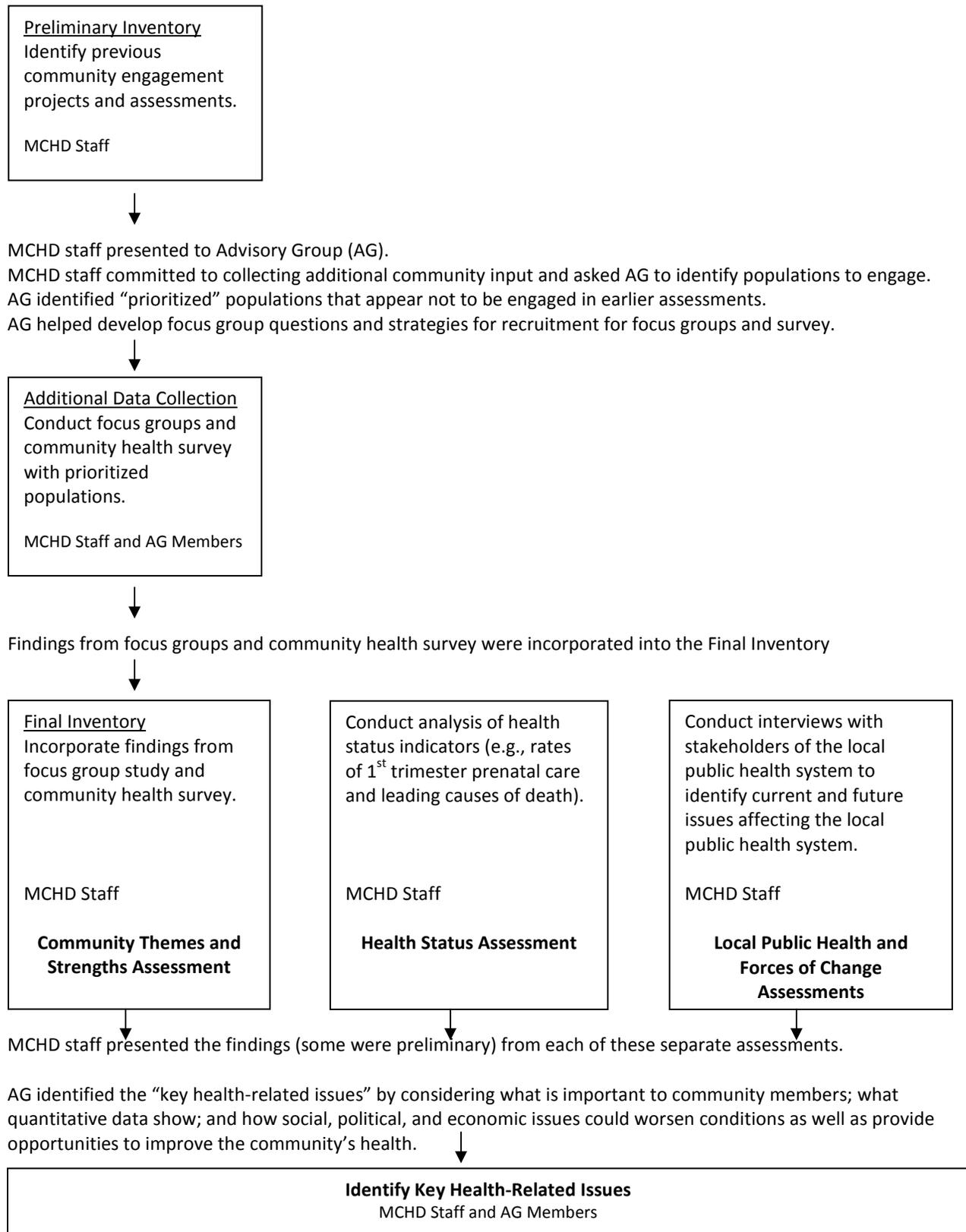
- (1) The Community Themes and Strengths Assessment identifies the health-related issues that are most important to community members.
- (2) The Community Health Status Assessment describes the health of the community through quantitative data on key health indicators (e.g., leading causes of death, rates of first trimester prenatal care).
- (3) The Local Public Health System Assessment highlights the strengths and challenges of our current local public health system.
- (4) The Forces of Change Assessment identifies the political, social, and economic issues that could affect the local public health system’s ability to address health-related priorities.

Multnomah County Modifications to the MAPP Model

The Multnomah County Assessment was tailored to capitalize on community engagement efforts previously conducted by community-based organizations and local government. These changes meant the Community Themes and Strengths Assessment could build on community input previously collected.

Additionally, the Local Public Health System Assessment and Forces of Change Assessment were combined because the information collected for each was obtained through 43 interviews with more than 50 leaders in public health, local government, community-based services, transportation, education, employment, and planning. All of whom were qualified to speak to the current capacity and future opportunities and uncertainties affecting the local public health system. The model used in the Multnomah County Community Health Assessment is illustrated in Figure 1.

Figure 1: Multnomah County Community Health Assessment Model



The Multnomah County Community Health Assessment Advisory Group and Stakeholders

The Multnomah County Community Health Assessment Advisory Group was convened specifically for the community health assessment and was comprised of partners from several programs within the Multnomah County Health Department, city bureaus and community-based organizations. The Advisory Group met five times between October 2010 and June 2011. Special efforts (i.e., phone conversations, e-mail and meetings) were made to solicit feedback from members who were unable to make meetings as well as from partners, who were unable to formally join the Advisory Group, but provided feedback during the process.

The Advisory Group was asked to participate in the development of the MAPP assessments and to use the findings from each of the assessments to identify “key health-related issues.” These issues are intended to inform future public health planning and the development of a health improvement plan.

II. THE MAPP ASSESSMENTS

The MAPP assessments use community members’ input, population-based quantitative data, and expertise of stakeholders in the public health system to answer the following questions.

- (1) What do community members think are the most important health issues?
- (2) How healthy is our community?
- (3) What does the current local public health system do well and where can it improve?
- (4) How will future economic and political issues affect the capacity of the local public health system?

The methodology and findings for all of the MAPP assessments will be discussed briefly in this section. There are separate reports describing each of these assessments in depth. Information about these additional reports is provided at the end of this document.



Community Themes and Strengths Assessment

The purpose of the Community Themes and Strengths Assessment was to learn the most important health-related issues according to people in Multnomah County. To this end, significant effort was put into engaging as many people as possible. The first step was to identify multiple community assessments and engagement projects conducted within recent years,² with an emphasis on those conducted within the last five years. In all, findings from 29 community assessments and engagement projects were compiled into the first iteration of an “inventory,” (i.e., a compilation of assessment descriptions and their findings).³

² The majority were conducted within the last five years.

³ Summary information from *Multnomah County Community Health Assessment: Identifying the Most Important Health Issues through Multiple Community Engagement Processes, Community Themes and Strengths Assessment*, August 2011. Christine Sorvari

These community assessments and engagement projects included large-scale surveys, focus groups, photovoice projects, and stakeholder interviews.

Table one presents the themes from the assessments and engagement projects included in the preliminary inventory. The themes are presented in order by the number of community assessments and engagement projects in which they were identified (i.e., the first theme was identified in the most efforts, etc.).

