

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

**FY 2010-2011
ANNUAL PLAN**



HEALTHY PEOPLE IN HEALTHY COMMUNITIES



May 1, 2010

**MULTNOMAH COUNTY HEALTH DEPARTMENT
LOCAL PUBLIC HEALTH AUTHORITY FOR MULTNOMAH COUNTY
FY 2010-2011 ANNUAL PLAN**

I. EXECUTIVE SUMMARY

The FY 2010-2011 Local Public Health Authority Annual Plan for Multnomah County serves to demonstrate compliance with Oregon statute ORS 431.416, which mandates that each county in the state provide a minimum level of service to protect the health of individuals and communities through the implementation of five public health core functions, including:

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

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

- An organizational structure that assures an effective public health system.
- Health education and information in schools, workplaces, and community settings.
- In-home health education for parents of children living in high-risk conditions.
- Training for teens about pregnancy prevention, abstinence and nutrition education.
- Prevention programs to address chronic health conditions such as heart disease, obesity, stroke, asthma, lead poisoning, diabetes, etc.
- Monitoring and addressing racial and ethnic health disparities.
- Emergency preparedness planning, exercises, and coordination.
- Health services to support the provision of medical and dental care to medically underserved communities throughout Multnomah County.

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

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

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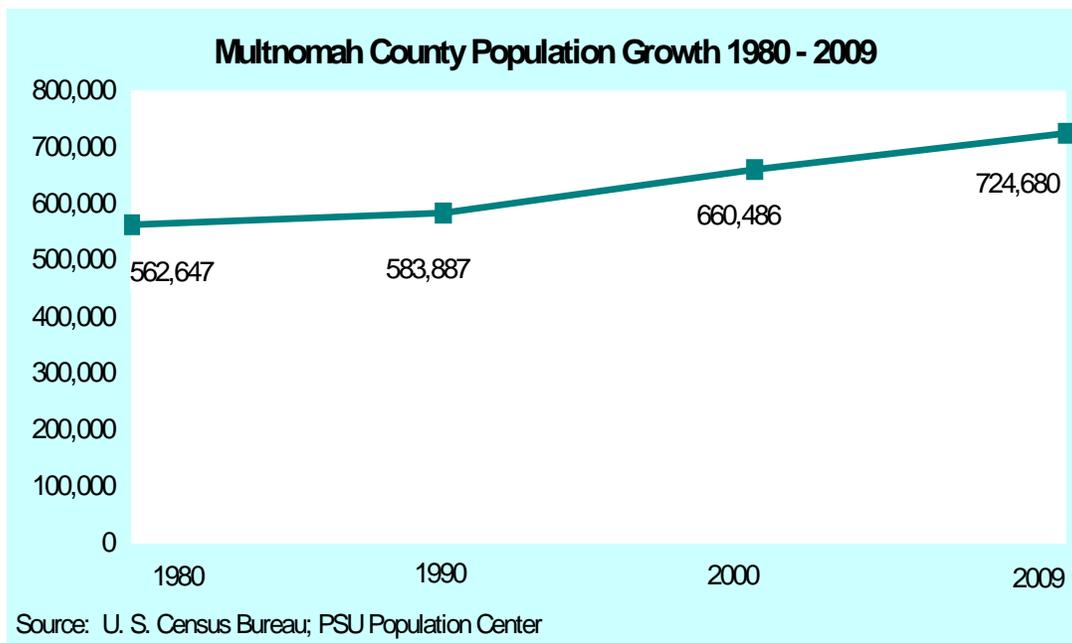
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II. ASSESSMENT

A. Multnomah County Overview

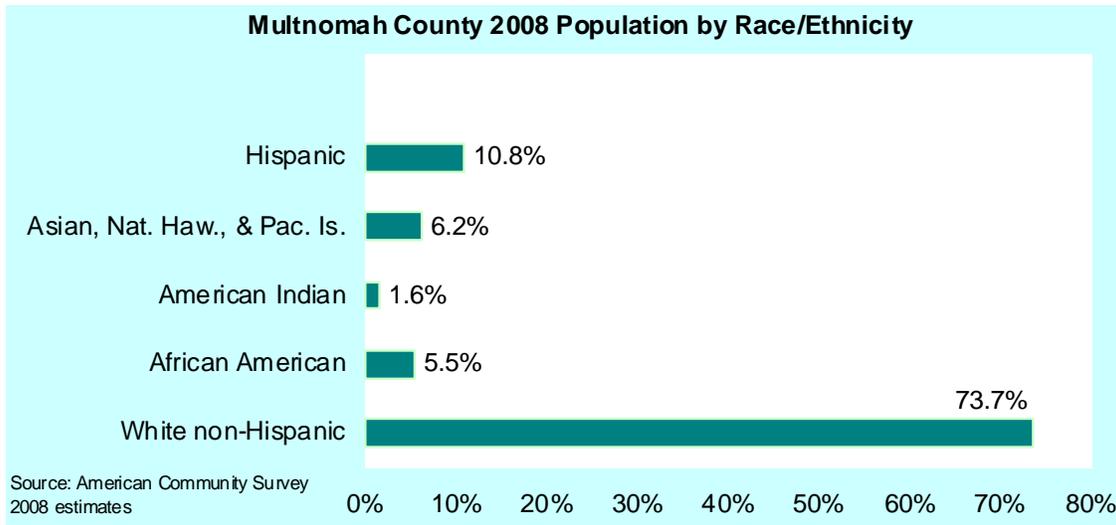
A.1 Background & Socioeconomic Characteristics - Multnomah County occupies 450 square miles in northwestern Oregon and is home to Portland, the largest city in the state. The county is approximately 90 miles inland from the Pacific Ocean; and it borders the Columbia River on the north (a border shared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

Population - Multnomah County, located in the northwest corner of Oregon, continues to be the most populous county in Oregon with 19% of the State's population. Multnomah County grew to 724,680 residents in the year 2009. The population increase from 2000 to 2009 was 9.7%, or 64,194 persons. Over the same period, the population of Oregon increased 11.8%, or 402,066 persons.

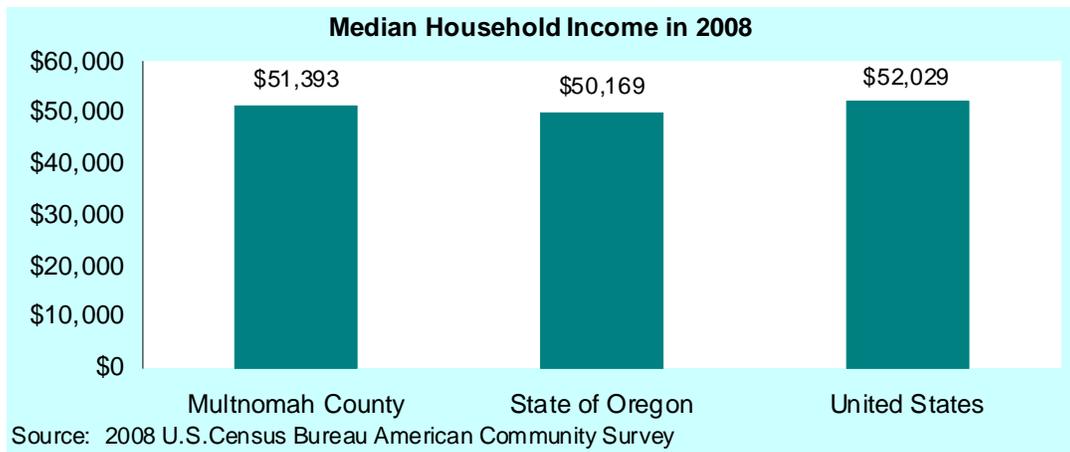


The racial and ethnic mix of the population varies in Multnomah County. North Portland is the most racially diverse geographic area, while the West side is the least diverse. In 2008, Multnomah County was comprised of 73.7% White non-Hispanics, 5.5% African Americans, 1.6% American Indians, 6.2% Asians, Native Hawaiians and Other Pacific Islanders, and 10.8% Hispanics.

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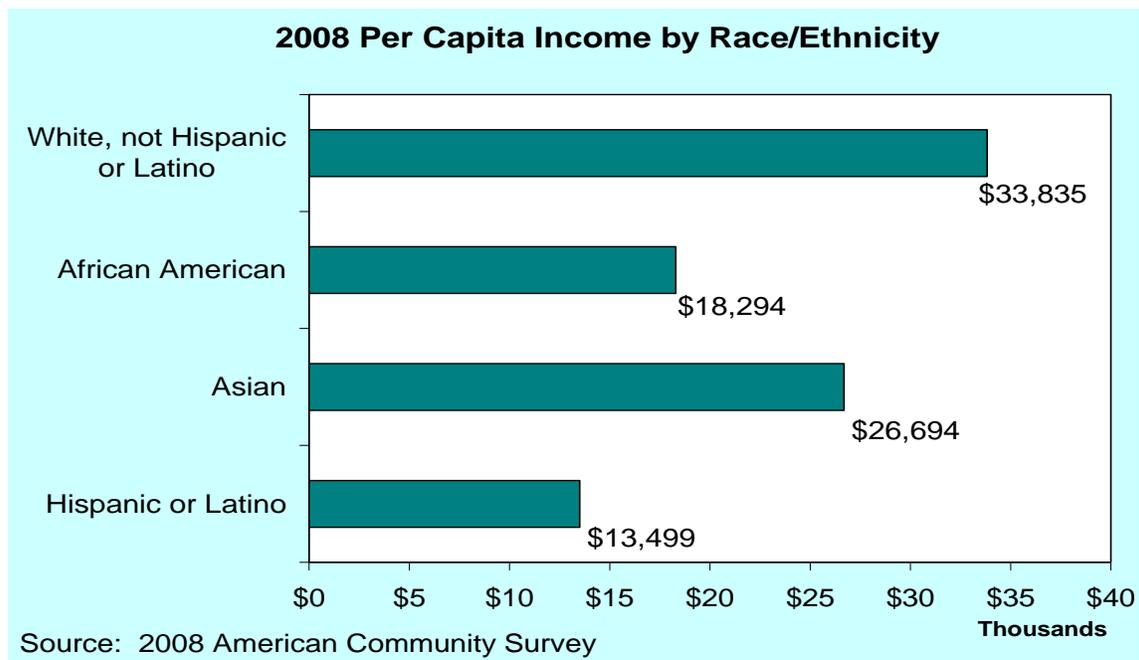


Income and Poverty - Median household income for Multnomah County was \$51,393 in 2008. This is slightly higher than the median income for Oregon, and lower than the United States.



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Approximately 14.1% of Multnomah County residents had incomes below the Federal Poverty Level according to the 2008 Census Bureau's American Community Survey. This is higher than Oregon (13.6%) and the United States (13.2%). The per capita income in Multnomah County was \$33,835 for White non-Hispanic or Latino, \$26,694 for Asians, and \$18,294 for African Americans. Hispanic or Latino per capita income was \$13,499.



Health Care Insurance - According to the SMART BRFSS (Selected Metropolitan/Micropolitan Area Risk Trends Behavioral Risk Factor Surveillance System), 16.2% of Multnomah County adults were without some type of health care coverage in 2008 compared to 12.8% without health insurance in 2002.

B. Summary of Health Indicators for Multnomah County

B.1 Healthy People 2010: Leading Health Indicators in Multnomah County - The national Healthy People 2010 health indicators cover physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, injury and violence, environmental quality, immunization, and access to health care. For nearly all of the health indicators, Multnomah County's performance is comparable or slightly better than those reported for Oregon and the U.S. For example:

- Multnomah County has exceeded or is approaching the national objective target rates for:
 - Adults who engage in recommended moderate and/or vigorous physical activity.

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- Deaths due to motor vehicle crashes.
- Multnomah County's rates compare favorably to the U.S. for:
 - Adolescent and adult tobacco use.
 - Adolescent alcohol use in the past 30 days.
 - Adolescents who abstain from sexual intercourse or use condoms if sexually active.
 - Homicide mortality rates.
 - Non-institutionalized adults 65 and older vaccinated for influenza and pneumococcal.
 - Outdoor air that meets the EPA's health standards for ozone.
- Multnomah County's rates are similar to U.S. rates for:
 - Children, adolescents, and adults who are overweight or obese.
 - Adolescents who participate in the recommended amount of vigorous physical activity.
 - Adult binge drinking.
 - Persons with health insurance coverage.
- Challenges for Multnomah County include:
 - First trimester prenatal care utilization.
- Local data is not available for the following Healthy People 2010 objectives:
 - Sexually active persons who use condoms.
 - Adults with recognized depression who receive treatment.
 - Non-smokers exposed to environmental tobacco smoke.
 - Persons who have a specific source of ongoing health care.

B.2 Racial and Ethnic Health Disparities in Multnomah County - Despite overall improvement in the health of the nation's population over the last 50 years, the health of persons of color lags behind that of White non-Hispanics on many measures. The status of racial and ethnic health disparities in Multnomah County are discussed in a report prepared by the Health Department that can be viewed at http://www.co.multnomah.or.us/health/hra/reports/health_disparities_2006.pdf.

The Department's 2006 report on racial and ethnic health disparities in Multnomah County examines disparities for 17 health status indicators. Using White non-Hispanics as a comparison group, health disparities were calculated for four minority populations groups: African Americans, Asians, Native Americans, and Hispanics. The 2006 report also tracked health disparities from 1990 to 2004 in order to analyze trends. Across the 17 indicators and four minority groups, African Americans experienced the greatest number of health disparities, though the magnitude of health disparities in the African American community showed improvement over time and some health disparities have been eliminated in recent years. For example, across the 17 health indicators examined for all populations of color, 29 health disparities were identified for the 1990-1994 period. However, by the 2000-2004 time period, six disparities had been eliminated (three of which were in the African American community) and 14 disparities had been reduced.

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The Department continues to monitor the impact of health disparities and, in March 2008, released a report entitled *Report Card on Racial and Ethnic Health Disparities* (see <http://www.co.multnomah.or.us/health/hra/reports/reportcard.pdf>). In examining 17 health indicators, the greatest disparities were in rates of new cases of sexually transmitted diseases. For example, as compared to White Non-Hispanics:

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

Another area of concern is the rate of births to teenage mothers in communities of color. In the 2001-05 period the percent of live births to Hispanic teens was more than six times higher than for White non-Hispanic teens. For African American residents, the teen birth rate was more than two-and-half times the rate for White non-Hispanics. Finally, the homicide death rate was over six times greater among African American residents when compared to White non-Hispanics.

B.3 H1N1 Influenza Response - The emergence of the H1N1 influenza virus was recognized in April 2009, and the World Health Organization declared it a pandemic in June 2009. During the fall, the Health Department's Incident Command System was activated to enable widespread, mass vaccinations on a scale in line with the anticipated vaccine supply of roughly 50,000 doses per week (the amounts of vaccine received never approached the initial CDC estimates). The Health Department scheduled clinics at WIC sites and other public vaccine distribution clinics administered 8,315 vaccines in October and November (more than half of these went to minority populations and the majority went to those in priority populations such as pregnant women, children under age five and people with chronic disease who are at high risk for serious illness from influenza). Ultimately, the Health Department distributed almost 240,000 doses of H1N1 vaccine between October 2009 and March 2010.

Health Department outreach resulted in vaccination coverage that exceeded the national averages in terms of priority populations and health care personnel. For example, our primary care clinics vaccinated 46% of their priority populations served, as opposed to the national average of 30%. Nationally, just 22.3% of health care personnel were vaccinated, as opposed to over 80% of the Health Department's health care personnel.

C. Summary of Public Health Services Provided

C.1 Department's Mission - The mission of the Multnomah County Health Department is "*In partnership with the communities we serve, the Health Department assures, promotes, and protects the health of the people of Multnomah County.*" The Department promotes its mission through strategic goals, programs and initiatives.

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C.2 Public Health Services of the Health Department - The Multnomah County Health Department complies with Oregon statute ORS 431.416 to provide basic public health services. Public health services are performed in a manner consistent with the *Minimum Standards for Local Health Departments* adopted by the Conference of Local Health Officials (CLHO). As required under the Chapter 333-014-0050 (1) of the Oregon Administrative Rules:

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

As directed under OAR 333-014-0050 (2), this section of the Comprehensive Annual Plan for Multnomah County provides a brief description of the programs and services that enable the Health Department to comply with the Oregon Revised Statutes to meet State requirements for the following essential public health services:

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

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

- Control of Reportable Communicable Disease [OAR 333-014-0050 (2)(a)] – The Health Department’s role for protecting the population from reportable communicable disease includes providing epidemiologic investigations to report, monitor, and control communicable disease and other health hazards; providing diagnostic and consultative communicable disease services; assuring early detection, education, and prevention activities to reduce the morbidity and mortality of reportable communicable disease; assuring the availability of immunizations for human and animal target populations; and collecting and analyzing of communicable disease and other health hazard data for program planning and management to assure the health of the public. See action plans A-1 through A-4 beginning on page 16 in Section III.
- Parent and Child Health [OAR 333-014-0050 (2)(b)] – The Health Department plays a leading role to ensure the health and wellness of parents and children in Multnomah County. This includes initiatives of education, screening and follow up, counseling, referral, health services, family planning, and care for pregnant women, infants, and children. Parent and child health services are shared across all service divisions of the Department, with primary responsibility provided through the Community Health Services (via the Early Childhood Services Program) and Integrated Clinical Services division (via clinical facilities). The Department’s Early Childhood Services Program (ECS) staff utilize a variety of methods to contribute to the health and wellbeing of individuals, families, and communities. Programs

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include Services for First Time Parents; Services for High Risk Prenatal Program; High Risk Infants and Children Program; Family Planning Services; Women, Infants and Children (WIC); and Immunization Services. See action plans beginning on page 23 in Section III.

- Environmental Health Services [OAR 333-014-0050 (2)(e)] - Environmental Health Services of local public health departments in Oregon include inspection, licensure, consultation and complaint investigation of food services, tourist facilities, institutions, public swimming and spa pools, regulation of water supplies, solid waste and on-site sewage disposal systems, and other issues where the public health is potentially impacted through contact with surrounding environmental conditions. Programs of the Health Department to address environmental health issues include the Community Environmental Health Program; Lead Poisoning Prevention Health Inspections and Education Program; Vector-borne Disease Prevention and Code Enforcement; and Environmental Health Inspections. See action plan beginning on page 32 in Section III.
- Health Statistics [OAR 333-014-0050 (2)(c)] – The ability to monitor and analyze trends and assess local health conditions is dependant on the availability of accurate and valid health statistics including birth and death reporting, recording, and registration; analysis of health indicators related to morbidity and mortality; and analysis of services provided. The Health Department’s capacity to meet the community’s need for health statistics is achieved through the Vital Records Program implemented within the Environmental Health Services unit. See action plan beginning on page 34 in Section III.
- Information and Referral Services [OAR 333-014-0050 (2)(d)] – Providing information and referral services for individuals and communities seeking access to health and human services is an essential function of local public health departments. The Multnomah County Health Department accomplishes this function through the Appointment and Information Center. The Appointment and Information Center processes an average of 20,000 client calls per month (these calls would otherwise require handling by various Department staff that are busy serving clients). The centralized function allows for greater efficiency, extended hours of service, focused education and training of operators, and consistent appointment scheduling practices. See action plan beginning on page 35 in Section III.
- Public Health and Regional Health Systems Emergency Preparedness [OAR 333-014-0050 (3)(b)] - The Department's day-to-day disease prevention and control activities and emergency medical services need to be prepared to operate at a significantly high level of efficiency should an event such as a communicable disease outbreak, toxic substance release, mass casualty or other event pose a sudden and acute public health emergency. The Department’s focal point for emergency preparedness training and responsibility is the Incident Management Team. Preparedness extends to others in the Department through training and exercises and is coordinated with health departments in neighboring jurisdictions, as well as many other local agencies (e.g., hospitals, first responders, elected officials, emergency management, etc.). See action plan beginning on page 36 in Section III.

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

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

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

General Public Health Functions

- Coordination/Integration/Leadership – The Department Leadership Team creates and communicates a clear vision and direction for the organization and is responsible for systems-based integration of health services and operations (e.g., leadership and direction for public health issues; assurance that financial commitments are met; continuous improvement of service delivery systems; maintenance of a diverse and qualified workforce, strategic partnerships, etc.). Additional details about the structure, roles and operations of the Department Leadership Team are presented on page 44.
- Health Officer - The Department’s Health Officer provides consultation, medical and technical direction, and leadership by public health physicians to support effective public health practice. The program promotes Health Department and community understanding of health issues, and guides appropriate and effective action to address critical issues. During 2007, the role of the Health Officer was expanded to serve county jurisdictions in the surrounding Portland metropolitan region in addition to Multnomah County, including Clackamas and Washington Counties.
- Health Planning, Program Evaluation, & Grant Development – The Department provides critical support for public health programs and services through three work units including Health Assessment and Evaluation, Program Design and Evaluation Services, and Grant Development.
- Systems and Quality Support Services Program – The Department’s Systems and Quality Support Services Program provides coordination, oversight and support for all programs of the Department’s Community Health Services Division (this division oversees the State-mandated public health functions and services of the Department, including Communicable Disease, Vital Records, Early Childhood Services, Information and Referral, and Environmental Health).
- Emergency Medical Services – The Department’s Emergency Medical Services program develops plans; and 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

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- 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 and policy change.
- Community Capacitation Center - The Community Capacitation Center assists constituents both internally and externally to develop their capacity to promote health across all levels of the socio-ecological model. The Community Capacitation Center also addresses the social determinants of health by actively promoting healthy behaviors, including those that are particularly vulnerable to disease and the (but not limited to) racial and ethnic minority communities.
- Health Promotion Coordination and Capacity Building – The Health Department continues to implement a Health Promotion Change Management Process to increase its ability to promote health by empowering communities and addressing the underlying social determinants of health. The resulting Health Promotion Framework process requires a systematic and long-term commitment to be successful.
- Chronic Disease Prevention Program – The vision of the Chronic Disease Prevention Program is *healthy people in healthy places*, and it emphasizes reducing barriers to healthy living that are shared among the community. The program is based on a socio-ecological model of health to understand the complex social and environmental factors that affect individual behavior and develop initiatives to address health inequities. The Chronic Disease Prevention Program implements environmental and policy strategies to reduce the burden of chronic diseases most closely linked to physical inactivity, poor nutrition, and tobacco use like cancer, diabetes, obesity, heart disease, asthma, and stroke. During February 2010, the Health Department received a \$7.5 million ARRA grant through the CDC to initiate a two-year communitywide health and wellness initiative.
- Tobacco Prevention Program - The Tobacco Prevention Program is organized within the Chronic Disease Prevention Program. Tobacco is the leading cause of preventable death in Oregon, and every year in Multnomah County more than 1,200 people die from tobacco use (which is 22% of all deaths), and 23,700 people suffer from a tobacco-related illnesses. The Tobacco Prevention Program’s work is population-based so that all Multnomah County residents benefit from smoke-free environments.
- Adolescent Health Promotion Program - The Adolescent Health Promotion Program is designed to support academic success of middle school and high school-aged children by breaking down barriers to staying in school. Research indicates that young people who delay sexual involvement until the age of 16.5 are more likely to protect themselves from pregnancy and disease. This program gives students the skills and confidence to delay sexual involvement and reduces participation in other risky activities. The program also promotes healthy behaviors, and access to information and resources. More than 11,000 school aged students and their parents in five school districts (49 schools total) in Multnomah County are

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

- Building Better Care Initiative - The Health Department's Integrated Clinical Services division completed the initial phase of restructuring through the Building Better Care Initiative. The initiative was designed to "develop a patient-centered primary care system that emphasizes panel management, team-based care, nursing case management, patient self management, and integrated behavioral health to improve timely access to appropriate level of care, cost-effectiveness of care, continuity and coordination of care, and quality and safety of care." During FY 2010-2011 efforts to continue quality improvement in the Department's primary care clinics will focus on a new disease management model for individuals with diabetes or depression. Efforts will also build internal capacity to implement process improvements including call management, pre-visit planning and clinic visit cycle time.

Clinical Health Services and Support Systems

- Primary Care Services – The Health Department operates the largest health care safety net in the state, providing health services for the community's low income, medically underserved residents (approximately 38,000 residents were served in 2008). The Department's six clinics are certified through the Joint Commission, and they are recognized as Community Health Centers through the Federal Bureau of Primary Health Care. Each of the Department's clinics provides culturally competent services, which include primary healthcare, well child care, family planning, and immunizations; health services for homeless children and adults; mental health services; outreach services; drug and alcohol assessment services; and appropriate referrals for specialty care. Primary Care Services are overseen by the Multnomah County Community Health Council. The Council includes a majority of members who are consumers of health services at the Health Department; and it is organized to address issues of budget/finance, policy, scope of services, long range planning, diversity, and other issues associated with providing care to the underserved.

The National Association of County and City Health Officials (NACCHO) honored Multnomah County Health Department for implementing a program that demonstrates exemplary and replicable qualities in response to a local public health need. *Integrating Behavioral Health in Primary Care* is one of 25 local public health programs selected from across the nation to receive NACCHO's Model Practice Award. The Health Department's program integrates social workers and psychiatric nurse practitioners within the County's primary care clinics. Primary care providers can connect patients to behavioral health staff immediately after medical appointments, and right in the exam rooms. Patients get help the day of their medical visit, instead of waiting weeks to a month for behavioral health care. This team-based care has resulted in better recognition of depression and rapid access to help. Screening for depression has increased fourfold in six months using this model.

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- Services for Persons Living with HIV - Since 1981, approximately 4,800 people have been diagnosed with HIV in Multnomah County; over 2,000 persons living with HIV/AIDS (PLWH/A) have died, while over 2,700 are still living with this disease. This program aims to address unmet health needs of low-income persons living with HIV disease in the Portland metropolitan area. Local AIDS prevalence increased by 22% from 2001 to 2006, fueling the need for services to address this continuing public health problem. Over 4,000 people with HIV live in the service area; 56% suffer mental illness and 36% have substance abuse problems. The Health Department's HIV care system consists of the HIV Health Services Clinic and the HIV Care Services Program to meet the health care needs of the community's most vulnerable clients (e.g., 73% have incomes below the federal poverty level, 28% are minorities, 24% lack permanent housing, and 13% lack health insurance).
- Corrections Health Services - As a part of its health services, the Health Department provides health care for adult and juvenile inmates housed at Multnomah County's Justice Center, Restitution Center, Inverness Jail, and Juvenile Detention Center. The Corrections Health Services unit assures that each individual who enters the jail system is evaluated by a nurse. Corrections Health staff are on duty 24 hours a day in the Justice Center and Inverness Jail, and all inmates have access to health care a minimum of three times a day to address health, mental health and dental issues. Corrections Health provided services to 24,447 inmates and provided 75,621 visits.
- School-Based Health Centers - Since 1986, School-Based Health Centers have provided access to comprehensive healthcare to uninsured school-aged youth, as well as youth with insurance who cannot or do not access providers. The services are confidential, culturally competent, and age-appropriate. During FY 2010/2011, the Department will continue to operate 13 fully equipped school-based medical clinics. Twelve clinics are located in schools and one clinic is located at a County-owned facility that is school-linked. Program locations are geographically diverse, and all school-aged youth are eligible to receive services (including those who are attending other schools, drop-outs, homeless, in detention, etc.). School-based clinics served 6,500 individuals and provided 21,000 visits.
- Dental Services – The Health Department's Dental Services Program provides urgent, routine and preventative oral health care through clinic based and school-based programs. Poor dental health has been shown to affect a person's overall health, which can result in unnecessary and costly medical care. The Health Department is the largest safety net provider for dental care in Multnomah County. It focuses on underserved populations including uninsured, at-risk children, pregnant women, homeless, disabled, minorities, and non-English speaking residents. The Department's four dental clinics served 19,000 individuals and provided 54,000 clinical visits.
- Clinical Services Infrastructure Group – The Clinical Services Infrastructure Group includes Pharmacy, Laboratory, X-ray, Language Services, and Medical Records Management. This group provides essential support services needed to ensure the delivery of high quality care to clients of the Department's care clinics, which include a large percentage who are women and children, uninsured, and mentally ill.