Table 1: Identified Health Issues: Themes from Preliminary Inventory of Community Assessments and Engagement Projects

<ul style="list-style-type: none"> • Involvement in public decision making (22) • Economic and employment opportunities for everyone (20) • Community health promotion activities (19) • Healthy built environment (15) • Universal health care (15) • Strong sense of community (15) • Access to behavioral and mental health services (14) • Education opportunities for everyone (14) • Stable housing (13) • Elimination of racism (11) • Public safety (10) • Access to public transportation (10) • Affordable and healthy food (10) 	<ul style="list-style-type: none"> • Environmental health (9) • Preservation of cultural diversity (9) • Commitment to child health and welfare (7) • Equitable health care spending (6) • Access to technology (5) • Access to language classes (5) • Personal responsibility for health (4) • Transparency in research practices (4) • Protection of the natural environment (3) • Presence of art and cultures (2) • Chronic disease prevention (1) • Health education and literacy (1) • Limited government involvement in health care (1)
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(#) The number of assessments/engagement projects in which issue was identified

Once the findings from the initial inventory of community assessments and engagement projects were compiled, they were presented to the Advisory Group. The group reviewed the inventory findings to identify populations that did not appear to be adequately involved in these early efforts. As a result of this process, the group recommended that focus groups and a survey be conducted with community members who did not appear to be engaged in these earlier efforts.

Additional Community Input Collected

Specifically, these community members included residents in Mid-County and East County who were aged 20 to 40 years, residents of rural communities, those with low income, members of specific communities of color (Native Americans, African Americans displaced from North and Northeast Portland, Pacific Islanders), immigrants/refugees, renters and those who were homeless. Special efforts were made to engage these community members. Between the survey and focus groups, most of the identified populations were engaged, but some were not included to the desired levels. This limitation was a result of a variety of factors including the difficulty in recruitment and limited resources.

Advisory Group members helped develop the focus group guide and one member conducted two of the 13 focus groups. All the information learned through these groups and the community health survey informed the final version of the inventory.



Community Health Focus Groups

During February and March 2011, 13 focus groups with 72 participants were conducted in Mid-County and East County. The purpose of these discussions was to learn what people feel are the most important issues affecting their health and that of their families and communities. The questions asked were developed by the Health Assessment Advisory Group based on what had and had not been asked in previous assessments. Prior to group discussions participants were asked to provide demographic information on a confidential survey.⁴

Demographic information provided by participants is listed below:

- The vast majority of participants had household incomes of less than \$20,000 (79%); were unemployed (65%); and were renting their housing (81%).
- Almost one third of the participants did not have health insurance and another 40% were on the Oregon Health Plan (Medicaid).
- Two-thirds of the participants were female; one-third male.
- Almost 40% of the participants were between the ages of 26-39.

Participants were asked to identify their race and ethnicity. Of those providing this information:

- 46% were White/Caucasian,⁵
- 21% were African,
- 14% were African American,
- 13% were Hispanic/Latino,
- 4% were Native American/American Indian, and
- 3% were Asian Pacific Islander.

All of the participants lived in Mid-County or East County at the time the groups were conducted.

The Multnomah County Health Department partnered with community-based organizations, churches, and public health stakeholders to recruit participants for these groups. Specifically, staff worked with the Immigrant and Refugee Community Organization (IRCO), Multnomah County Rockwood Health Center, Wood Village Baptist Church, and two low-income housing organizations in Mid-County and East County: Human Solutions and Innovative Housing, Inc.

⁴ Summary information from *Multnomah County Community Health Assessment: Discussions with People Living in Mid-County and East County, Focus Group Report*, August 2011. Erin Mowlds and Christine Sorvari

⁵ Language used NACCHO MAPP Community Strengths and Themes Survey

Eleven of the groups were facilitated by Multnomah County Health Department Staff (Health Assessment and Evaluation and the Community Capacitation Center) and two were conducted by an Advisory Group member from We Can Do Better (formerly the Archimedes Movement). Five of the groups were conducted in languages other than English (i.e., Somali, Spanish, and Amharic) with the support of the IRCO and the Community Capacitation Center.

Focus Group Findings

Focus group participants defined health and wellness as having comprehensive health care; connections with other people; choosing and having the ability to practice healthy behaviors; and the resources to prevent and manage serious health problems, such as diabetes and asthma.

There was strong agreement that people may be more likely to practice healthy behaviors if they had resources such as money, health care, affordable grocery stores, healthy restaurants (i.e., not only fast food establishments), accessible transportation, and places to socialize and be physically active.

Most participants had difficulty answering, *“Do you think your community is healthy?”* A common response to this question was, *“Some people are and others are not.”* In most groups, as the conversation progressed, participants began talking about how they think that for the most part, their communities were not that healthy due to, *“stress from being poor.”* People discussed the connections between the reality of being poor and the unhealthy things they observed in their communities. Examples of these problems included drug use, criminal activity, *“directionless youth,”* unhealthy eating, hopelessness about finding work, and depression.

People wanted to be self sufficient and felt that government has the responsibility to provide a safety net for those people who are unable to take care of themselves, whether this inability is due to individual limitations or hard economic times.

Most participants appreciated public safety-net services but felt that government could do a better job advertising the services, broadening the eligibility requirements, and making the application processes easier. There was a fairly strong sentiment that the system does not work when it cuts all help rather than maintaining or prorating support for a short time while people are, *“getting on their feet”* (e.g., starting a job after being unemployed for a long time).

Many people wanted to become more active in public input activities that inform public decision making. Because of daily responsibilities, not knowing how to become involved, and, for some, not having the confidence, getting involved is difficult. Participants appreciated that this project, *“came to us”* and thought that more of their community members would participate if decision makers made the effort to come to their housing developments and other places they frequent regularly, such as churches and social service agencies.



Community Health Survey

The Community Health Survey was conducted during the spring of 2011. The purpose of the survey was to collect opinions and perceptions of health in Multnomah County from specific populations that may have been missed in previous health assessments such as residents of Mid-County and East County. Survey questions elicited opinions on key factors that improve quality of life, the most important health problems, and risky behaviors that have the greatest impact on community health in this county. The survey also asked respondents to rate their health and their community's health on a five point Likert scale. The 15-question survey was adapted from the NACCHO MAPP Community Strengths and Themes Survey. Additionally, demographic information was collected including household income, education level, ethnicity, age, sex and insurance status.⁶

Potential survey respondents were Multnomah County residents 18 years or older who were willing to complete the survey. Surveys were available in English and Spanish. There were 476 completed surveys. The majority of the survey respondents, like the focus group participants, were from Mid-County and East County. The survey reached individuals with higher household incomes than those participating in the focus groups. The survey sample was also older and less racially and ethnically diverse than the focus group participation.

Demographic information provided by respondents is listed below:

- Almost 40% reported household incomes of more than \$50,000 and 30% of respondents had household incomes below \$20,000.
- Almost 90% of respondents had private or public health insurance.
- Two-thirds of the respondents were female; one-third male.
- Almost 25% of the respondents were between the ages of 26-39 and 25% were over the age 65.

Respondents were asked to identify their race and ethnicity. Of those providing this information:

- 71% were White/Caucasian,⁷
- 12% were African/Black/African American,
- 11% were Hispanic/Latino,
- 3% were Native American/American Indian, and
- 3% were Asian Pacific Islander.

To reach residents of Mid-County and East County, survey staff identified potential organizations, events and other opportunities to administer the surveys. Churches were identified as one potential outlet to reach a large portion of the prioritized populations including: populations between 20 and 40 years old, people with low-income status and communities of color.

⁶ Summary information from *Multnomah County Community Health Assessment: A Survey of Multnomah County Residents, Survey Report*, August 2011. Maya Bhat and Emily Francis

⁷ Language used NACCHO MAPP Community Strengths and Themes Survey
Multnomah County Health Assessment and Evaluation
Contact: christine.e.sorvari@multco.us

Church administrators in Mid-County and East County were identified by zip code and then called to ask if they would like to involve their congregants in the survey. Additionally, MCHD staff contacted neighborhood associations in Mid-County and East County and attended their meetings to administer surveys. To reach low-income and elderly residents Health Department staff worked through Loaves and Fishes to distribute surveys.

MCHD staff attended the Early Head Start family picnic and Día de los Libros y Día de los Niños (Day of the Books and Day of the Children) to survey populations between 20 and 40, low-income, renters, communities of color and young Latina mothers. Día de los Libros y Día de los Niños is a bilingual literacy celebration and was identified as an event in Mid-County and East County to survey priority populations.