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III. FY 2010-2011 Action Plans

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

- A. Epidemiology and Control of Reportable Communicable Diseases [OAR 333-014-0050 (2)(a)]
 - A.1 Communicable Disease Prevention and Control Program (page 16, also see Attachment 1 on page 63 for the Guidelines for BT/CD Assurances)
 - A.2 Hepatitis C Surveillance Program (page 17)
 - A.3 TB Prevention and Control (page 19)
 - A.4 STD, HIV and HCV Programs (page 21)

- B. Parent and Child Health Services [OAR 333-014-055 (2)(b)]
 - B.1 Early Childhood Services (page 23)
 - B.2 Babies First! (page 25)
 - B.3 Family Planning Services (page 25, see also Attachment 2 on page 67 for the FY 2010-2011 Family Planning Program Annual Plan)
 - B.4 Family Planning through School-Based Health (page 27)
 - B.5 Women, Infants & Children (page 29, also see Attachment 3 on page 69 for the FY 2010-2011 WIC Nutrition Education Plan; Attachment 4 on page 74 for the FY 2010-2011 WIC Staff Training Plan; and Attachment 5 on page 75 for the Evaluation of the WIC Nutrition Education Plan of FY 2009-2010)
 - B.6 Community Immunization Program (page 29, also see Attachment 6 on page 83 for the Immunization Progress Report and Plan FY 2008-2011)

- C. Environmental Health [OAR 333-014-0050 (2)(e)]
 - C.1 Environmental Health Services (page 32)

- D. Health Statistics [OAR 333-014-0050 (2)(c)]
 - D.1 Health Records Program (page 34)

- E. Information and Referral [OAR 333-014-0050 (2)(d)]
 - E.1 Information and Referral Program (page 35)

- F. Public Health Emergency Preparedness [OAR 333-014-0050 (3)(b)]
 - F.1 Emergency Preparedness Program (page 36)

- G. Other Issues
 - G.1 Healthy Communities Program (page 39)
 - G.2 Tobacco Prevention Program (page 41)

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**A. Epidemiology and Control of Reportable Communicable Diseases
[OAR 333-014-055 (2)(a)]**

**A.1. Communicable Disease Prevention and Control Program (FY 2010-2011
Action Plan)**

- a. Current condition or problem - Epidemiology and the control of communicable diseases is addressed through the Communicable Disease Prevention and Control Program (a unit within the Communicable Disease Services team). The purpose of this program is to protect the community from the spread of communicable disease and decrease the level of communicable disease in Multnomah County. The work of the program involves investigating, counseling, and recommending control measures to individuals diagnosed with a communicable disease. Other primary activities include public health surveillance (involving collection and analysis of statistical data), as well as screening and diagnosis of clients in high-risk occupations who have no other source of medical care.

With continuing concerns regarding bioterrorism and other incidents involving mass casualties, this program works closely with the Department's Emergency Preparedness Program and with infection control community partners to improve the Department's capacity to respond to all possible communicable disease threats. Program staff also work collaboratively with the Multnomah County Health Officer, Emergency Medical Services Medical Director, and Environmental Health Program staff, the Oregon Department of Human Services/Health Services, as well as with other local health departments and public safety responders in the Portland metropolitan region to improve the reporting, investigation, and implementation of control measures for all communicable diseases occurring in Multnomah County.

Program staff have been trained in the basic Incident Command System, with select staff having past responsibilities on the Department's Incident Management Team. Program staff have also participated in multi-agency bioterrorism/emergency preparedness response exercises, as well as in the local response to the 2009 H1N1 mobilization. Staff from other programs in the Communicable Disease Services unit, including staff from the Immunization and Tuberculosis Programs, are trained to provide surge capacity in the event of a large outbreak or bioterrorism event. A 24 hour/day hot line is available for use when the volume of calls increases above the ability to provide a personal response; and an on-call system has been created to ensure an appropriate staff response at anytime (i.e., evenings, weekends and holidays).

- b. Goal - The goal of the program is to identify, prevent and control epidemics and emerging communicable diseases and environmentally-related threats.
- c. Activities - Target population includes all residents of Multnomah County. Major activities include:

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- Providing epidemiologic investigations to report, monitor and control communicable disease and other health hazards.
- Providing diagnostic and consultative communicable disease services.
- Assuring early detection, education, and prevention activities which reduce the morbidity and mortality of reportable communicable disease.
- Assuring the availability of immunizations for human and animal target populations.
- Collecting and analyzing communicable disease data and other health hazard data for program planning and management to assure the health of the public.
- Collaborating with other public and private health care providers and infection control professionals as well as public safety personnel, schools, day cares, nursing homes, and work places to assure timely response to communicable disease issues of public health importance.

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

- d. Evaluation - The effectiveness of the Communicable Disease Prevention and Control Program is evaluated by monitoring the timeframe that cases are reported to the Oregon State Department of Human Services/Health Services (DHS). According to DHS, 90% of all communicable disease cases must be reported within the standards set forth in OAR Chapter 333, Divisions 1, 12, 24, and 43. Monthly meetings are held with staff in order to review case reports and conduct quality assurance activities. The Clinical Nursing Supervisor reviews cases before case reports are submitted to the State. Client satisfaction surveys are reviewed and findings are distributed.

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

A.2. Hepatitis C Surveillance Project (FY 2010-2011 Action Plan)

- a. Current condition or problem - The Hepatitis C Surveillance Project is a unit within the Communicable Disease Services team. The project is funded through a grant from the Center for Disease Control and Prevention in Atlanta. The purpose of the project is to perform epidemiologic surveillance of persons in Multnomah County diagnosed with the hepatitis C virus (HCV). Medical laboratories in Multnomah County report hepatitis C to the Health Department's Communicable Disease Program. The Communicable Disease Program maintains a Communicable Disease database of individuals with HCV in order to conduct surveillance on chronic HCV cases to:
1. Better understand the burden of disease and transmission patterns.
 2. Provide best practice evidence on managing HCV.
 3. To provide education on preventive behaviors to reduce the morbidity and mortality of HCV.

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Staffing to support the Hepatitis C Surveillance Project includes a research evaluator/analyst, data manager and a program manager to supervise activities. Adequate staff is assigned to assure that all data is entered into the database in a timely manner.

- b. Goal – The goal of the HCV Surveillance Project is to identify descriptive and clinical characteristics and disease burden of persons with confirmed chronic HCV infection reported in Multnomah County.
- c. Target Population/Activities – The target population is comprised of all residents in Multnomah County, with a focus on individuals with chronic HCV. Major activities include:
- Capture data reported by medical laboratories and health care providers.
 - Mail health education information and community resource guide to confirmed HCV infected individuals reported by laboratories and providers.
 - Interview all individuals ages 18-30 who are newly reported to the HCV Surveillance Project with a confirmed or presumptive HCV diagnosis for a more thorough review of their socioeconomic characteristics, medical pathologies, risk factors for HCV and the need for medical and preventive services.
 - Analyze surveillance data for demographic and socioeconomic characteristics of persons with HCV infection, estimate the burden of disease among persons newly-identified with HCV, estimate of the duration of infection and extent of ongoing transmission in Multnomah County, assess the stage of illness and the need for medical and personal preventive services (e.g., health insurance status, access to primary and specialty care, history of vaccination against hepatitis A and B, and current alcohol/drug use).
 - Collect and be informed about current research concerning best practices on clinical management and prevention of hepatitis C infection.
 - Disseminate data and findings to health care providers and outreach prevention programs.

The program also conducts its work through the HCV “Fax Surveillance Project, which is intended to establish profiles about individuals with confirmed chronic HCV infection reported in Multnomah County. A one-page form is faxed to the individual’s health care provider requesting information on the patient’s race/ethnicity, primary language, reasons for HCV testing, risk factors for HCV infection, referrals made to specialists, vaccination and treatment history. Faxes are not sent to facilities where a provider cannot be identified, such as blood/plasma donation centers and correction facilities.

- d. Evaluation - The effectiveness of the Hepatitis C Surveillance Program is measured by the following outcomes:
- 90% of hepatitis C cases are reported to Oregon Department of Human Services, Public Health Division within specified time frame.
 - 100% of clinicians from an eligible facility are sent a fax surveillance form for newly reported HCV patients.
 - 70% of providers respond to the fax surveillance.
 - 50% of patients 18-30 years of age participate in an interview.
 - Surveillance results are disseminated to appropriate groups (reports and presentations).

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Data collection, data analysis and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services Public Health Division, funding partners, and to others upon request.

A.3 Tuberculosis Prevention and Treatment (FY 2010-2011 Action Plan)

- a. Current condition or problem - The Health Department’s Tuberculosis (TB) Program (a unit within the Communicable Disease Services team) provides case management services for residents with active TB disease, which includes directly observed therapy (DOT) and case contact investigations. The TB Program also provides screening for high risk populations and preventive treatment for those with latent TB infection (LTBI). In 2009, Oregon’s TB case rate was 2.3 cases per 100,000 population. The same year Multnomah County reported 4.1 cases per 100,000 population (an increase in Multnomah County’s 2008 case rate of 3.8 cases per 100,000 population). TB Program staff must continue aggressive efforts in order to maintain current trends in TB case rates.

Tuberculosis Rates By Year, 2005-2009 Multnomah County & Oregon^{a,b}		
Year	Multnomah County	All Oregon
2005	5.8	2.8
2006	4.6	2.2
2007	3.9	2.5
2008	3.8	2.0
2009	4.1	2.3

^a Reported data from Oregon DHS TB Program;
^b Rate per 100,000 population.

- b. Goals - The primary goal of the TB Program is to prevent the spread of tuberculosis and to reduce its harmful effects on individuals and communities. Short term goals include assuring active cases complete treatment, contacts are evaluated and treated as needed, and high risk populations receive screening, evaluation, and treatment when indicated. Long term goals include decreasing TB case rates to the Center for Disease Control (CDC) case rate goal of 3.5 cases per 100,000 population, decreasing LTBI in the community, and increasing awareness of TB among all residents, especially high risk populations.
- c. Activities - The service activities offered by the TB Program include:
- Case Management Services - A TB Nurse Case Manager (TB-NCM) is assigned to each suspected or confirmed active TB case. The TB-NCM assures that the case begins appropriate therapy within one working day of receipt of the case/suspect report or, when appropriate, after disease work up is completed and a decision to treat has been made. A Direct Observed Therapy (DOT) priority assessment is made for each case of TB. DOT is the standard of care for all TB cases. The TB-NCM monitors each of the TB cases’ treatment and clinical response to treatment through the completion of therapy. They

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begin the contact investigation within 72 hours of verifying the case/suspect and assure appropriate and timely contact investigation is performed. The TB Program follows infected contacts through the completion of their therapy. The TB-NCM completes all TB reporting forms within required timeframes.

- Outreach Prevention Services - The Department's TB Program screens high risk populations for evidence of TB infection or disease. The high risk populations in Multnomah County are refugees and immigrants from countries with disproportionately elevated TB rates, and dormitory style homeless shelter occupants and employees. Screening services include the TB skin test, QuantiFERON-Gold in tube blood test, chest radiography, history and symptom evaluation, sputum collection and testing, and physician assessment as indicated. Bi-weekly shelter screening clinics are conducted on-site at an established homeless shelter. Residents are given a shelter clearance card that must be renewed annually.
 - Smoking Cessation Risk Counseling - The TB Program plans to develop new methods to address the increased health risk of patients with TB who smoke. The risks include increased progression from latent TB infection to pulmonary disease, the increased probability of disease relapse after TB treatment, and an increase in TB case fatality. Smoking damages the body's ability to fight off infections and increases the severity of TB. The methods the TB Program plans to develop and implement will include a patient information brochure, staff training on how to counsel a patient on TB and smoking risk factors, and revising TB medical history and interviewing forms.
- d. Evaluation - The effectiveness of TB disease control and prevention is evaluated by monitoring the following indicators:
- The number of active cases, types of cases, duration of infectiousness, and the percent of cases that complete treatment.
 - The number of contacts, Class B immigrants and refugees, and homeless shelter residents who complete an evaluation and, of those found to be infected, the number who start and complete preventive treatment.
 - The completion of immigrants and refugees TB evaluation within the required time period.

The Department's TB Program staff developed and consistently implements a quarterly end of treatment review. Each TB case that has completed treatment is presented by the nurse case manager assigned to the patient. During the review, treatment issues, contact investigation findings, and challenges are discussed. The State of Oregon TB Program and representatives from other local health department TB programs attend and present cases. Monthly chart reviews are conducted on cases currently on treatment and clients on preventive treatment for latent TB infection. Charts are reviewed to determine if required evaluation components have been completed and documented. A summary of findings is provided to all staff and individual issues are resolved in one-to-one meetings. Aggregate

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data reports are reviewed annually. Client satisfaction surveys are reviewed and findings are distributed.

Data is unavailable for the TB Program Performance Measures for CY 2009 until 2011 due to the length of treatment. Completion of therapy data on infected contacts that initiated treatment for latent TB infection is also unavailable due to the length of treatment.

Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services, and others upon request.

A.4 STD, HIV and HCV Program (FY 2010-2011 Action Plan)

- a. Current Condition/Problem - STDs, HIV, and Hepatitis C (HCV) account for over 80% of all reportable diseases in the county and disproportionately affect racial/ethnic and sexual minorities. Approximately 4,850 people have been diagnosed with HIV in Multnomah County since 1981; over 2,100 persons living with HIV/AIDS (PLWH/A) have died, while over 2,700 are still living with this disease. In addition, an estimated 24,000 county residents use injection drugs, a leading cause of HCV. Delayed diagnosis and treatment increases disease spread and costly chronic conditions. Preventing these diseases saves money over the course of a lifetime. For example, each prevented HIV case saves an estimated \$360,000 over a lifetime, and each prevented HCV case saves an estimated \$66,000. Economic studies examining the costs associated with HIV infection have found that the avoided cost per HIV infected person by syringe exchange runs about \$4,000 to \$12,000, which is considerably less than the lifetime medical costs of treatment for a person who is infected, and preventions avoids the pain and trauma associated with the disease.

STD, HIV and Hepatitis C (HCV) Programs target and serve newly affected, emerging, and underserved populations impacted by HIV, STDs, and HCV through testing, prevention services, treatment of bacterial STDs; notification and referral for partners of those diagnosed with HIV and STDs; primary care services; early intervention services; medical case management; and support services. The program's emphasis is on community prevention, outreach and early diagnosis reduces disease transmission and the likelihood of devastating long-term outcomes.

Additionally, this program serves as a Ryan White grantee, serving six counties in two states including Multnomah, Washington, Clackamas, Columbia, and Yamhill Counties in Oregon, and Clark County in Washington. Nearly 4,000 PLWH/A reside in this six county area. There are high levels of co-morbidities among PLWH/A, and an increased need for HIV-related services. PLWH/A have much higher rates of socio-economic problems than does the general population, such as poverty, homelessness, substance abuse, and mental illness. Among PLWH/A, 53% have a mental illness (over two times the rate found in the general population) and 25% have both a mental illness and substance abuse diagnosis. Among the clients served by this program, 68% have incomes below 100% FPL, 18% lack permanent housing, and 13% lack health insurance. The primary care, early intervention, medical case

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

- b. Goals - The goals of the STD, HIV and HCV Program are to: 1) prevent the further spread and harm of STD, HIV and HCV infection, especially among highest risk community members; 2) eliminate sexual health disparities, especially among African Americans and men who have sex with men, through collaborative strategies; and 3) effectively manage the Federal Ryan White grant so HIV clients have access to primary health care and support services.
- c. Activities – This program targets high risk populations, including men who have sex with men, injection drug users, partners of persons living with HIV/AIDS; persons living with HIV/AIDS at highest risk of transmitting or acquiring HIV, HCV, or STDs; and low income PLWH/A living the six county area served by the Ryan White-funded Care Services Program. Prevention services include:
- Community testing is provided by staff who visit bars, jails, internet and other "hookup" sites to test, educate, and promote behavior change among the target population.
 - Syringe exchange and disposal is a proven intervention to keep infection rates low among injectors, partners and their infants; refer injectors into social services; and reduce drug-related harm
 - Behavior Change Education and Counseling involves individual interventions to reduce risky sexual behavior and drug use.
 - STD prevention includes testing and treatment for bacterial STDs, surveillance of reportable STDs and HIV, partner notification and referral for partners of those diagnosed with HIV and STDs, and referral into primary care for newly diagnosed PWLH/A.
 - Community collaborations with partnering organizations increase community awareness and education, address social determinants of sexual health disparities, and increase community capacity to advocate for policy and structural change to support sexual health.
 - Service locations include community test sites and STD clinics, correctional facilities, drug treatment agencies, and other targeted community venues. Programs directed at African-American youth from 13-24 include the “KnowSex/NoSex” community health information and awareness campaign, and the MARS and SiHLE evidenced-based group interventions to address local racial/ethnic sexual health disparities. Another CDC evidenced-based intervention, “MPowerment,” is an initiative targeting highest risk men who have sex with men.
 - Primary care services in the six county service area include medical care, medications, oral health care, substance abuse treatment, mental health therapy, and health insurance premium/co-pay assistance. Services are provided through contracts with both public and private health systems and community-based organizations.
 - Early Intervention Services targets recently diagnosed and other PLWH/A who have not engaged in primary medical care. Services are provided through the MCHD HIV Community Test site and STD Prevention Program and through a community-based organization that provides HIV prevention and testing services to those at highest risk.

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- Medical case management in the six county area is coordinated with the major medical health systems and funded by both mainstream and Ryan White resources. Case management develops individual service plans with each client based on a thorough health and psychosocial assessment of service needs and support systems, and connects clients with health insurance, primary care, housing, and other services critical to remaining in care.
 - Support services for PLWH/A in the six county area promote retention in medical care and assist clients in meeting basic needs. Services provided by public agencies and community-based organizations include housing, psychosocial support, and food/home-delivered meals.
- d. Evaluation - HIV and STD infection rates in Portland are the lowest of all large west coast cities (e.g., syphilis is one-fifth and gonorrhea one-half of the rates they were 15 years ago). Evaluation of programs has demonstrated positive results, including lower HIV mortality (there has been an 86% decrease in mortality between 1994 and 2004), and prevention and care services are better targeted. Staff performed ~5,500 HIV tests and ~12,000 STD clinical encounters in FY 2009.

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

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

B.1 Early Childhood Services (FY 2010-2011 Action Plan)

- a. Current condition or problem - The Early Childhood Services Program (a unit within the Community Health Services Division) contributes to the health of children and their families by serving nearly 10,000 children and their parents each year. Early Childhood Services consists of community health nurses, community health workers, office assistants, program supervisors and managers and program-specific staff. Staff are located in geographically designated offices, identified as project-specific teams (e.g., Nurse Family Partnership, Healthy Start and Healthy Birth Initiative) or staff may be out-stationed as members of multidisciplinary, interagency teams in various community-based locations such as Head Start programs and Child Care Resource and Referral of Multnomah County. The ECS staff utilizes a variety of methods to contribute to the health and well being of individuals, families, groups, and communities.
- b. Goals - The goal of the Early Childhood Services Program is to improve the overall health of women, infants, children, and fathers through preventive health programs and services that build on the strengths of specific populations and community partnerships.
- c. Activities - The target population includes children and families in Multnomah County. Key activities include:

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- Early Childhood Services home visiting teams work to promote wellness, with an emphasis on families with young children. The primary focuses of ECS Teams are to “promote healthy pregnancy in populations at risk of not having a healthy pregnancy; and “promote healthy infant/child growth and development in populations at risk of not achieving healthy growth and development.” Services include home visits, coordination with community health providers, groups, classes, and health promotion activities. Services are provided to approximately 10,000 parents and children annually, with priority to teen parents, first-time parents, premature infants, children with special healthcare needs, and high-risk families. During FY 2009, ECS home visiting staff made 31,273 to 9,576 unduplicated clients

- Services are delivered through a series of programs, including:
 - Healthy Start is a state funded program that provides screening, assessment, referral and home visit services to first time parents in Multnomah County. Health Department staff visit local hospitals to assess first time parents using the New Baby Questionnaire. Families eligible for home visit services are referred to contracted community agencies, and Health Department ECS staff for ongoing services of case management and parenting education. The Immigrant and Refugee Community Organization, Impact NW and Insights Teen parent Program are contracted to provide Healthy Start home visiting services.
 - Insights Teen Parent Program provides assessment case management, support groups, pregnancy prevention, parent education, and, referrals, to first time teens giving birth in the county. Services are focused on teens 17 and under.
 - Healthy Birth Initiative addresses disparities in perinatal health among African American women residing in specific zip codes, which reflect high infant mortality rates. The project covers pregnancy and interconceptional phases through the infant’s second year of life. Home-visits, support groups, classes, and community consortium are key activities.
 - Nurse Family Partnership follows the model developed by David Olds’ research. MCHD is an official NFP site contracted by the National NFP Service Office. Services are provided to first time pregnant women beginning early in their pregnancy until children reach age two. Nurse home-visitors follow the NFP curriculum and guidelines.

- d. Evaluation - The effectiveness of the Early Childhood Services Program will be measured by the following types of outputs/outcomes:

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- Percent of mothers who are breastfeeding at six months postpartum.
- Percent Healthy Start enrolled parents reporting positive parent-child interactions.
- Percent of pregnant and postpartum women screened for domestic violence.
- Percent of infants 0-12 months with developmental screening.

Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services, and others upon request.

B.2 Babies First! (FY 2010-2011 Action Plan)

- a. Current condition or problem – The Babies First! Program (a program that is part of the Early Childhood Services unit) is a developmental screening program for children at risk of developmental delay due to a variety of risk factors including premature birth, drug exposed infant during pregnancy, low birth weight, age of the parent/caregiver, low income/ poverty, and other factors. Referrals come primarily from prenatal providers, WIC, and hospitals. Babies First! serves children from birth to age four when potential problems can be detected quickly and interventions started and monitored regularly. Public health nurses conduct in-home health and developmental screening for participating children on a regular basis. Nurses work closely with families on parenting skills, health education, advocacy, and referrals to services in other agencies. Babies First! focuses on helping families learn to care for and better understand their children.
- b. Goal - The goal of Babies First! is to improve the physical, developmental and emotional health of high risk infants and children ages birth to four years.
- c. Activities – The target population includes high-risk infants and children from birth to four years of age in Multnomah County. Key activities include:
 - Outreach
 - Home visits
 - Health assessment and developmental screening
 - Monitoring neurological development and growth
 - Case management and counseling
 - Parenting education
 - Information and referral
 - Advocacy

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

- d. Evaluation - Data is collected per ORCHIDS Babies First! requirements and is electronically transferred to DHS Public Health. Referral sources and risk criteria are reviewed annually. The key performance measure is the percent of infants 12 months of age or younger who had developmental screening. Data collection, data analysis, and program evaluation occurs at the

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program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services, and others as requested.

B.3 Family Planning (FY 2010-2011 Action Plan)

- a. Current condition or problem - During FY 2009, family planning services were provided to 3,479 adolescents, accounting for 41% of the total family planning clients; an estimated 753 adolescent pregnancies were averted; 8,434 total clients were seen, a 6% decrease from the 2007 number; and a system was developed to reduce FPEP and Medicaid billing denials and improved FPEP supply billing. Family planning services are offered through primary care clinics, field offices, School-Based Health Centers, and other community sites. Based on 2005 Ahlers data, over 9,480 clients receive family planning services each year, approximately 42% are teenagers. The Ahlers calculation estimated that 2,100 unintended pregnancies were averted in 2005.
- b. Goals - The primary goal of family planning effort is to reduce unintended pregnancies and improve the health and well-being of children and families.
- c. Activities - The target population is all Multnomah County residents. Family planning activities are divided among the three areas described below.
 - Family planning through Primary Care Clinics:
 - Comprehensive history and physical exam
 - Breast exam and diagnostic procedures as indicated
 - Pap smears
 - Colposcopy for the evaluation of abnormal pap smears
 - STI testing as indicated
 - STI treatment and follow-up
 - Review of family planning goals, birth control methods education, comprehensive birth control options offered, ongoing BC management, or maintenance provided
 - Preconception health education (prenatal and postnatal care are provided in Primary Care)
 - Miscellaneous family planning activities
 - Community outreach and education
 - New computer-based education in clinics to provide access to high quality websites, guidance and printers to download needed information
 - Technical assistance to teachers and in-class teaching on reproductive health topics
 - Educational displays for school hallways
 - Peer-lead abstinence education
 - Initiation of hormonal contraception by Field Nurses
 - Comprehensive contraceptive counseling by Field Nurses
 - Family Planning Program administrative activities
 - Monitor contraceptive access in School-Based Health Centers.
 - Bill all appropriate Medicaid and FPEP contraceptive visits and supplies

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d. Evaluation - Outcome measures include:

- Percent of visits of 19-21 year olds receiving family planning services.
- Percent of 15 to 17-year-old female family planning clients who do not get pregnant during the year.
- Number of clients treated for an STI.
- Number of clients evaluated for an abnormal pap smear.
- Maintaining contraceptive access at the same level as FY 2009.
- Capturing all appropriate Medicaid and FPEP reimbursements for contraceptive visits and supplies.

Data collection and analysis occurs at the program level. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and others as requested.

B.4 Family Planning through School-Based Health (FY 2010-2011 Action Plan)

- a. Current condition or problem - The vision of the Multnomah County Health Department School-Based Health Center Program is to facilitate access to comprehensive preventive, primary, and mental healthcare for Multnomah County school-age youth to keep them healthy and ready to learn.

Since 1986, the Department's School-Based Health Centers (SBHC) have provided significant access to comprehensive healthcare to uninsured school-aged youth, as well as youth with insurance who cannot or do not access providers. The services are confidential, culturally competent, and age-appropriate.

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

SBHC are located in close proximity to children in order to create continuous, trusting relationships to encourage high-risk youth to seek help and make better life choices, including staying in school. Such positive interventions can be crucial to later independence and success in life. Parent/guardian involvement is encouraged to ensure successful clinical outcomes and support educational success.

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

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- Provide culturally sensitive and age-appropriate healthcare, education, outreach, and referrals to school-age youth;
- Facilitate early identification of high-risk behaviors and health issues that enable timely intervention and treatment;
- Reduce barriers to healthcare by being conveniently located in schools and by offering confidential care in a safe environment regardless of insurance coverage and ability to pay;
- Promote healthy lifestyle choices and empower youth to take responsibility for their health and healthcare;
- Encourage parent or guardian involvement to support and sustain successful health outcomes.

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

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

Key activities that will be implemented during FY 2010/2011 include the following:

- SBHC planning to determine the feasibility of opening SBHCs in east Multnomah County high schools (e.g., Gresham/Barlow, and the Centennial school districts). This project is being funded through a State school-based health center planning grant, and it is currently underway, and supported by a 30-member community volunteer steering committee.
 - Portland Public Schools are in the process of a high school re-design (it is unclear what impact this will have on SBHC locations).
 - Federal Health Care Reform Act includes funding for SBHCs, and the Health Department may pursue opportunities that are consistent with its strategic direction.
 - Lincoln Park Elementary SBHC is being moved to David Douglas High School. Clinic services will be expanded to five days per week (up from three), and include students K-12 (currently students K-8 are served). This expansion is made possible from Federal funding provided through the American Recovery and Reinvestment Act.
 - Partnering with Multnomah Youth Commission to start youth advisory boards at all of high school SBHC locations.
- e. Evaluation - The effectiveness of the School-Based Health Center Program is measured by the following types of outcomes:
- Number of youth who receive preventive and primary health care.

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

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

B.5 WIC (FY 2010-2011 Action Plan)

- a. Current condition or problem - The federally funded WIC program builds healthier families through nutrition education, supplemental foods, and community networking. WIC services are offered at three Multnomah County clinic sites (East County, Mid-County, and Northeast), and during FY 2010 the Health Department provided WIC services to 30,419 individuals (83,842 encounters). WIC is a prevention-oriented program that addresses the need to increase birth weight, lengthen the duration of pregnancy, improve the growth of at-risk infants and children, reduce rates of iron deficiency, and decrease infant mortality. This Action Plan represents a summary of the FY 2009-2010 WIC Nutrition Education Plan for Multnomah County (this plan was submitted to the Oregon Department of Human Services/Health Services WIC Coordinator on May 1, 2010 (see Attachment 3 beginning on page 69, Attachment 4 on page 74, and Attachment 5 beginning on page 75).
- b. Goals - The goal of the County's WIC Program is to provide quality nutrition education that is appropriate to the clients' needs; improve the health outcomes of clients and staff; and improve breastfeeding outcomes of clients and staff.
- c. Activities - Key activities of the WIC Program for this fiscal year are specified in the WIC Nutrition Plan and WIC Training Plan presented in the attachments section of this document.
- d. Evaluation - The effectiveness of WIC is measured by the average number of pregnant women served per month as a percent of WIC caseload. Data collection and analysis and program evaluation occurs at the program level. Results are reported to the Board of County Commissioners, the Oregon Department of Human Services/Health Services, and others as requested.