Survey Findings

Individual and community health

- In general, respondents were most likely to rate their own health as “very healthy” or “healthy” regardless of age, educational attainment, or income. At the same time, most respondents rated the community’s health as “somewhat healthy.”

Characteristics of a healthy community

- “Low crime and safe neighborhoods” and “good schools” were two of the three most important characteristics of a health community according to most respondents.
- Those who rated the community as “somewhat healthy,” “unhealthy” or “very unhealthy” were more likely to pick “good jobs and healthy economy,” and “access to health care” as two of their top three factors for a healthy community.
- Those who rated their own health as “somewhat healthy,” “unhealthy” or “very unhealthy” were more likely to pick “affordable housing” as one of the three most important factors of a healthy community.

Community health problems and risky behaviors

- In identifying the most important community health problems there was broad agreement across demographic lines that mental health, child abuse, and domestic violence were the three issues with the greatest impact on the community’s health. Respondents selected drug abuse and alcohol abuse as two of the top three risky behaviors that have the greatest impact on overall community health.
- Mental health and related issues topped the list of community health problems and risky behaviors identified by survey respondents. Stress and other mental health issues are known to be associated with child abuse, domestic violence, and substance abuse. These survey results may indicate the community's support for stronger mental health and substance abuse prevention efforts on a community-wide basis.

Focus Group and Community Health Survey Findings Incorporated into the Inventory

The input collected through these additional data-collection efforts confirmed 17 of the 26 themes that were presented in the preliminary inventory. The first 10 themes remained the same after adding the findings from these additional studies; however “access to behavioral and mental health services” and “education opportunities for all” moved up within the top 10.

The themes that were supported by both the focus groups and the survey include, “access to behavioral and mental health services”; “education opportunities for all”; “public safety”; “commitment to child health and welfare”; and “chronic disease prevention.” Preventing chronic diseases had been previously identified as a priority by only one earlier community engagement effort, but was identified in both of the additional studies. The prevention and management of chronic and serious diseases was considered one of the main dimensions of “health and wellness” in the focus group discussions.

Three new themes were added to the inventory as a result of the focus group and survey findings. These issues include, “increased accessibility of resources,” “governmental accountability and responsibility,” and “domestic/intimate partner violence.” The final themes are presented in Table 2.

Table 2: Identified Health Issues. Themes from the Final Inventory of Community Assessments and Engagement Projects⁸

<ul style="list-style-type: none"> • Involvement in public decision making (23)* • Economic and employment opportunities for everyone (22)* • Community health promotion activities (20)* • Healthy built environment (16)* • Universal health care (16)* • Access to behavioral and mental health services (16)* • Strong sense of community (16)* • Education opportunities for everyone (16)* • Stable housing (14)* • Elimination of racism (12)* • Public safety (12)* • Access to public transportation (11)* • Affordable and healthy food (11)* • Environmental health (10)* 	<ul style="list-style-type: none"> • Preservation of cultural diversity (9) • Commitment to child health and welfare (9)* • Equitable health care spending (6) • Access to technology (5) • Access to language classes (5) • Personal responsibility for health (5)* • Transparency in research practices (4) • Protection of the natural environment (3) • Chronic disease prevention (3)* • Presence of art and cultures (2) • Health education and literacy (1) • Limited government involvement in health care (1) • Increased accessibility of resources (1)* • Government accountability and responsibility (1)* • Domestic/Intimate partner violence (1)*
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(#) The number of assessments/engagement projects in which issue was identified
***Finding supported (or identified) by focus groups and/or community health survey**

⁸ As a result of the focus group and community health survey, the final inventory includes the findings of 31 assessments and community engagement projects; the preliminary included 29.



Community Health Status Assessment

Multnomah County Health Department routinely examines a wide variety of health status indicators, such as maternal child health-related measures, incidence of communicable disease, unintentional injury, and leading causes of death. These indicators are disseminated in the series of reports that comprise the Health of Multnomah County, the Health Assessment Quarterly, and the Report Card on Racial and Ethnic Health Disparities. The health status indicators included were selected based on a review of these reports.⁹

Health status indicators were assessed on five factors: 1) comparison to Oregon and the U.S., 2) trends over time, 3) racial disparities, 4) severity of health issue, and 5) comparison to national benchmarks.¹⁰ The health status indicators selected for inclusion in this report meet at least two of the five conditions listed below:

- The Multnomah County rate is higher than Oregon or the U.S.;
- The trend is worsening;
- There are racial or ethnic disparities;
- The health issue is severe in terms of long-term consequence or premature death;
- The County does not meet the national benchmark, Healthy People 2020.

Health Status Assessment Findings

The health outcomes included here as findings meet three or more of these factors and should be given consideration as priority health issues for the County.

Maternal and child health

- The percent of women receiving first trimester prenatal care is decreasing in the County. The County does not meet the national objective for first trimester prenatal care. Communities of color in Multnomah County continued to have significantly higher proportions of mothers who did not receive prenatal care in the first trimester of pregnancy compared to White non-Hispanics.
- The County meets the national objective for premature births; however, there has been a slight increase in premature births. The percent of premature births is greater among African Americans and Native Americans.
- Although the infant mortality rate has been decreasing for Native Americans and African Americans in the County; they have been persistently higher than those of other racial and ethnic groups as well as the national objective.

⁹ Summary information from *Multnomah County Community Health Assessment: Using Quantitative Data to Measure the Community's Health, Community Health Status Assessment, August 2011*. Claire Smith

¹⁰ (95%) confidence intervals around rates were used to compare the County rate to Oregon and the U.S. Significance testing was done to determine trends. Racial and ethnic disparities were determined using either rate ratios or 95% confidence intervals around rates. The severity of a health outcome was determined by Years of Potential Life Lost, a measure of premature mortality or whether a health outcome has long-term consequence.

Sexually transmitted disease

- The rate of chlamydia is increasing in the County and the rate is higher than Oregon and the U.S. In the County, chlamydia rates are greater for African Americans, Native Americans, and Hispanics.
- Gonorrhea rates are greater in the County compared to Oregon. While Gonorrhea rates have not significantly changed in the last 10 years, they remain greater for African Americans and Hispanics.

Health behaviors

- The County does not meet the national objective for reducing adult smoking. Tobacco use was related to 24% of the County deaths in 2008. Native Americans have a greater percent of adults smoking compared to other groups.
- The percent of 8th and 11th graders meeting nutritional recommendations for fruits and vegetables has decreased in the County. The percent of 11th graders in the County meeting recommendations is lower than U.S. 11th graders. Not meeting nutritional recommendations among teens can have long-term consequences to health.

Chronic disease and related conditions

- Diabetes deaths are increasing in the County. The County rate is higher than the U.S. African Americans have significantly higher rates of diabetes deaths.
- Although cancer mortality rates are decreasing in the County, the rate remains higher than the U.S. The County does not meet the national objective, and White non-Hispanic and African American cancer death rates are greater than other groups.
- Female breast cancer rates have decreased; however, they do not meet the national objective.
- Lung cancer death rates, while decreasing in the County, do not meet the national objective. Rates are greater among White non-Hispanics and African Americans compared to other racial and ethnic groups.
- Adult obesity rates in the County have increased. The percent of African Americans who are obese is greater compared to other racial and ethnic groups. Obesity can have a significant impact on health outcomes.

Other rates of death

- Unintentional injury deaths are increasing and the County does not meet the national objective for injury deaths. Injury deaths are the number-one cause of premature mortality. The death rate due to injury is greater for White non-Hispanics than other groups.
- Accidental poisoning deaths are increasing in the County. The County rate is higher than Oregon and the U.S., and the County does not meet the national objective for reducing accidental poisoning deaths.
- Suicide death rates are decreasing in the County but the County does not meet the national objective. The death rate due to suicide is greater among White non-Hispanics.

- Alzheimer’s disease has significantly increased in the County, and the death rate is greater than the U.S. rate. The death rate due to Alzheimer’s disease is greater for White non-Hispanics compared to other racial and ethnic groups.



Local Public Health System and Forces of Change Assessments

The Local Public Health System Assessment and The Forces of Change Assessment are critical parts of a Community Health Assessment. The goals of both are complimentary; the Local Public Health Assessment identifies current strengths and weaknesses within the local public health system. The goal of the Forces of Change Assessment is to look at what social, political, or economic issues could affect the capacity for the public health system. This second goal is an especially pertinent component of this assessment because of the current economic climate and changes with health care reform.¹¹

Definition of Public Health System

For the purposes of this assessment, the “public health system” was defined as all departments, organizations and agencies who work on the traditional/core public health services or the “social determinants of health” including public, private, and nonprofit organizations. This broad definition allowed the use of a wide lens to examine capacity and all the different elements that are needed to create a healthy, thriving community.

Identification of Stakeholders to Interview

The Community Health Assessment Advisory Group, along with Health Department staff developed a list of key stakeholders to interview for the Local Public Health and Forces of Change Assessments. Stakeholders were selected based on their experience, expertise, and ability to represent the different components and levels of work within the public health system. State and local health departments, other government entities, and community-based organizations were included in the list. The variety of stakeholders provided a wide array of perspectives at both the big-picture and the on-the-ground levels. Given the large role the local health department plays in the public health system, multiple individuals from the Health Department were included as key stakeholders.

Interview Questions

Questions were developed to illicit discussion on services, overall strengths, challenges and recommendations for the public health system. The final interview guide included four questions.

- (1) What do you see as your role in the local public health system or in contributing to the health of the community?

¹¹ Summary information from *Multnomah County Community Health Assessment: Interviews with Local Public Health System Stakeholders about Future Opportunities and Challenges, Local Public Health Care System & Forces of Change Assessments*, August 2011. Erin Mowlds and Nicole Hermanns
 Multnomah County Health Assessment and Evaluation
 Contact: christine.e.sorvari@multco.us

(2) How would you describe (summarize) your department or agency's role in the local public health system?

(3) What opportunities, assets, and strengths do you see that affect or could potentially impact public health or your work? (Upcoming changes like collaborations, funding, technology, legislation, etc.)

(4) What challenges do you see that may affect public health or your work? (Upcoming changes like collaborations, funding, technology, legislation, etc.)

Interview Process and Data Analysis

Project staff conducted 43 interviews involving more than 50 stakeholders between July 2010 and August 2011. Interviews were conducted one-on-one, or with groups of stakeholders who worked for the same organization. Notes were taken by the project staff during all interviews and then analyzed in aggregate at the conclusion of the interviews for recurring themes and key points.

Interview Findings

One of the major roles of public health is to be “at the table” to show how health matters and how health is connected to other issues. Being at the table is also critically important during health care reform to shape the role of public health and secure funding for public health services.

Collaboration is an essential part of the development and delivery of effective public health services. We need more deliberate partnerships and collaborative efforts that support our strategic vision. Clear roles for partners that are based on experience and expertise must be identified for all collaborative relationships.

Prevention must be considered on multiple levels, and public health work must be balanced between upstream and downstream approaches.

Equity must be incorporated into all public health work. In order to do this, leadership must dedicate resources to educate staff and the public about equity and health, and dedicate funds for the implementation of equity tools. Equity work needs to be driven by community needs that have been identified through community health assessments, and it must include culturally specific services and practices.

There are current gaps in access to relevant data. Critical gaps include culturally competent data collection, data at the local levels, and the ability to access data across technology/data systems.

III. IDENTIFIED KEY-RELATED HEALTH ISSUES

To identify the 11 “key health-related issues,” the Advisory Group used the findings from each of the MAPP assessments: 1) The Community Themes and Strengths Assessment, 2) Community Health Status Assessment, and 3) Local Public Health System and Forces of Change Assessments.

The group decided to select most of the key health issues from the Community Themes and Strengths Assessment with the belief that addressing these larger, community-identified issues would improve the problems identified through the Health Status Assessment. For example, rates of obesity, diabetes, and heart disease could be reduced by making healthy food accessible, implementing community health promotion activities, improving access to health care, and promoting physical activity. The group recommended that the health data presented through the Health Status Assessment be used to track progress on specific health conditions that would be expected to improve as a result of addressing these larger issues.

The preliminary findings from the Local Public Health System and Forces of Change Assessments were used to guide the development of strategy ideas for each of the 11 key health issues. One example of how these findings influenced the strategy ideas is to collaborate with partners working in education to improve high school retention rates for students of color as a way to influence life-long health.

Table 3 lists the “key health-related issues” and indicates from which of the MAPP assessments each of the issues was identified. Table 4 includes the strategy ideas developed for each health-related issue.

As might be expected, not all issues were directly identified in all of the MAPP assessments. Findings from the Community Themes and Strengths Assessment focused on the social determinants of health and included some specific health conditions. Information from the Health Status Assessment included population-based rates for health conditions such as diabetes deaths, and social determinants of health like education and income. Information gathered from the Local Public Health System and Forces of Change Assessments focused on gaps in the system and ideas for ensuring that all essential public health services are provided. Rarely did condition-specific information (e.g., asthma) come up during this later assessment.

Many of the health-related issues and associated strategies presented in the following tables are currently being implemented by the health department and partners; others would be new and would require additional partnerships. Advisory Group members emphasized that effective strategies addressing the identified health issues would require collaboration between multiple partners and that the health department could not be expected to (or should) take the lead on all of the issues. An example of one of the key health issues for which the health department could serve as a convener but not the lead is “poverty, economic support and opportunities.”

Table 3: Key Health-Related Issues and in which MAPP Assessments they were Identified

Key Health-Related Issues Identified by Advisory Group (In alphabetic order)	Community Themes and Strengths Assessment	Community Health Status Assessment	Local Public Health System Assessment and Forces of Change Assessment
Access to affordable and healthy food	X		
Community health promotion activities	X		X
Education	X	X	X
Elimination of institutional racism and health disparities	X	X	X
Infant mortality		X	
Involvement in public decision making	X		X
Poverty, economic support and opportunities	X	X	
Promote healthy sexuality across the lifespan		X	
Promote physical activity	X		
Strong sense of community	X		
Universal health care	X		

Table 4: Key Health-Related Issues and Strategy Ideas

Key Health-Related Issues Identified by Advisory Group (In alphabetic order)	Strategy Ideas ¹²
<p>Access to affordable and healthy food: Access to affordable, culturally appropriate, nutritious food; access to education about nutrition</p>	<p>Promote the “backyard garden” in addition to community gardens. For some, community gardens may be seen as “gated communities” with limited access.</p> <p>Work with resettlement agencies to teach new immigrants and refugees about the pitfalls of unhealthy food in this country. For example, fast food and soda. They are cheap but unhealthy. Help them find ways to continue to eat the types of food they ate in their old country and healthy options here that they may not be familiar with (e.g., connect with specific stores, farmers markets, gardening programs, etc).</p> <p>Work with immigrant and refugee children to counter any negative pressure they receive from other children about their traditional food to prevent their wanting to eat only “Americanized food.” Develop a deliberate plan for this education for new comers. Explore ways to do this for people already here too.</p> <p>Provide education about opportunities (e.g., zoning codes and urban agriculture). Work to provide opportunities for people to “take control of their access.”</p> <p>Work on neighborhood retail initiatives. Hold conversations about price differentials as a way to make healthier food more affordable.</p> <p>Continue to focus on the healthy built environment and how this work can promote food accessibility.</p> <p>Change what is being served to children at school.</p> <p>Look at WIC foods. They are very dairy-focused. This is not good for all people. Lobby for revisions to the federal farm bill (up for vote in 2012) so unhealthy foods are not subsidized.</p>

¹² Specific terms or issues named by Advisory Groups are identified by quotation marks in order to illustrate the thinking of the group as they identified key issues.