B.6 Community Immunization Program (FY 2010-2011 Action Plan)

- a. Current condition or problem - The Community Immunization Program (CIP) promotes and provides immunizations throughout Multnomah County for uninsured and underinsured children. The program oversees the immunization school law process for vaccine requirements for children and students in day care facilities, preschools, Head Start programs, and private, alternative and public schools. Blood lead screening for children six years of age and younger, adult immunization services, and antibody testing are also

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provided. There is still difficulty in reaching primary and middle school populations who may not be complete on their immunizations, and there are a growing number of families who seek the State's religious exemption to avoid having their children vaccinated. There remains great need to continue providing no/low cost vaccination services to children who have no insurance or whose insurance does not cover immunizations. The walk-in clinic serves as a safety net for those children who cannot access immunization services elsewhere. Also see Attachment 6, Immunization Progress Report and Plan 2008-2011 on page 75.

- b. Goals - The primary goal of the County's immunization efforts is to promote and provide immunizations to prevent vaccine-preventable disease in children by reaching and maintaining high lifetime immunization rates. A secondary goal is to provide occupational health services (immunizations, TB testing, antibody testing) to adults who are required to receive certain services for school, work or in the event of an exposure to a vaccine-preventable disease.
- c. Activities - Multnomah County Health Department's Community Immunization Program works through partnerships with community groups and the Multnomah Education Service District (MESD) to deliver immunization services. Clients are asked to pay a \$15 administration fee per injection but no child who is eligible to receive immunizations through the VFC (Vaccines for Children) program is refused service for inability to pay. The program offers all childhood immunizations and provides blood lead screening for children up through six years of age. Families who have insurance that covers immunization services are encouraged to receive vaccines at their private provider, unless there is a problem with additional costs that makes it difficult to do so. CIP also offers adult immunizations and antibody testing to which standard fees apply. Key activities include:
- Childhood Immunizations
 - Conducting year-round outreach and educational activities for parents and private providers to increase immunization rates in Multnomah County.
 - Conducting the annual immunization school law process to ensure that children and students in day care centers and schools are up-to-date or complete with their immunizations.
 - Partnering with MESD to provide in-school clinics for uninsured and underinsured children.
 - Collaborating on eSIS immunization database upgrade with MESD to include two new school law requirements in school year 2008-2009.
 - Conducting trainings on the immunization school law process for staff of day care facilities, preschools, kindergartens, Head Start programs, and private and alternative schools.
 - Increasing emphasis on vaccinating infants and children for influenza.
 - Increasing emphasis on vaccinating children (1 year of age and older) for Hepatitis A in compliance with a new school law requirement implemented in school year 2008 – 2009.
 - Integrating service delivery between WIC and Immunization programs to decrease client barriers and increase utilization of services.

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- Collaborating with delegate agencies (community clinics) to facilitate receiving VFC and “317” vaccine, as well as assistance with online vaccine ordering, inventory, and technical support.
- Participating in the Oregon Partnership to Immunize Children (OPIC) coalition.
- Adolescent Immunizations
 - Implementing “catch-up” immunization schedules as needed, particularly among immigrant and refugee populations.
 - Providing oversight of VFC vaccines for staff at School-Based Health Centers in elementary, middle and high schools.
 - Replacing Td booster with the Tdap (tetanus, diphtheria, pertussis) vaccine to increase protection against pertussis.
 - Increasing emphasis on vaccinating students (7th graders) for Tdap in compliance with school requirements.
- Adult Immunization, Antibody Testing and TB Testing Services
 - Offering immunization services for adults over 19 years of age, including tetanus/diphtheria/pertussis, influenza, pneumococcal, and hepatitis A and B.
 - Procuring and offering State-supplied vaccine for high risk individuals who qualify, namely injection drug users, men who have sex with men, and persons living with HIV/AIDS and hepatitis C.
 - Providing antibody testing for hepatitis B, measles, mumps, rubella, and varicella.
 - Providing TB testing.
 - Collaborating with various schools and businesses to provide immunizations and TB testing for students and/or employees as requested.
- Technical Support to Integrated Clinical Services (ICS) for immunizations
 - Monitoring vaccine storage and handling procedures based on administrative guidelines and State quality assurances, which includes:
 - Ensuring proper appliance temperatures for refrigerated and frozen vaccine via electronic datalogger downloads.
 - Responding to temperature excursions.
 - Training on and oversight of online vaccine ordering.
 - Compiling monthly inventories and reporting to the State.
 - Troubleshooting and coordinating vaccine issues among clinics.
 - Collecting wasted/expired/destroyed vaccine for return to the State.
- Strategizing on ways to improve immunization rates in two-year-olds.
- Developing and implementing a comprehensive training program for ICS staff which includes Vaccine Coding, Basics of Vaccine Forecasting and use of two statewide immunization databases (IRIS and ALERT).
- Overseeing quality assurance of vaccine coding to ensure proper use of State-supplied vaccine based on VFC and 317 Program eligibility requirements.
- Collaborating with clinical management staff when new vaccines become available.
- Communicating immunization updates (e.g., vaccine shortages; assist with implementing new vaccines).
- Conducting a physical inventory of State-supplied vaccine at all Health Department and contract agency clinics at the end of each fiscal year.
- Revising Administrative Guidelines regarding immunizations.

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- d. Evaluation - Performance of the Community Immunization Program is measured by the annual number of immunizations administered; the (decrease in) number of school exclusion letters sent; percent increase in the number of two year olds up-to-date on immunizations; and increased accuracy of vaccine coding. Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services, and others upon request.

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

C.1 Environmental Health Services (FY 2010-2011 Action Plan)

- a. Current condition or problem – The Environmental Health Services unit is responsible for assuring safe food and water for the public by regulating selected businesses and accommodations, enforcing State and local environmental health laws and rules conducting surveillance for food, water and vector borne disease, and conducting investigations to curtail food, water and vector borne disease outbreaks. Housing inspections are conducted to assure rental housing complies with housing codes. The Healthy Homes, AIR and CAIR programs all work to remediate unhealthy housing conditions and support health care providers with critical information about the living situations of asthmatic children and/or children exposed to lead. The unit certifies County birth and death records (see Vital Statistics below). Environmental Health Services staff work in cooperation with other programs in the Department to achieve and assure healthy people in healthy communities and improve health equity, for example:
- The Communicable Disease Prevention Program to refine procedures for responding to communicable disease.
 - Emergency Preparedness Program to refine responses to a broad range of disasters and emergencies that can threaten the health of the community (e.g., floods, vectors, earthquakes, intentional contamination of food and other mass casualty events).
 - The Health Equity Initiative to refine strategies designed to overcome health disparities.
 - The Chronic Disease Program to improve obesity (menu labeling and the built environment), tobacco prevention.
 - State and national initiatives on climate change as it impacts the overall health of the population and the environment.
- b. Goals - The goals of Environmental Health Services are to (1) analyze local environmental health issues from a public health perspective; (2) regulate specified businesses and accommodations; (3) enforce State and local environmental health laws and rules; (4) engage and empower the community to identify and remediate identified environmental public health issues; and (5) develop policy recommendations that address environmental public health issues.
- c. Activities – The target population includes all residents of Multnomah County. The following activities are implemented on an ongoing basis:

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- Environmental health assessment and planning.
- Food handlers training and certification.
- Emergency preparedness.
- Vector and nuisance control.
- Lead poisoning prevention.
- Inspection, licensure, consultation, and compliance investigation of food services, tourist facilities, institutions, public swimming and spa pools, and drinking water systems to assure conformance with public health standards.
- Inspection and remediation of housing issues, education and training for landlords and tenants, convening of community partners to impact policy change.
- Community education about environmental health risks and hazards including asthma, housing, poor indoor air quality, lead poisoning, food borne illness, and vectors.
- Data analysis to identify environmental health trends and future service needs.

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

- d. Evaluation - The effectiveness of the Environmental Health Services program as a mechanism to support disease control and prevention is measured by the types of data listed in the table below. Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, Oregon Department of Human Services/Health Services, and others upon request.

Program Area	Measurable Outcome
Health Inspections	Number of critical violations identified in food service facilities
	Number total food program complaints received
	Number food borne illness complaints received
	Number food borne illness outbreaks investigated
	Number food borne illness outbreaks confirmed
	Number of total cases for all confirmed outbreaks
Food Handler Training and Certification	Percent of food handler tests passed
	Number of food handler tests taken by language
Lead Poisoning Prevention Program	Number of Elevated Blood Level (10+ ug/dL) households receiving Lead Poisoning Prevention information and referral to assistance programs
	Number of calls to the LeadLine
Vector Control	Number of rodent complaints/Number of initial and follow-up rodent inspections
	Number of nuisance complaints/Number of initial and follow-up

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Program Area	Measurable Outcome
	nuisance inspections
	Number of mosquito pools where there were species identified as potential mosquito borne disease carriers
	Number of tobacco education & prevention complaints/Number of initial and follow-up tobacco education & prevention inspections
Community Education and Outreach	Number of educational events conducted
	Number of individuals who attend the educational events
	Pre and post tests of information presented to evaluate if there is an increase in knowledge
	Results from customer satisfaction surveys given to attendees of educational events

D. Health Statistics

D.1 Health Statistics (FY 2010-2011 Action Plan)

- a. Current condition or problem - The purpose of maintaining Vital Records at the government level is to:
 - Assure that birth and death certification is complete and accurate.
 - Analyze public health statistics to analyze the status of health in the county.
 - Identify populations at risk for the provision of intervention services.

- b. Goals - Short term goals are to assure accurate, timely and confidential certification of birth and death events minimizing the opportunity for identity theft. Populations at risk for poor health outcomes can be identified for the provision of proactive interventions. Ongoing and long term goals provide an opportunity for comprehensive and longitudinal analysis of health on a population through analysis of public health information consistently gathered on birth and death certificates.

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

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support analysis of the perinatal system to promote healthier birth outcomes. These efforts are overseen by staff in Early Childhood Services and Communicable Disease programs.

Key activities related to Health Statistics include:

- Data collection and analysis;
 - Birth and death reporting, recording, and registration;
 - Analysis of health indicators related to morbidity and mortality; and
 - Analysis of services provided.
- d. Evaluation - Data collection, data analysis and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commission, the Oregon DHS Health Services and other funders as required.

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

E.1 Information and Referral Services Program (FY 2010-2011 Action Plan)

- a. Current condition or problem - The Health Department's Health Information and Referral Program (I&R) provides information and referrals for individuals seeking access to health services in Multnomah County. Health Department staff are available to link callers with existing services by phone only. I&R uses a telephone-based information and education program serving residents of Multnomah County. I&R's information specialists serve as guides for individuals and families seeking information and access regarding services provided by the Health Department; schedule prequalification appointments for financial assistance appointments; collect and enter client demographics into a computer-based system for statistical reports; and make referrals to 1-800-SAFENET. I&R staff includes Health Information Specialists who are bilingual in Spanish, Vietnamese, and Russian.
- b. Goal - The goal of the Information and Referral Program is to provide information and referral services to the public regarding Health Department services and referrals. During FY 2008-2009 I&R services were improved to reflect the goals of the Department's Building Better Care Initiative.
- c. Activities - The Information and Referral Program will continue to provide services in FY 2010/2011. The program was enhanced during 2008 to include a new system know as "Primary Care Access and Referrals" (PCAR) in response to the Department's Building Better Care Initiative. PCAR strives to provide access to primary care services for *new* low income, uninsured individuals seeking primary care services. PCAR includes the following components:
- Focuses on appointing new patients into the system, so that resources for uninsured Multnomah County residents are optimized by providing one-time referrals to assign individuals to a primary care medical home.

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- Collaboration with other County organizations that also provide services to underserved individuals and internal service providers, as well as with Corrections Health and other Department providers.
- Access to comprehensive, collaborative planning process that is patient centered, respectful and attentive to resource stewardship.
- Patients assigned a primary care “home” are now able to call their medical home for appointments, cancellations and advice during hours of operations.
- WIC appointments are now decentralized to the WIC Programs service sites: East County Health Center, Northeast Health Center and Mid-County Health Center.
- Health Department Information and Referral continues to be provided from a centralized location, using a new, updated and streamlined database.
- Eventually all new primary care patients will be appointed by PCAR team members and the Primary Care Appointments and Referrals Referral Coordinator, and there is a new phone number for new patient appointments.
- The new process was phased in during the fall of 2008; and all outside agencies, new CareOregon patients, Corrections Health patients and uninsured Multnomah County residents are now appointed by the Primary Care Appointments and Referrals Team.

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

- d. Evaluation - The effectiveness of the current Information and Referral Program is measured by the following types of measures:
- Number of human services referral calls taken per FTE.
 - Number of prequalification appointments for financial assistance programming including SCHIP, FPEP, Oregon Health Plan, etc.

Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, Oregon DHS, and others upon request.

F. Public Health Emergency Preparedness

F.1 Emergency Preparedness Program (FY 2010-2011 Action Plan)

- a. Current Condition or Problem - The Health Department’s Emergency Preparedness Program is established under the following:
1. Ensure a coordinated and effective emergency medical system through paramedics, medical technicians, and hospitals.
 2. Monitor, evaluate, and respond to disease and environmental threats when manifested as a public health emergency.

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Emergency preparedness activities must ultimately develop the capacity to mobilize all Department resources, and leverage public and private partner organizations to appropriately respond to the public health impacts of any emergency regardless of its scale.

While the core of the Emergency Preparedness Program resides in the Directors office, it is related to many formal and informal organizational structures that advance its goals and objectives including:

- The Tri-County Public Health Officer, Deputy Department Director, Emergency Medical Director, Emergency Preparedness Manager, and NW Oregon Health Preparedness Organization Manager lead and cultivate regional collaborative efforts within public health, emergency medical, and healthcare system communities. Performance is measured in the results of those efforts.
- The Director's Office in consultation with the Department's Leadership Team determines Department-wide investment for emergency preparedness activities.
- The Director represents the Department on a Regional Public Health Leadership Group of public health administrators (UASI region) and health officers.
- The Deputy Director represents the Department on the County's Emergency Management Policy Team.
- The Emergency Preparedness Manager:
 - Represents the Department on the Regional Public Health Emergency Preparedness Coordinator's Working Group; the Regional Public Health Leadership Group provides strategic and policy direction for this Group. The Group carries forward regional public health emergency preparedness priorities and projects. Performance is measured by progress toward accepted goals, objectives, and deliverables.
 - Is responsible for maintaining an Incident Management Team and Response Plans. Performance is measured by the number of Incident Management Team members (90 persons authorized), training/experience, and evaluation of exercises/operations/plans.
 - Directs and is on an Advisory and Oversight Committee for a National Association of County and City Health Officials Advanced Practice Center. (APC). The APC is developing national benchmarks for just-in-time training of surge personnel for large-scale disease investigation and mass prophylaxis operations.
- Incident Management Team members are the focal point of Department investment to develop emergency response leadership and technical expertise. Team leaders for each of the command and general staff functions of the Incident Command System are responsible for developing IMT members assigned to those functions in consultation with the EP Manager. Performance is measured by evaluation of performance during major annual exercises. Multnomah County Health Department serves as Regional Lead Agency for Healthcare Preparedness Region 1 (Clackamas, Clatsop, Columbia, Multnomah, Tillamook and Washington Counties in Oregon). The Department staffs the NW Oregon Health Preparedness Organization (HPO), a regional planning collaboration of hospitals, public health and related healthcare and governmental organizations working to ensure that Northwest Oregon is prepared and responds effectively and efficiently to large-scale health emergencies that have impacts across institutional and jurisdictional lines.