<p>Community health promotion activities: Commitment to culturally-appropriate disease prevention, wellness programs, health education and health promotion activities including access to opportunities for physical activity; services provided in appropriate languages</p>	<p>Strengthen the Community Health Worker (CHW) role. Viewing it as a “paraprofessional” position makes it vulnerable to becoming a lower-paying and lower-status position. This can disproportionately affect people of color and other disadvantaged populations.</p> <p>Invest more resources to help people learn how to navigate systems.</p> <p>The County could help develop more leaders within communities (e.g., CHWs).</p> <p>Direct resources toward activities and facilities that support culturally relevant physical activity (e.g., soccer fields, joint agreements with parks and recreation facilities).</p> <p>Develop mental health services that are culturally and financially accessible.</p>
<p>Education: Access to culturally competent, relevant, quality education and skill-building opportunities, especially related to employment attainment; commitment to healthy learning environments; address unequal education /achievement disparities; navigating education system; assistance in navigating system/ planning for college and job training; good schools</p>	<p>Collect community input on education issues. “Why do we have these ‘drop outs’?” Galvanize community to find solutions. CHWs have a role.</p> <p>Look at institutional racism (e.g., disproportionate discipline, fewer staff of color, and lower expectations for students of color). “What are the expectations for certain student groups?”</p> <p>Understand why students are dropping out. Address reasons when possible. For example, help students who need to support their families, are pregnant, or not learning and being left behind. Also, support students whose families may be dealing with mental illness, immigration issues, abuse, etc.).</p> <p>Understand that youth are losing respect for authority figures including teachers, police, and legal system. Work as a community to counter this trend.</p> <p>Teach students about the long-term consequences of dropping out compared to the short-term benefits.</p> <p>Target education approaches for different populations.</p>

<p>Elimination of institutional racism and health disparities: Commitment to issues related to racism and discrimination including cultural competence, achievement disparities, criminal justice disparities, mistreatment at the hands of authority (especially police), exclusion from opportunities, direct violence, stress, and lack of respect; commitment to equity; eliminate police intimidation and harassment</p>	<p>Use tools like the equity and empowerment lens. Continue working with CHWs.</p> <p>Track health status and outcomes for disparities and trends.</p> <p>Have conversations with community members, organizations, and governmental agencies about what is meant by institutional racism and how we got here.</p> <p>Capture people’s stories to illustrate where they run into barriers due to institutional racism. For example, Trimet was well intentioned and they developed bus lines to reach communities; however, the buses are all heading downtown not north and south (on east side of river). Also, they are not running frequently and long enough for people working swing shifts.</p> <p>Work with partners to Identify and address immigration, police, and corrections system issues. All of these issues can affect individual and community health by increasing stress, disintegrating families, and preventing people from being self sufficient.</p> <p>The County and Cities could work to educate the community at large about disparities in health and opportunities to address these disparities. The increase in awareness and understanding may get public backing for investing in equity efforts.</p>
<p>Infant mortality: Prevention of infant deaths with an emphasis on African American and Native American populations</p>	<p>Focus on populations with disparities, specifically Native American and African Americans. These populations have had persistently higher rates of infant deaths than other racial/ethnic communities.</p> <p>Address factors contributing to poor perinatal health including income, stress, and opportunities for self sufficiency.</p>

<p>Involvement in public decision making: Commitment to social and civic engagement; responsiveness and accountability to community input and priorities; access to the legislative process; self-advocacy; knowing your voice counts; voting</p>	<p>Invest in leadership development (CHW and others).</p> <p>County (and other jurisdictions) can be more intentional in how they get public input. <i>“A good way to do this is to follow the community engagement principles the City of Portland has adopted.”</i>¹³</p> <p>These principles focus on partnership, early involvement, building relationships and community capacity, inclusiveness and equity, good quality process design and implementation (appropriate involvement for scope), transparency, and government accountability. (Note: The Health Department was credited as being a leader in community engagement activities.)</p>
<p>Poverty, economic support and opportunities: Commitment to economic prosperity, sustainability and innovation and to workforce development; equity in access to living wage, employment opportunities and economic recovery; commitment to poverty reduction; access to financial education; hiring of more bilingual/ bicultural staff; pay incentives for linguistic and cultural skills; providing basic needs for survival; assistance with utility bills; ability to become self sufficient</p>	<p>Advocate against unfair employment practices. For example, <i>“If someone doesn’t have a driver’s license they can be paid less than someone doing the exact same job who does have a license.”</i></p> <p>Legitimize different work and economic opportunities. For example, food made and sold from home versus food carts. Work to open doors and address barriers to help people grow their business into <i>“legitimate businesses”</i> so they can become self sufficient. This type of work could possibly be a way to increase the number of food carts offering healthy foods.</p> <p>Encourage business creation opportunities for disenfranchised populations.</p> <p>Work on employment discrimination issues.</p> <p>Deepen understanding of why so many disenfranchised youth (especially youth of color) leave school. How can schools better support youth of color? For some families, students leave so that they can contribute to their families’ incomes. Work to help students finish high school while respecting their role in the family.</p> <p>Advocate and collaborate for stable, affordable housing. People need to have a home in order to successfully work and support their family.</p>

¹³ From City of Portland Public Involvement Principles, Adopted by the City of Portland, Oregon on August 4, 2010
 Multnomah County Health Assessment and Evaluation
 Contact: christine.e.sorvari@multco.us

<p>Promote healthy sexuality across the lifespan: The use of policies, supportive environments, responsive health services, community empowerment, and comprehensive education to enable all people to enjoy sexual health. A holistic vision of sexuality encompasses relationships, sexual orientation and gender identity, sexual and reproductive health, and sexual pleasure and safety.</p>	<p>Promote dialogue about sexuality, gender roles, and sexual orientation in all communities. CHWs play an important role, as well as elders, parents, schools, media, medical providers, peers, etc. Promote healthy relationships.</p> <p><i>“We need to figure out what healthy sexuality is for people. It is different in different communities.”</i> For example, there are different expectations and acceptance of teens becoming parents. There must be respectful, two-way discussions about these types of issues. There also needs to be appropriate services.</p> <p>Work to eliminate stigma so that people will use preventive practices and seek treatment for sexually transmitted infections.</p>
<p>Promote physical activity: Commitment to improving personal health behaviors and encouraging people to exercise; personal responsibility for their own health; focus on multigenerational habits and norms. Commitment to an accessible and sustainable built environment including sidewalks, streets, neighborhoods, community gardens, bike routes, walking routes, bike parking, landscape character, parks, recreation areas, community and meeting spaces; provision of social services, and city centers; creation of “20-minute neighborhoods”; clean neighborhoods</p>	<p>Continue to focus on the healthy built environment and how this work can promote physical activity.</p> <p>Work with parks, gyms, and youth sports to make them affordable.</p> <p>Work with education policy to restore physical education and recess.</p> <p>Work with communities to learn what types of activities, resources, and spaces they would like to use for activities.</p> <p>Promote existing places and develop new ones. Many people in a lot of different communities play team sports (adults and youth). They need places to go that are close by, safe, and affordable (e.g., soccer fields, basketball courts, etc.).</p>

<p>Strong sense of community: Commitment to community distinctiveness and diversity. Commitment to community empowerment; social connectivity, social cohesion, and access to social networks; community activities</p>	<p>This discussion was about the role of government in cultural identity, integrity, and pride.</p> <p>County (and other jurisdictions) can partner to provide services that create an environment that insulates families from elements that disintegrate (e.g., mental illness, stress, poor education system, unemployment, and child protection system’s lack of support for different cultural practices/beliefs).</p> <p>Systems and services can be developed and strengthened to encourage family structure.</p> <p>Utilize CHWs and community-based organizations as cultural translators.</p>
<p>Universal health care: Access to affordable, culturally appropriate and sustainable health care/ medical care; navigating health and medical care system; coverage for undocumented people; including dental/ oral health; unrestricted (by gender, age or status with or without kids); access to preventive care</p> <p>Access to mental health services; access to behavioral health care including drug and alcohol counseling; mental health and drug addiction as chronic diseases.</p>	<p>Work to ensure culturally appropriate medical homes for people. Use CHWs to help make these connections.</p> <p>Strengthen the health care workforce, especially encouraging a culturally competent workforce.</p> <p>Develop school programs to reach students early. Take an active role in the development of the health care workforce through schools and internship opportunities. Provide support to help students remain in health care programs and complete college and graduate programs.</p>

IV. MULTNOMAH COUNTY COMMUNITY HEALTH ASSESSMENT REPORTS

The following six reports, written by the Health Assessment and Evaluation and Grants Development Teams, describe the methodology and findings of the multiple components of the Multnomah County Community Health Assessment.