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- The Department's Deputy Director is responsible for Business Continuity. Performance is measured by periodic reviews of adequacy.

- b. Goal – The goal of the Emergency Preparedness Program is to prevent and mitigate the public health impacts of natural and human-caused disasters. Program objectives to achieve and maintain this goal are:
 - Objective 1 - Improve internal capacity to respond to bioterrorism, major communicable disease outbreaks, and environmental health hazards through the following steps:
 - Maintain the NW Oregon Health Preparedness Organization and a County Public Health Emergency Response Plan that is aligned with regional partners' efforts.
 - Maintain an internal staff and an Incident Management Team as a focal point for emergency preparedness training and responsibility.
 - Build emergency management experience and competence.
 - Develop, maintain and test emergency response protocols/plans.
 - Improve and maintain a notification, alert, decision and activation framework for emergency response, including the FY 2010-2011 Department-wide implementation of the automated Health Alert Notification system.
 - Improve emergency communications within the Department and externally.
 - Develop active surveillance in coordination with the State (e.g., bring CD database into compliance with BT/CD guidelines; develop depth in CD nurse epidemiology investigators; develop and test emergency response CD protocols).

 - Objective 2 - Assure business continuity during an emergency, and maintain workable business continuity plans and processes.

 - Objective 3 - Assure that diverse communities' needs for emergency preparedness and response are recognized and effectively addressed through the following activities:
 - Further develop and exercise Community Connector concept in coordination with County Emergency Management starts administering the program in 2010/2011.
 - Planning and operational links to community-based organizations including expansion of Push Partner Registry partners who agree to distribute medication during emergencies to include administering vaccine.

 - Objective 4 - Integrate public health response to emergencies across Health Department programs, County Emergency Management, other County Departments, and with external partner organizations (e.g., local hospitals, community groups, etc.). Know, plan, and exercise with partner organizations by conducting a major annual exercise involving staff from many partner organizations.

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

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- d. Evaluation - Data collection, data analysis, and program evaluation occur at program, division, department and regional levels. Program performance is measured by assessing the outcomes associated with specific program activities, including the following:
- Progress made leading and cultivating regional collaborative efforts within public health and emergency medical organizations and in the general communities with respect to emergency preparedness.
 - Investments made to support emergency preparedness (equipment, training, etc.).
 - Identification of public health priorities and projects that represent progress toward meeting program goals and objectives.
 - Evaluation of exercises/operations/plans conducted under the direction of the Emergency Preparedness Manager in conjunction with the Incident Management Team and Department's Response Plans (performance is measured by the number of Incident Management Team members, training/experience, etc.).
 - Performance of staff during major annual exercises to develop emergency response leadership and technical expertise using the Incident Command System.
 - Participation on the NW Oregon Health Preparedness Organization Steering Committee to understand and contribute to the Region 1 strategic priorities and direction.
 - Periodic reviews of the adequacy of the Department's Business Continuity Plan.

G. Other Health Issues

G.1 Healthy Communities Program (FY 2010-2011 Action Plan)

- a. Current Condition or Problem - Chronic diseases are the number one driver of healthcare costs. It is estimated that 75% of healthcare dollars are spent treating chronic diseases. When combined, heart disease, stroke, diabetes, cancers, and chronic lower respiratory diseases account for more than three out of five deaths in Oregon. Nearly 90% of Oregonians have a risk factor for chronic disease such as smoking tobacco, being overweight or obese, consuming too few fruits and vegetables and physically inactivity. In Oregon, 69% of adults have a chronic disease or hypertension or high cholesterol. In Multnomah County more than 1/2 of adults are considered overweight or obese. More than 40% of adults do not meet the Centers for Disease Control's standards for physical activity. Tobacco use alone is the leading cause of preventable death in Oregon, and every year in Multnomah County, 1229 people die from tobacco use (which is 22% of all deaths). In addition 24,021 people suffer from a tobacco-related illness. The economic burden of tobacco use amounts to \$193 million in medical expenses and \$206 million in lost productivity each year in Multnomah County alone. While chronic conditions impact a large amount of people in Multnomah County, some communities are disproportionately impacted by some chronic conditions. For example, African Americans had the highest heart disease, stroke, lung cancer and diabetes mortality rates. Non-Hispanic whites and Native Americans had the highest lung cancer rates.
- b. Goals - The goal of the Healthy Communities Program is to develop and implement strategies that are grounded in CDC best and promising practices for prevention, early detection and self-management of chronic diseases. The program implements local

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population based initiatives that reduce the burden of chronic diseases most linked to tobacco use, physical inactivity and poor nutrition. The Healthy Communities Program developed a three-year Community Action Plan (CAP) based on assessment findings, review of best practices and guidance from a multi-disciplinary and diverse Community Health Advisory Council (CHAC). The plan seeks to make sustainable environmental change, such the adoption of new policies or activities that help to shift social norms in a variety of settings where people live, work, play and learn. Primary objectives of the Healthy Communities Program include:

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

- c. Activities - The Healthy Communities Program's work is population-based so that large segments of Multnomah County benefit from increased opportunities for physical activity, healthy food options and chronic disease self-management. A key function of the program is the development and implementation of a Community Action Plan (CAP). The Healthy Communities Program's Work Plan consists of multiple best practice objectives in support of tobacco free lifestyles, easy access to healthy foods, easy and safe access to physical activity, early detection services and chronic disease self-management programs for people living with chronic diseases. The 2010 Multnomah County Healthy Communities Program's best practice objectives include (proposed FY 2010-2011 best practice objectives):

- By June 2011, Multnomah County will recommend 1-2 nutrition access policies for consideration by Board of County Commissioners (or county executive leadership).
- By June 2011, the Health Department will assess legal feasibility of limiting advertising and youth access to tobacco through licensure agreements.
- By June 2011, the Chronic Disease Prevention Program will recommend policy changes to Department leadership that will provide Chronic Disease Self Management Programs as a supported benefit for employees.

In order to meet these objectives, Healthy Communities Program staff will engage in specific plans of action based on the following key activities: 1) coordination and collaboration, 2) assessment and research, 3) community education, outreach, and media, 4) policy development and 5) policy implementation. Much of the work of the program will be carried out through issue-specific coalitions and multidisciplinary partnerships, including the coordination of a broad-based Community Health Advisory Council. The role of the Community Health Advisory Council, comprised of key leaders in the chronic disease prevention, is to provide strategic direction in the development of the program's plans of action related broadly to chronic disease prevention and specifically to the Healthy Community Program's planned activities. The Healthy Communities Program coordinates its efforts as much as possible with the diverse coalitions, such as the Community Health Action

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Response Team (CHART), convened as part of the National Association of Chronic Disease Directors ACHIEVE grant to address root causes of chronic diseases disproportionately impacting African Americans, Africans and Blacks in Multnomah County.

- d. Evaluation – The Healthy Communities Program’s effectiveness is tracked by the Oregon Health Promotion and Chronic Disease Prevention Program (HPCDP) as a part of its statewide evaluation activities. The HPCDP program will embark on a participatory evaluation of County programs and the state programs that support them. Behavior Risk Factor Surveillance (BRFSS) and Healthy Teens Survey data will be reviewed yearly to identify nutrition and physical activity trends among adults and youth. Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services, and others as requested.

G.2 Other, Tobacco Prevention (FY 2010-2011 Action Plan)

- a. Current Condition or Problem - Tobacco is the leading cause of preventable death in Oregon, and every year in Multnomah County, 1,229 people die from tobacco use (which is 22% of all deaths) and 24,021 people suffer from a tobacco-related illness. Approximately 110,568 Multnomah County residents reported smoking cigarettes. The economic burden of tobacco use amounts to over \$193 million in medical expenses and over \$206 million in lost productivity due to tobacco-related disability and death. In Multnomah County, 20% of adults smoke, compared to 19% statewide. According to the 2007 Oregon Healthy Teens Survey, among 8th grade students in Multnomah County, 9% smoke (the same for statewide); and among 11th graders, 16% smoke (compared to 17% statewide). While overall cigarette consumption in Oregon is decreasing, smoking prevalence remains higher in some communities. For example, American Indians (38.3% of adults), the LGBTQ community (22/4% of Bisexual adults), and African Americans (29.9% of adults) have a high prevalence of smoking.
- b. Goals - The goals of Multnomah County’s Tobacco Prevention Local Program is to develop and implement strategies that are grounded in CDC best practices, and seek to make sustainable environmental change, such the adoption of new policies or activities that help to shift social norms around tobacco use and smoking. Primary objectives of the Tobacco Program include:
- Reduce and eliminate exposure to secondhand smoke.
 - Counter pro-tobacco influences.
 - Promote quitting and increase access to cessation resources, including the Oregon Quit Line.
 - Reduce youth access to tobacco and prevent the initiation of tobacco by youth.
 - Build capacity for prevention, early detection and self management of tobacco-related chronic diseases.
 - Eliminate disparities in tobacco use and exposure.

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- c. Activities - The Tobacco Program's work is population-based so that large segments of Multnomah County benefit from smoke-free environments. A key function of the program is the enforcement of applicable smoke-free laws, including the Oregon Indoor Clean Air Act. The Tobacco Program's Work Plan consists of multiple best practice objectives in support of tobacco-free multi-unit housing, outdoor venues, and worksites as well as tobacco retailer licensing and building capacity for chronic disease prevention, early detection and self-management. The proposed best practice objectives include:
- Multnomah County will fully implement and enforce the Oregon Indoor Clean Air Act in support of smoke-free worksites. For example:
 - By June 2011, Multnomah County TPEP will have received and responded to all complaints of the Oregon Indoor Clean Air Act (ICAA).
 - By June 2011, Multnomah County TPEP will have conducted all site-visits, follow-up visits and subsequent visits per OAR333-015-0030.
 - By June 2011, Multnomah County TPEP will have responded to all ICAA-related calls and requests for assistance from businesses and the public.
 - By December 31, 2010, Multnomah County TPEP will have modified any enforcement protocols to include policy interpretations revealed through analysis of ORS/OAR and enforcement of the Indoor Clean Air Act.
 - By June 30, 2011, the Multnomah Board of County Commissioners will adopt a tobacco free policy at all Health Department owned facilities/campuses.
 - By June 2010, one property management (either public or private) entity will adopt a smoke-free policy.
 - By June 2011, Multnomah County TPEP will develop retail licensure recommendations to be considered by the Board of County Commissioners and/or the City Council.
 - By June 2011, two faith-based institutions serving African Americans, Africans and Blacks in Multnomah County will adopt healthy nutrition policies.

In order to meet these objectives, Tobacco Program staff will engage in specific plans of action based on the following key activities: 1) coordination and collaboration, 2) assessment and research, 3) community education, outreach, and media, 4) policy development and 5) policy implementation. Much of the work of the program will be carried out through issue-specific coalitions and multidisciplinary partnerships, including the coordination of a broad-based Community Health Advisory Council. The role of the Community Health Advisory Council, comprised of key leaders in the chronic disease prevention, is to provide strategic direction in the development of the program's plans of action related broadly to chronic disease prevention and specifically to tobacco prevention. The Tobacco Program coordinates its efforts, and receives guidance, as much as possible with diverse coalitions such as the Community Health Action Response Team (CHART), convened as part of the National Association of Chronic Disease Directors ACHIEVE grant to address root causes of chronic diseases disproportionately impacting African Americans, Africans and Blacks in Multnomah County.

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- d. Evaluation - Tobacco Program effectiveness is tracked by the Oregon TPEP as a part of its statewide evaluation activities. For example, State data has shown that the 8th grade smoking rates were reduced by 59% between 1996 when the program started and 2006. There was a 46% drop among 11th graders during the same time period, as well as a 41% decline in cigarette consumption and a 21% decrease in adult smoking. The Multnomah County Tobacco program routinely evaluates its effectiveness and responsiveness in enforcing Oregon's Indoor Clean Air Act (the State's smokefree workplace law). Data collection, data analysis, and program evaluation occurs at the program, division and department levels. Information is reported to the Board of County Commissioners, the Oregon Department of Human Services, and others as requested.

IV. ADDITIONAL REQUIREMENTS

Board of Health - The Multnomah County Board of County Commissioners constitutes the Multnomah County Board of Health under ORS 431.410 and 431.415. The composition of the Board changed unexpectedly in March 2010 after then County Chair Ted Wheeler was appointed to fill the Oregon State Treasurer's seat by Governor Ted Kulongoski following the death of Treasurer Ben Westlund. In April 2010, Jeff Cogan (Commissioner for District 2), was voted by the Board to serve as Interim Chair for the remainder of the term vacated by former Chair Wheeler, and Barbara Willer was appointed Interim Commissioner for District 2 through the remaining term of the seat vacated by Commissioner Cogan (ending on December 31, 2010). Members of the Board include:

Jeff Cogan, Interim County Chair
Term ends: December 31, 2010
Phone: (503) 988-3308, fax (503) 988-3093
E-mail: mult.chair@co.multnomah.or.us
Web: <http://www.co.multnomah.or.us/cc/chair>

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

Barbara Willer, Interim Commissioner for District 2
Term ends: December 31, 2010
Phone: (503) 988-5219, fax (503) 988-5440
E-mail: district2@co.multnomah.or.us
Web: <http://www.co.multnomah.or.us/cc/ds2>

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

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

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

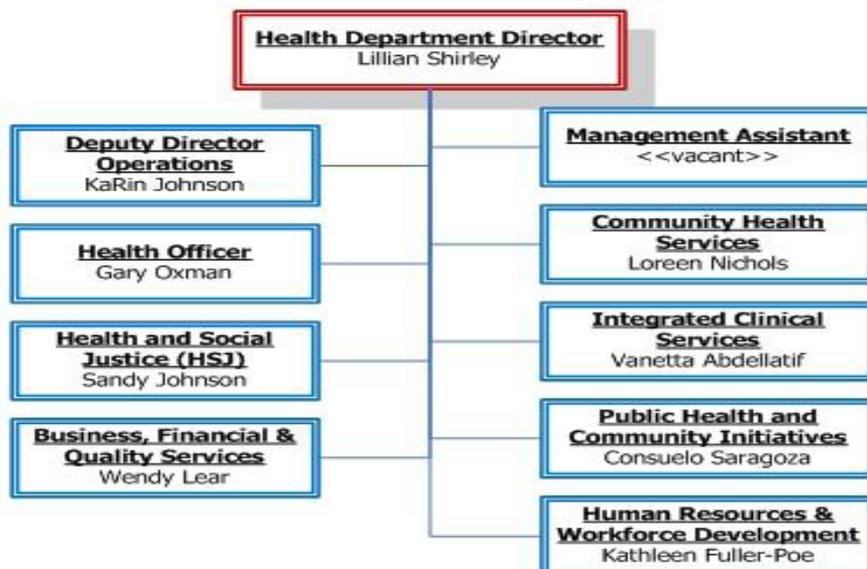
Organizational structure - The Health Department employs the largest number of staff among Multnomah County's seven departments with more than 870 FTEs working in the Health Department's eight distinct divisions, including the Director's Office, Health Officer, four service divisions and two support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

- **Director's Office** - The Director's Office of the Health Department is represented by the Department Director and the Department's Assistant Director. The Director's Office is responsible for supporting the development and implementation of County policies regarding public health; supporting the development and implementation of the annual budget and financial management policies; establishment of implementation of internal and external communications; providing leadership to the organization and community regarding public health issues; and assuring that services are responsive to the needs of culturally diverse communities and oversees the Department's emergency preparedness responsibilities. The Director's Office also oversees the Department Leadership Team to coordinate activities across the organization. This team is comprised of the Director, Deputy Director for Operations, Health Officer, and the division directors of the Department's four service divisions and two support divisions.
- **Health Officer** – The Health Officer is the County's legal authority for local administration of laws that govern public health in the State; is responsible for programs in emergency medical services; and provides professional consultation in response to a wide range of public health issues. The Health Officer is also responsible for implementing public health policies to monitor and respond to communicable disease issues; medical director services to provide clinical supervision of providers; utilization review; clinical quality improvement; and implementation of special initiatives.
- **Service Divisions** - The Department's four service divisions include the following:
 - *Integrated Clinical Services* - ICS assures that medically underserved residents have access to affordable, high quality and culturally appropriate health and related services (e.g., primary care, dental, well child care, corrections health, HIV care, healthcare for the homeless, teen health care, and WIC) and oversees related support systems (e.g.,

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- electronic health records, information and referral, X-ray, pharmacy, laboratory and language services).
- *Community Health Services* – CHS is dedicated to improving the health of the community through a variety of public health services and programs (environmental health services, TB prevention and treatment, Early Childhood Services, Immunization Program, STD Prevention and Treatment, HIV Prevention, and Communicable Disease Prevention and Control). The division also implements health promotion initiatives (e.g., tobacco prevention, adolescent health, and chronic disease prevention).
 - *Public Health and Community Initiatives* - PH&CI establishes and maintains local partnerships, and implements health initiatives with communities that are served by the Department.
 - *Health and Social Justice* – HSJ provides a number of functions designed to address local public health capacity, quality and evaluation.
- Support Divisions - The Department’s financial and administrative functions are supported by the *Business, Financial and Quality Services* division and the *Human Resources and Workforce Development* division. The Business, Financial and Quality Services division is responsible for implementing financial management policies (grants management, AR/AP, contracts, and supporting auditing procedures, etc.); and overseeing the Department’s budget development process; quality improvement initiatives, and IT support and training. The Human Resources and Workforce Development division is responsible for implementing Department-specific HR policies; overseeing collective bargaining processes; and implementing workforce development programs. Both divisions work with the County’s Central Budget Office and Central Human Resources Office to ensure that Department’s operations are appropriately coordinated and consistently applied across all County government departments.

Organizational Chart



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Coordination with SB 555 Planning Process - The Multnomah County Commission on Children and Families is responsible for developing the Comprehensive Plan for children under the age of 18 as defined in Senate Bill 555. The Commission has used an extensive community input process in their plan development. For the plan submitted in January 2010, the Commission started the process by reviewing existing community plans that address children and youth issues (approximately 30 plans of various types). Based on the review the Commission identified issues and questions and invited key partners for input. In order to coordinate the Annual Planning process with the SB 555 Comprehensive Plan, Health Department staff were participants in several input sessions ranging from basic health care needs through School-Based Health Centers to Early Childhood Services to prevention efforts. In addition, Health Department staff currently participate as members on the Commission's ongoing Early Childhood Council and the School Age Youth Council, which also provide input into the planning process.

V. UNMET NEEDS

The Health Department's ability to implement public health services and address unmet needs is directly aligned with the availability of financial resources. Multnomah County has experienced successive years of declining revenues, which has resulting in severe budget constraints for all County departments. As of March 2010, the County Budget Office has projected a FY 2010-2011 budget deficit of \$5.5 million over the FY 2009-2010 budget (this projection is up from a deficit of \$3.9 million forecasted in October 2009). Given the same fiscal planning assumptions used to analyze the status of revenues, the FY 2011-2012 deficit is forecasted to grow to \$11.2 million.

Preparation of the County budget for FY 2010-2011 consists of a complex and time consuming process involving Department staff, County elected leaders, local communities and the public. The County's budget process was recently delayed after County Chair, Ted Wheeler, was appointed to fill the Oregon State Treasurer's seat by Governor Ted Kulongoski following the death of Treasurer Ben Westlund. As a consequence, the Interim County Chair, Jeff Cogan, will not submit his final Executive Budget until May 13, 2010, and it is not yet possible to fully report the impact of the County's projected operating deficit in terms of public health services.

Anticipated unmet needs, along with the potential impacts resulting from budget deficits have been assessed by various public health programs, and the conclusions of these assessments are summarized below (this discussion is not presented in any particular priority).

- **Communicable Disease Prevention and Control Program** - There will likely be a decrease in County General Fund support available for the Communicable Disease Prevention and Control Program, which will result in a decrease in staff positions to deliver services. The Department is currently identifying the critical services and mandated functions of the program, and will apply process improvement tools and techniques to determine how best to deliver quality essential services in an efficient and cost-effective manner, while maintaining

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patient and staff satisfaction. This will create an improvement framework for the program to respond to current and future budget restraints.

A communicable disease of growing concern is hepatitis B and its disproportionate impact on some local communities (the majority of cases are found among Asian refugees and immigrants). The Communicable Disease Prevention and Control Program plans to work with providers and community-based organizations in order to provide hepatitis B education to high risk populations. The program will collaborate with the State's newly formed Hepatitis B Task Force to conduct community hepatitis B screening and vaccination clinics. The Communicable Disease Prevention and Control Program also plans to train bilingual staff (i.e., Vietnamese, Russian and Spanish) to provide culturally and linguistically competent hepatitis B prevention services to these communities.

- Hepatitis C Virus Surveillance and Treatment - Until 2010, the Hepatitis C Registry was maintained as part of a research project to investigate the value of this novel approach to enhance local hepatitis C surveillance. Unfortunately, a decrease in funding has resulted in the elimination of the project's epidemiologist. The loss of this position caused the Communicable Disease and Control Program to assess the critical services and mandated functions supported by the Hepatitis C Registry. As a consequence, process improvements will be used to determine how best to deliver quality essential services in an efficient and cost-effective manner, while maintaining patient and staff satisfaction for the entire Communicable Disease Program in response to current and future budget constraints. As an initial step in the process improvement, data from the Hepatitis C Registry (formerly housed in its own database) will now be stored in the Communicable Disease and Control Program's database. It is anticipated that moving the Hepatitis C Registry data to the Communicable Disease and Control Program's database will result in better communications with the State and increased efficiency for staff authorized to access the communicable disease database.
- Early Childhood Services: Early Childhood Services (ECS) anticipates a reduction in funding beginning July 2010, and subsequently the loss of 4.5 FTE Nurse Family Partnership staff. Reductions are due to the ending of a federal CDC grant, along with a reduction in State Healthy Start funding and a loss of Medicaid revenues. To address revenue losses, the ECS program is planning to reorganize its infrastructure to improve monitoring and accountability of Medicaid billing processes; reduce the staff-to-supervisor ratio for home visiting staff, and move towards a best practice Nurse Family Partnership model of service. The Early Childhood Services program is also prioritizing the target population to include first birth women with medical risks affecting pregnancy outcomes, and children with special health care needs, with an overall emphasis on clients who are OHP eligible.
- Environmental Public Health - A wide spectrum of issues will affect the community's unmet needs for environmental public health services. For example:
 - There is a need to identify the public health impacts resulting from climate change by convening resource experts to clarify issues and define the public health role in remediation and education.

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- It is essential that the Health Department continue its role to develop and expand system-wide housing remediation and education interventions that support improved health outcomes for vulnerable populations.
- Because of the significant impact of housing on childhood asthma and other health conditions there is a need to dedicate management staff to oversee the implementation of the Housing and Urban Development Healthy Homes Demonstration Program grant awarded to the Department in March 2010. This grant will leverage \$2.3 million in local funding to support community-based interventions and remediation of housing-related health issues.
- Environmental Health Services staff will continue to be called upon to participate in the development of environmental policy through an environmental justice lens.
- Emergency Preparedness - Several issues have been cited as emerging or unmet needs by the Emergency Preparedness program, including:
 - Quality Improvement review concerning the Department's use of its Incident Command System in response to the 2010 H1N1 influenza pandemic. This review was initiated in April 2010 and it will include Incident Command System and general aspects of the Emergency Preparedness Program. The work of the Emergency Preparedness Program is done by a few individuals dedicated to the program, rather than through the Incident Management Team members representing functional service areas who serve on work groups to create or improve plans and materials. Since 2007, the Emergency Preparedness Program has also been without a policy group with members tied to other Department programs. This dynamic is of particular concern in terms of understanding the implications of integrating Emergency Preparedness Program functions throughout the Department.
 - Resources to continue the Advanced Practice Center project will be exhausted as the funding contract is set to expire during October 2010. It is anticipated that the Department will be eligible to submit a proposal to continue the project to address concerns that cannot sufficiently be developed before the contract's expiration.
 - Solidifying Emergency Preparedness Integration with core public health programs continues to be a concern and unmet need for the Department. The urgency for local emergency preparedness following 9/11 enabled emergency preparedness to be institutionalized within the Department over a short period of time. Major program achievements include establishing a 90-person Incident Management Team in 2006, and a significant investment in local response training in 2007. Unfortunately the loss of resources has led to a decline in new initiatives, and a loss of support to sustain past initiatives. For example, the Department has disbanded the Emergency Preparedness Policy Group; and only half of the Incident Management Team members were activated for the 2008 major exercise and during extended 2009 H1N1 operations. The appropriate level of investment in emergency preparedness relevant to potential threats needs to be addressed in order to maintain a constant level of emergency preparedness, readiness, training and capacity.
 - Clarifying roles and responsibilities of the Health Department Emergency Preparedness and the Multnomah County Emergency Management Office is an essential unmet need for the community. In some instances the Health Department's emergency preparedness

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response capacities have been developed in the absence of the County Emergency Management Office. As the County Emergency Management Office becomes more solidified, it would be beneficial to look at the overall functioning of both departments to delineate response and preparedness roles and responsibilities in order to ensure appropriate utilization of resources.

- Healthy Communities Program – The Health Department’s Healthy Communities Program will be taking steps to address and review numerous unmet needs, including the following:
 - Explore strategies and emerging practices to increase access to healthy food and beverages, and include strategies that limit access to unhealthy food and beverages (e.g., incentive pricing, counter marketing, nutrition standards, etc.).
 - Identify opportunities through the Family Smoking Prevention and Tobacco Control Act, which gives the FDA authority to regulate tobacco products, and gives expanded authority to states to restrict the time, place, and manner of tobacco products.
 - As a participant in the NACHHO sponsored “Big Cities Collaborative” with other tobacco and obesity prevention programs across the nation, define strategies that multiple cities can embark on simultaneously so that information can be shared and resources leveraged. Potential strategies seek to reduce availability and marketing of unhealthy food.

- Tobacco Prevention Program – Several developments and issues affecting the Tobacco Prevention Program will be monitored and responded to in terms of addressing unmet needs in this public health service area, they include:
 - Recent passage of the Family Smoking Prevention and Tobacco Control Act authorizes the Food and Drug Administration to regulate tobacco products. The Act also gives states expanded authority to restrict the time, place, and manner in which tobacco products are bought and used. The Health Department’s Tobacco Prevention Program will be monitoring the Act’s implementation for opportunities it may create to support local tobacco prevention programs.
 - Funding to support the Tobacco Prevention Program is partially based on tobacco tax revenue. During FY 2009-2010, the Multnomah County Tobacco Program experienced nearly a 25% decrease in funding, which directly impacts the goals the program can accomplish.
 - The Tobacco Prevention Program was invited to participate in a NACHHO-sponsored “Big Cities Collaborative” along with other tobacco programs across the nation. The collaborative seeks to define strategies that multiple cities can embark on simultaneously so that resources can be shared and leveraged. One of the proposed goals of the Big Cities Collaborative is linked to tobacco retailer licensure which is a strategy for the FY 2010-2011 plan.
 - Explore strategies to reduce access and marketing of tobacco, including retail licensure, advertising restrictions, hard hitting counter marketing, reducing the number of places tobacco is sold, and sampling bans.

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- Health Care Reform Act of 2010 – During March 2010, President Obama signed a landmark health care reform bill (HR 3590) into law (Public Law 111.148) known as the Patient Protection and Affordable Care Act. The Act will have significant implications for residents of Multnomah County and Oregon. According to Governor Kulongoski, the Federal law, when fully implemented and combined with the State’s Healthy Kids Program, will provide access to care for some 500,000 Oregonians, or about 85 percent of the state’s uninsured.