Multnomah County Community Health Assessment Mobilizing for Action through Planning and Partnerships (MAPP) to Identify Health-Related Priorities
Summary Report, August 2011

Christine Sorvari, MS and Erin Mowlds, MPH



Multnomah County Community Health Assessment: Identifying the Most Important Health Issues through Multiple Community Engagement Processes
Community Themes and Strengths Assessment, August 2011

Christine Sorvari, MS



Multnomah County Community Health Assessment: Discussions with People Living In Mid-County and East County
Focus Group Report, August 2011

Erin Mowlds, MPH and Christine Sorvari, MS



Multnomah County Community Health Assessment: A Survey of Multnomah County Residents
Survey Report, August 2011

Maya Bhat, MPH and Emily Francis, MPH



Multnomah County Community Health Assessment: Using Quantitative Data to Measure the Community's Health
Community Health Status Assessment, August 2011

Claire Smith, MURP



Multnomah County Community Health Assessment: Interviews with Local Public Health System Stakeholders about Future Opportunities and Challenges
Local Public Health Care System & Forces of Change Assessments, August 2011

Erin Mowlds, MPH and Nicole Hermanns, MA

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Multnomah County Health Department

Strategic Plan FY2010 – FY2014



Public Health
Prevent. Promote. Protect.

426 Stark Street
Portland, OR 97204
Phone: 503 988-3674
Fax: 503 988-3383

<http://www.co.multnomah.or.us/health/>

MULTNOMAH COUNTY HEALTH DEPARTMENT

Vision

Healthy people in healthy communities.

Mission

In partnership with the communities we serve, the Health Department assures, promotes, and protects the health of the people of Multnomah County.

Values

- We believe that health is a "state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity." (World Health Organization (WHO), 1978)
- We honor the diversity of the individuals and communities we serve and value their differing approaches to health and well-being.
- We believe in partnerships to improve the health of our communities.
- We believe the Department's actions should assist our communities in addressing underlying factors that affect good health.
- We value effective leadership as a fundamental tool to improve the health of our communities.
- We believe in being responsible stewards of the public trust and resources.
- We value a diverse staff and believe our staff should be selected with care, treated with respect, held accountable for their performance, and encouraged in their personal growth.
- We believe in continuously improving the quality of our work.
- We believe in balancing scientific knowledge and practical experience with the wisdom and beliefs of those we serve to improve the health of our communities.
- We emphasize prevention, health promotion, and early intervention.

Purpose of the Strategic Plan

October 2009

I am pleased to present the Multnomah County Health Department Strategic Plan for Fiscal Years 2010-2014. Over the past year the Health Department has held fast to our goals of providing high quality services, accountability and responsiveness to the community despite the challenges faced by our county, state, and nation. The plan we are presenting includes three goals and eight objectives that reflect our commitment to assuring a healthy community for all County residents and to being an effective, accountable and responsive organization. It is our intent that the FY 2010-14 Strategic Plan be a “living document” that is responsive to changes in community needs and values. Thus, the current document contains a set of strategies to guide the development of our annual work plans. These strategies will be revisited each year and changed as needed.

The strategic plan outlined in this document reflects the priorities set by the Multnomah County Health Department for the next five years. Strategic activities are those which reflect new or enhanced goals, objectives, processes, and programs. It is vital that these activities are fully integrated with the vision, mission and values of the health department. The resulting Strategic Plan will create a pathway that provides direction to the Health Department, and ensures accountability and evaluation of our progress over time. This plan will guide our work within the department as well as within the community, and will help shape the relationships we build with community partners. The strategic plan includes focused and prioritized work that is over and above the day-to-day activities that have become the ongoing work central to the Health Department.

The creation of this plan was a collaborative effort involving input from staff who served on a cross-departmental coordinating team, managers and supervisors, and senior leadership. In addition, we strived to ensure that the voices of community heard through our outreach and community activities are reflected in this plan and continue to be present in our work. Thank you to all who participated in the development of this strategic plan. Each service group and program has a stake in action plan development and in meeting each objective. Integration of key strategic activities is vital to our ultimate goal of a healthy community.



Lillian Shirley, BSN, MPH, MPA, Director

Goal 1: Assure all individuals, families, and communities gain greater control over the factors that influence their health.

Objectives:

1.1 Increase health promotion activities internally and externally.

Strategies:

- Increase internal and external health promotion efforts aimed at achieving health equity and social justice.
- Implement the health promotion framework.

1.2 Improve the quality and quantity of Health Department-community collaborations so that community capacity, leadership and responsibility to promote health are shared.

Strategies:

- Improve community health assessment and strategic planning processes by expanding community input.
- Use community-based participatory research activities as appropriate.

1.3 Advance policies at the local, state, and federal levels that create conditions to improve health.

Strategies:

- Identify and prioritize policies to be addressed.
- Assess health effects of proposed policies and programs to enhance health benefits or mitigate possible harms.
- Build community capacity to influence policy and assure that community groups are involved in policy development.

Goal 2: Improve the health of our diverse communities

Objectives:

2.1 Reduce health inequities.

Strategies:

- Use interventions at policy, provider, and individual levels to address health inequities among those most affected.
- Use an “equity lens” to assess the effects of program decisions across population groups.

2.2 Optimize access to MCHD’s health care services.

Strategies:

- Continue quality and systems improvement to improve access (i.e., Service Delivery System Renewal).
- Work with partners to increase access to care through programs such as dental, school-based and primary care in the East County area.

Goal 3: Be an adaptive, learning organization that serves as an effective and accountable local public health authority and provider of community health services

Objectives

3.1 Incorporate quality and performance management principles and tools into Health Department activities.

Strategies:

- Use quality management methods and systems to monitor performance and disseminate the results to stakeholders.
- Obtain public health accreditation.
- Optimize resources to assure quality and effectiveness of clinical delivery programs (e.g., Building Better Care, clinical information technology, and American Recovery and Reinvestment Act grants and projects.)

Goal 3: Be an adaptive, learning organization that serves as an effective and accountable local public health authority and provider of community health services

Objectives

3.2 Assure opportunities for work force development.

Strategies:

- Assure appropriate professional training and development across job classes and programs.
- Develop and support leadership and accountability in our staff.

3.3 Strengthen public health and clinical service infrastructure.

Strategies:

- Research, identify and implement an electronic health record for Early Childhood Services, Corrections, and Dental.
- Develop customer and employee focused web presence with real time communication and on line customer service forms, tools, and information.

Multnomah County Health Department

2012 Annual Report

*Healthy People in
Healthy Communities*



Public Health
Prevent. Promote. Protect.



Vision

Healthy people
in healthy
communities.

Mission

In partnership with the
communities we serve,
the Health Department
assures, promotes and
protects the health of
the people of
Multnomah County.



Dear Multnomah County Residents,

Multnomah County Health Department's Annual Report is a testament to the commitment of staff and community partners who work together to ensure the people of Multnomah County benefit from comprehensive public health practices.

Our vision of healthy people in healthy communities drives us to build essential partnerships, expand capacity of services to address health inequity and help shape the social factors that affect an individual's health and wellness.

This report highlights some examples of how we achieve our goals in service to the community. Over the past year, the Health Department has worked closely with health care agencies to change how we deliver care in Oregon, shifting from acute care to prevention and community-based solutions. This new model, built around coordinated care organizations, provides families with access to health care, a right that is often limited for our most vulnerable residents. With the enrollment expansion of both public and private health insurance, more than 800,000 residents will have health insurance in Oregon. This new delivery of care is helping to invest in children's health and early childhood development. When children are healthy, they are able to focus in school and contribute to making a difference in their community.

I am pleased to present many of our accomplishments in this 2012 Annual Report. For additional information on programs and services, please visit: www.mchealth.org.

Sincerely,

Lillian Shirley

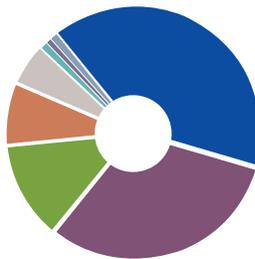
Director

Multnomah County Health Department

Services Provided in Fiscal Year 2012

Visit Type	Client Total
Dental	26,136
Early Childhood	7,940
HIV Health Services Center	1,272
Primary Care	44,418
School Based Health Centers	5,989
STD Program	6,160
Tuberculosis Program	943

Services Provided to Clients by Race-Ethnicity



- White 40.0%
- Hispanic 30.1%
- Black 12.1%
- Not Collected or Unknown 8.5%
- Asian 7.7%
- Pacific Islander 0.8%
- American Indian 0.7%
- Native Hawaiian 0.1%
- Alaskan Native 0.0%

Services Provided to Clients by Age Group



- Age 25-44 26.6%
- Age 45-64 16.1%
- Age 6-12 16.1%
- Age 13-18 12.4%
- Age 2-5 8.8%
- Age 0-1 8.2%
- Age 19-24 7.9%
- Age 65+ 3.9%

Assuring

clients and their families remain our priority

Through community outreach, education and screening activities more than **800** children received lead blood testing to identify and reduce lead exposure.

More than **20** public schools received environmental assessments and training resources to assess their Indoor Air Quality.

Clackamas, Multnomah and Washington County responded to the largest pertussis outbreak in the region since 1949. Of the 777 cases reported, 631 were confirmed and of those confirmed cases **43%** were under-vaccinated or unvaccinated.

Through the Discounted Car Seat Program nearly **200** families received car seats and participated in a certified car safety education session.



Multnomah County manages 13 School Based Health Centers (SBHC) and provides healthcare to nearly **6,000** young people to help keep them healthy and ready to learn. The new Franklin High School SBHC provided comprehensive health services to 590 school-age youth.

“ I like that everyone is nice and that the health center is easy to get to because I don’t have to miss a lot of my classes. Everyone learns who you are, which helps me to feel right at home. ”

*– Mackenzie Trapp
Franklin High School Student*

Collaborating

with community and national partners

Through the Community Asthma Inspection Referral (CAIR) program, nearly 300 low-income families are 3½ times less likely to visit emergency rooms. CAIR helps to save approximately **\$165,000** annually in hospitalization and emergency room visits and represents a 68% return on investment for the healthcare system.

The Future Generations Collaborative received a grant from the Northwest Health Foundation and partnered with **25** organizations and community members to help promote healthy pregnancies and healthy babies in Multnomah County's American Indian and Alaska Native community.

The Billi Odegaard Dental Clinic, the first permanent safety net dental clinic in downtown Portland will serve up to **1,500** clients per year.

The Robert Wood Johnson Foundation's Public Health Law Research provided a **\$150,000** grant to evaluate the health impact of school anti-bullying legislation in Oregon.

With a **\$7.5** million federal grant and working with more than 25 community partners to prevent chronic diseases:

- 580,000 Portland residents will have greater access to full-service grocery stores, community gardens and amenities like sidewalks, crosswalks, bike lanes and parks that offer the opportunity for healthy eating and physical activity.
- 105,000 residents of Gresham will benefit from neighborhood planning that works to increase access to healthy food and offers opportunities for active living.
- 88,000 students in 154 schools throughout seven school districts are drinking fresh water, increasing physical activity along with fruit and vegetable intake. This effort resulted into updating school facilities, adopting comprehensive nutrition policies and adding more movement before, during and after school.
- 17,500 students in 60 Schools Uniting Neighborhoods (SUN) schools are more active and have healthier snacks.



Creating

solutions and developing policies to support community needs

60,000 county residents are not drinking sugary beverages at events and services held at mosques, temples and churches as a result of faith-based community leaders adopting healthy food and beverage standards.

New electronic systems were implemented in Corrections Health: medication administration and health record. The systems helped to improve integration of medical information in order to provide better care for about **35,000** inmate clients.

5,000 seniors at 15 meal sites across Multnomah County are eating more fruits and vegetables as a result of a new Fresh Produce Policy and other innovative efforts adopted by senior meal providers.

Multnomah County works with two coordinated care organizations, Health Share of Oregon and FamilyCare Inc., that help to deliver better health care and lower costs for clients who receive care under the Oregon Health Plan. Multnomah County is one of **11 regional partners** that make up Health Share of Oregon.

“We wanted to increase healthy food access and improve the nutrition for older adults for some time, but were limited in our capacity. With support from the federal grant we have developed a nutrition and wellness policy, partnered with key local programs and distributed nearly 30,000 pounds of produce to low-income seniors.”



– **Amber Kern-Johnson**
Executive Director, Hollywood Senior Center

CCO Partners

- *Adventist Health*
- *CareOregon*
- *Central City Concern*
- *Clackamas County*
- *Kaiser Permanente*
- *Legacy Health*
- *Multnomah County*
- *Oregon Health & Science University*
- *Providence Health & Services*
- *Tuality Healthcare*
- *Washington County*

Grant Funding Highlights

Community-Centered Healthy Marriage and Relationships \$309,000

Funder: Department of Health and Human Services, Administration for Children and Families (Federal)

Four County Needs Assessment \$454,000

Funder: Oregon Association of Hospitals and Health Systems (Private)

STRYVE (Striving to Reduce Youth Violence Everywhere) \$225,000

Funder: Department of Health and Human Services, Centers for Disease Control and Prevention (Federal)

Tobacco Prevention Education Program \$397,405

Funder: Oregon Health Authority (State)

Healthy Start: Eliminating Health Disparities in Perinatal Health (for MCHD's Healthy Birth Initiative Program) \$850,000

Funder: Health Resources and Services Administration, Maternal Child Health Bureau (Federal)

Ryan White HIV Care Program (Part A) \$3,849,008

Funder: Health Resources and Services Administration, HIV/AIDS Bureau (Federal)

Ryan White HIV Early Intervention Services (Part C) \$910,321

Funder: Health Resources and Services Administration, HIV/AIDS Bureau (Federal)

Ryan White Coordinated HIV Services for Women, Infants, Children, and Youth (Part D) \$361,123

Funder: Health Resources and Services Administration, HIV/AIDS Bureau (Federal)

Ryan White Special Projects of National Significance \$300,000

Funder: Health Resources and Services Administration, HIV/AIDS Bureau (Federal)

Advanced Practice Center Program (Public Health Preparedness) \$291,960

Funder: National Association of County and City Health Officials (Private)

CORE- Alternative Treatment System for Chronic Pain \$164,800

Funder: CareOregon (Private)

CORE- Enhanced Patient Care \$177,215

Funder: CareOregon (Private)

FY13 Annual Plan \$8,082,423

Funder: Oregon Health Authority (State)

Health Care Innovation Challenge \$2,695,029

Funder: Department of Health and Human Services, Center for Medicare and Medicaid Innovation (Federal)

Health Center Program 330 Budget Period Renewal \$7,160,666

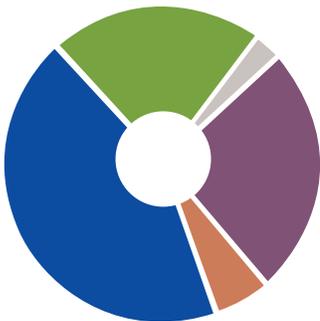
Funder: Health Resources and Services Administration, Bureau of Primary Health Care (Federal)

Community Health Initiative: Healthy Food Access \$180,000

Funder: Kaiser Permanente (Private)

FY 2012 Revenues

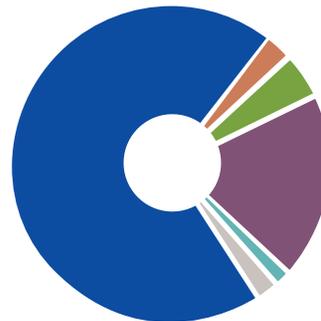
Total: \$156,537,730



- Fee for Services43.7%
- General Fund.....25.8%
- Grants/Revenue Contracts21.9%
- Misc Revenue.....5.7%
- Licenses2.9%

FY 2012 Expenses

Total: \$156,537,730



- Integrated Clinical Services.....69.8%
- Community Health Services.....18.9%
- Business and Quality4.7%
- Health & Social Justice.....2.5%
- Health Officer Program.....2.3%
- Director's Office1.8%



Health Department

426 SW Stark Street
Portland, OR 97204

503-988-3674

www.mchealth.org

October 2013



**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015**

As a condition of Title X funding, sub-recipient agencies are required to submit an annual plan to the OHA Reproductive Health (RH) Program, as well as a projected budget for the time period of the plan. In order to increase the relevance of the process, we have developed a new required format which more accurately reflects the services – both direct and indirect – that lead to better health outcomes.

The following goals (also located in the drop-down menu of the annual plan form) are derived from OPA Priorities and cover the areas of Clinical Services, Counseling Services, Program Outreach and Health Systems Transformation.

- A.** Assure that delivery of quality family planning and related preventive health services is in accordance with Title X Program requirements and nationally recognized standards of care.
- B.** Assure that delivery of reproductive health services to adolescents is in accordance with Title X Program requirements and nationally recognized standards of care (where they exist).
- C.** Direct services to address reproductive health disparities among your community's high priority and underserved populations.
- D.** Identify strategies for addressing the provision of health care reform and for adapting the delivery of reproductive health services to a changing health care environment.

To complete your annual plan, please choose a minimum of two goals, and then choose one corresponding objectives for each goal from the objectives drop-down list. It is also acceptable to choose two or more objectives for one goal. The objectives reflect National Standards of Care, where available, and best practices. Describe the activities you will conduct to achieve your benchmark and explain how you plan to evaluate your outcomes.

Additional information to help with this process, including suggested activities and program data, can be found at:

http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Documents/TitleX/annual_plan_supporting_information.pdf The new data reports provided here reflect your agency's work in many of these areas during the past fiscal year. The RH program suggests that you review your county's current status for each objective and make your decision based on the needs or issues for your agency.

Our intention is to evaluate your progress by periodically reviewing your agency data when objectives are measurable. For objectives that are not data driven, we will request periodic progress updates

NOTE: We will not be asking for your progress report for FY2014 until after June 30, 2014. You may want to take the opportunity to look at your current plan and evaluate your own progress as you determine your new goals.

If you have any questions, please contact Connie Clark @ (541) 386-3199 x 200 or Linda McCaulley @ (971) 673-0362.

**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015**

Goal # 1 C. Direct services to address reproductive health disparities among your community's high priority and underserved populations			
Objective	Current Status	Activities	Evaluation timeframe
C3. By June 30, 2015, participate in at least two community-based or other events to reach high priority populations with education, information and referral to reproductive health services	Currently not tracked – tracking to begin FY15	<ol style="list-style-type: none"> 1. MCHD will network with community partners such as Planned Parenthood to participate in their community events. MCHD will work with community partners to align events with identified high priority populations and locations. 2. County pamphlets with referral information are being created. These pamphlets will be offered to participants of these community events ensuring individuals have the contact information they need to access reproductive health services at MCHD. 3. The MCHD Reproductive Health Coordinator will connect with the Client Advisory Program Specialist to identify opportunities to participate in community events. 4. MCHD will track number of events, type of involvement, and general demographic of participants served or location of event to ensure high priority populations are being included. 	MCHD Reproductive Health Coordinator will evaluate progress quarterly.
Goal # 2 D. Identify strategies for addressing the provision of health care reform and for adapting the delivery of reproductive health services to a changing health care environment			
Objective	Current Status	Activities	Evaluation timeframe
D4. By June 30, 2015, will initiate (or complete) at least one activity toward supporting/providing insurance enrollment assistance to clients	Currently not tracked – tracking to begin FY15	<ol style="list-style-type: none"> 1. Group and individual enrollment meetings will be offered by MCHD staff through MCHD clinic sites and other identified priority locations to assist the uninsured with insurance enrollment. 2. Ongoing education will be provided to MCHD Eligibility 	MCHD Reproductive Health Coordinator will evaluate progress quarterly



**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015**

July 1, 2014 to June 30, 2015

		Specialists to ensure they screen for CCARE for those who remain uninsured or underinsured following an insurance eligibility screening. An example of this would include qualifying residents with FPLs between 138% and 250% who have not purchased an insurance plan.	
Goal # 3 B. Assure that the delivery of RH services to adolescents is in accordance with Title X Program requirements and nationally recognized standards of care (where they exist)			
Objective	Current Status	Activities	Evaluation timeframe
B3. By June 30, 2015, increase by 10 % the proportion of ESTABLISHED ADOLESCENT (18 yrs and under) clients who receive STD/HIV prevention and relationship safety counseling at least once a year	% who received STD/HIV counseling at least once: 46.0% % who received Relationship Safety counseling at least once: 29.7%	<ol style="list-style-type: none"> 1. Provide education for current and new providers of reproductive health services at MCHD around the need to provide STD/HIV prevention and relationship safety and to then document the education within the CVR. 2. MCHD RH staff will create a tool to ensure providers understand how to document this work in the CVR as to prevent data collection deficiencies. 3. Providers will be presented with the CY 2013 percentages, the goal, and periodic snapshots of the CY 2014 data to supportsand encourage investment in this work. 	MCHD Reproductive Health Coordinator will evaluate progress quarterly

**OREGON HEALTH AUTHORITY
PUBLIC HEALTH SERVICES
BUDGET PROJECTION
FOR FAMILY PLANNING ONLY**



Agency : Multnomah County

Fiscal Year : 2015

Please read the instructions on the reverse side of this form carefully

PE 41 Family Planning Grant Expenditures	Expenditures
Personal Services (Salaries & Benefits)	\$1,976,932.94
Services and Supplies	\$719,614.38
Capital Outlay	
Total PE 41 Expenses	\$2,696,547.32
PE 41 Family Planning Grant Revenue	Revenue
Title X State Family Planning Grant Payments	\$507,928.00
Title X Program Income:	\$81,223.90
a. Client Fees – Self-Pay	\$ 28,878.80
b. Donations	\$ -
c. Third Party Insurance Reimbursement	\$ 52,345.10
Total PE 41 Revenue	\$589,151.90

Debra Newton
PREPARED BY

2.23.14
PHONE

Debra Newton
AUTHORIZED AGENT

02.24.14
DATE