The Patient Protection and Affordable Care Act will provide support for the Health Department’s current system of health care, and it lays a strong foundation for continued progress in achieving the Department’s vision of “Healthy People in Healthy Communities.” This landmark reform legislation will support efforts to address health equity and wellness for all people in Multnomah County through public health policies and services. Key components of the Act include establishing significant investments in population-based prevention activities; recognizing the unique contributions of local public health departments; and expanding access to affordable health care.

The reforms include Federal funding for public health, mental health, chronic disease prevention and health care disparities and will support work already begun by the Oregon Health Authority and citizen Oregon Health Policy Board. Aspects of the law that will directly affect the Health Department in the future include:

- Establishment of the prevention and public health fund
- Support for community health centers
- Support for school-based services
- Support for oral health
- Support for home visiting programs
- Wellness and prevention focus
- Support for the public health workforce

The stable, reliable funding stream for disease prevention provided in the Act, along with support for the public health workforce, are essential to sustain population-based prevention activities that are beyond the reach of the current medical care system.

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VI. BUDGET

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

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

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

The Interim County Chair, Jeff Cogan, will not submit his final Executive Budget until May 13, 2010. The Multnomah County Chair's proposed FY 2010-2011 budget (which includes the Health Department's budget) will be presented at the following web address (after May 13, 2010):

<http://www2.co.multnomah.or.us/Public/EntryPoint?ch=0f2d343d69c94210VgnVCM1000003bc614acRCRD>

Once available, this proposed budget will be presented for local public review, and, therefore, changes may be made before it becomes final upon adoption by the Multnomah County Board of Commissioners during June 2010.

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VII. MINIMUM STANDARDS

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

Organization

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

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

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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.
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.

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41. Yes No There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes No There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes No A system exists for the surveillance and analyses of the incidence and prevalence of communicable diseases.
44. Yes No Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes No Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes No Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

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

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54. Yes ___ No X All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken. *(Note: This public health function is being conducted by the State of Oregon, not Multnomah County.)*
55. Yes X No ___ A written plan exists for responding to emergencies involving public water systems.
56. Yes X No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes ___ No X A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. *(Note: This public health function is being conducted by the City of Portland Environmental Services Bureau, not Multnomah County.)*
58. Yes X No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes X No ___ School and public facilities food service operations are inspected for health and safety risks.
60. Yes X No ___ Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes ___ No X A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. *(Note: This public health function is being conducted by Metro, not Multnomah County.)*
62. Yes X No ___ Indoor clean air complaints in licensed facilities are investigated.
63. Yes ___ No X Environmental contamination potentially impacting public health or the environment is investigated. *(Note this public health function is being conducted by a variety of local, state and federal agencies within the County.)*
64. Yes ___ No X The health and safety of the public is being protected through hazardous incidence investigation and response. *(Note: This public health function is being conducted by local HAZMAT agencies within the county. Additional local response may be provided by the County Health Officer and related bioterrorism response systems.)*

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65. Yes No Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes No All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

Health Education and Health Promotion

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

Nutrition

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

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77. Yes X No ___ Local health department supports continuing education and training of staff to provide effective nutritional education.

Older Adult Health

78. Yes X No ___ Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.

79. Yes X No ___ A mechanism exists for intervening where there is reported elder abuse or neglect.

80. Yes X 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 X 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 X No ___ Perinatal care is provided directly or by referral.

83. Yes X No ___ Immunizations are provided for infants, children, adolescents, and adults either directly or by referral.

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

85. Yes X 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 X No ___ Child abuse prevention and treatment services are provided directly or by referral.

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

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

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

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

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

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

Primary Health Care

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

94. Yes X No ___ The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.

95. Yes X No ___ The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.

96. Yes X No ___ Primary health care services are provided directly or by referral.

97. Yes X No ___ The local health department promotes primary health care that is culturally and linguistically appropriate for community members.

98. Yes X No ___ The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

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

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

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

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Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

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

Answer the following questions:

Administrator name: Lillian Shirley, RN, MPH, MPA

- | | |
|---|---|
| Does the Administrator have a Bachelor degree? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Does the Administrator have at least 3 years experience in public health or a related field? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Has the Administrator taken a graduate level course in biostatistics? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Has the Administrator taken a graduate level course in epidemiology? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Has the Administrator taken a graduate level course in environmental health? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Has the Administrator taken a graduate level course in health services administration? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

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

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

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

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.

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

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

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

OR

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

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

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

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

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

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

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

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

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

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

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

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

Hepatitis A

1. Surveillance
 - a. $\geq 95\%$ of reported suspect cases (e.g., fever, malaise, and jaundice) will be evaluated within 1 working day of report.
 - b. $\geq 95\%$ of confirmed or presumptive cases will be reported to DHS-Health Services within 1 working day of receipt of report.

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

Hepatitis B, Acute

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

Meningococcal Disease

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

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

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Reportable Disease	LHD Investigation	Exception	Report to DHS-HS	Prophylaxis/Disease Prevention Activities
Rubella	1 working day		Within 24 hours	Initiate control measures within 24 hours and complete within 72 hours.
Salmonellosis	1 working day		EOCW	
Shigellosis	1 working day		EOCW	
Typhoid Fever	1 working day		EOCW	Identify contacts of cases. Test contacts for typhoid. Provide or refer vaccination for asymptomatic contacts.
			*End of calendar week	

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**ATTACHMENT 2
FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
MULTNOMAH COUNTY HEALTH DEPARTMENT
FY 2010-2011
(this plan may be updated after May 1, 2010)**

As a condition of Title X, funding agencies are required to have a plan for their Family Planning Program, which includes objectives that meet SMART requirements (Specific, Measurable, Achievable, Realistic, and Time-Bound). In order to address State goals in the Title X grant application, each agency must identify how they will address each of the following two goals:

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

Please include the following four components in addressing these goals:

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

Agency: Multnomah County Health Department

Contact: Margo Salisbury

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

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

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

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

Objectives checklist:

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

Progress on Goals/Activities for FY 2009-2010 (Currently in Progress)

Goal/Objective	Progress on Activities
Serve adolescent reproductive needs.	
Capture all appropriate Medicaid and FPEP reimbursements for contraceptive visits and supplies.	We have developed systems to reduce our FPEP and Medicaid billing denials and have improved our FPEP supply billing process.

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**ATTACHMENT 3
FY 2010 - 2011 WIC Nutrition Education Plan Form**

County/Agency: Multnomah County WIC Program

Person Completing Form: David Brown

Date: April 5, 2010

Phone Number: 503 572-1123

Email Address: david.t.brown@co.multnomah.or.us

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2010
Sara Sloan, 971-673-0043

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

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

Activity 1: WIC Training Supervisors will complete the Participant Centered Education e-Learning Modules by July 31, 2010.

Implementation Plan and Timeline:

All WIC Training Supervisors will complete the Participant Centered Education e-learning Modules by July 31, 2010.

Activity 2: WIC Certifiers who participated in Oregon WIC Listens training 2007-2009 will pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010.

Implementation Plan and Timeline:

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By December 31, 2010 all WI C staff will complete the Participant Centered education e-learning training module and will have successfully completed the posttest.

Activity 3: Local agency staff will attend a regional Group Participant Centered Education training in the fall of 2010.

Note: The training will be especially valuable for WIC staff who lead group nutrition education activities and staff in-service presentations. Each local agency will send at least one staff person to a regional training. Staff attending this training must pass the posttest of the Participant Centered Education e-Learning Modules by August 31, 2010.

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

Multnomah County WIC staff will attend a regional Group Participant Centered Education training in the fall of 2010. At this point we expect to send all staff for this training.

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

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

Activity 1: Each agency will continue to implement strategies identified on the checklist entitled “Supporting Breastfeeding through Oregon WIC Listens” by March 31, 2011.

Note: This checklist was sent as a part of the FY 2009-2010 WIC NE Plan and is attached.

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Implementation Plan and Timeline:

Multnomah WIC will continue to identify strategies identified in the checklist entitled ‘Supporting Breast Feeding through Oregon WIC Listens’ through March 31, 2011. We will continue to use the observation tool as a means to fine tune our Oregon WIC Listens training.

Activity 2: Local agency breastfeeding education will include evidence-based concepts from the state developed Prenatal and Breastfeeding Class by March 31, 2011.

Note: The Prenatal and Breastfeeding Class is currently in development by state staff. This class and supporting resources will be shared at the regional Group Participant Centered Education training in the fall of 2010.

Implementation Plan and Timeline:

Breastfeeding education will include evidence-based concepts from the state developed Prenatal and Breastfeeding Class by March 31, 2011.

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

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

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

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

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Implementation Plan and Timeline:

WIC will invite partners that serve WIC participants and provide nutrition education to attend a regional Group Participant Centered Education training in the fall of 2010.

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

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

Implementation Plan and Timeline:

WIC will invite community partners that provide breastfeeding education to WIC participants to attend a Breastfeeding Basics training and/or complete the online Oregon WIC Breastfeeding Module by December 31, 2010.

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

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

Activity 1: Local agency staff will complete the new online Child Nutrition Module by March 31, 2011.

Implementation Plan and Timeline:

All Multnomah County WIC staff will complete the new online Child Nutrition Module by March 31, 2011. WIC staff will also continue to stay current in nutrition knowledge as demonstrated by Activity 4 in Attachment A.

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Activity 2: Identify your agency training supervisor(s) and projected staff quarterly in-service training dates and topics for FY 2010-2011. Complete and return Attachment A by May 1, 2010.

Agency Training Supervisor(s):

In-Service training supervisors are Mary Kay Diloreto, Joy McNeal and Elizabeth Berol-Render. Completed Attachment A is attached.

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ATTACHMENT 4

FY 2010-2011 WIC Nutrition Education Plan

WIC Staff Training Plan – 7/1/2010 through 6/30/2011

Agency: Multnomah County Health Department

Training Supervisor(s) and Credentials: Mary Kay Diloreto, Joy McNeal and Elizabeth Berol-Render

Staff Development Planned/Based on planned program initiatives, your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2010 – June 30, 2011. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July 2010	Participant Centered e-learning Modules	All nutrition supervisors, program manager and OA2 senior staff will have completed all State e-learning modules by July 31, 2010.
2	Fall 2010	Participant Centered Counseling Training	All Multnomah County WIC staff will attend a Participant Centered Education training event scheduled for Fall 2010.
3	December 2010	Participant Centered e-learning Modules	All WIC staff will have successfully completed all the State e-learning modules and posttests by December 31, 2010.
4	Spring 2011	College level Nutrition Basics course.	50% of certifier staff will have successfully completed or will be currently enrolled in a college level nutrition basics course by June 30, 2011.

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**ATTACHMENT 5
EVALUATION OF WIC NUTRITION EDUCATION PLAN
FY 2009-2010**

WIC Agency: Multnomah County

Person Completing Form: David T. Brown

Date: 4/1/2010 Phone: 503 988-3663 x26511

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2010

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

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

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

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

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

- Did staff complete the module by December 31, 2009?
- Were completion dates entered into TWIST?

Response:

All staff completed the appropriate sections of the new Food Package module. Completion dates were entered into TWIST.

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

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

- How were staff who did not attend the 2009 WIC Statewide Meeting trained on the topic of infant feeding cues?
- How has your agency incorporated the infant cues information into ‘front desk’, one-on-one, and/or group interactions with participants?

Response:

All staff received training in the basics of interpreting infant feeding cues. Those who did not attend the 2009 statewide meeting attended a Multnomah County fall forum in infant cues. We have incorporated this training into our everyday operations. At the front desk, staff is trained to refer clients who want to reduce or stop breast feeding to the appropriate certifier for further evaluation; training has refined certifiers skills in one-on-one counseling and lesson plans have been adjusted to reflect infant cues training.

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

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

- Were nutrition education lesson plans and written materials reviewed and revised?
- What changes, if any, were made?

All classes developed by the State addressing Key Nutrition Messages, ‘Get the Skinny on Milk’, ‘Vary Your Veggies’, ‘Focus on Fruit’, etc, were incorporated into our regular, monthly class schedule for clients and are currently part of our class repertoire. Other classes consistently reflect these same messages.

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Activity 4: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2009-2010.

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

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

FY 2009-2010 WIC Staff In-services

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
<p>Example: Providing Advice</p> <p>Facilitated discussion during October 2009 staff meeting using the Continuing Education materials from Oregon WIC Listens.</p>	<p>Example: This in-service addressed several competencies in the core areas of Communication, Critical Thinking and Nutrition Education</p>	<p>Example: One desired outcome of this in-service is for staff to feel more comfortable asking permission before giving advice. Another desired outcome is for staff to use the Explore/Offer/Explore technique more consistently.</p>
<p>August 2009: OWLS training – group presentation and small group role playing.</p>	<p>Specifically addressed the area of Communication. Practiced listening to clients and not correcting them.</p>	<p>Desired outcomes focused on listening to client concerns and restating for clarification.</p>
<p>October 2009: OWLS Training – Group</p>	<p>Focused on Elements of Effective Education and</p>	<p>Desired outcomes included culturally</p>

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Presentation	Multicultural Awareness.	appropriate presentations, clear and relevant how to action steps to accomplish education topic.
January 2010:	Emphasis was on Critical Thinking and Communication	Identify perceived barriers to OWLS in the individual and group setting.
May 2010: Present new classes, review and evaluate program's BF strategy.	Life cycle Nutrition and Education.	Reviewed effectiveness of BF strategy, adjust all class outlines with and OWLS approach.

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

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

Activity1: Each agency will identify the core components of participant centered services that are being consistently utilized by staff and which components need further developing by October 31, 2009.

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

- Which core components of participant centered services are used most consistently with your staff? What has made those the most easiest to adopt?
- Which core components have the least buy-in? What are the factors that make these components difficult to adopt?

Response:

Staff related that the component of PCE that was easiest to adopt was the practice of talking less and listening more. Factors that made this the easiest were: staff was tired of doing all the talking, clients 'opened up' more if allowed to and it was easier to associate client's immediate concerns and provide

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appropriate advice. The core component that had the least ‘buy-in’ or most difficult to adopt was the practice of always asking permission first. A possibility as to cause revolves around certifiers being used to a didactic pushing information rather than waiting for an opening to deliver it when client is ready. Asking permission opens the possibility that the client is not ready to receive information.

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

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

- What strategy has been implemented to maintain the core components of participant centered services during a time of change?
- What strategy has been implemented to advance staff skills with participant centered services?

Response:

WIC has been using the ‘observation’ tool as a training mechanism to advance skills in participant centered services for certifiers. Multnomah County WIC has also employed the services of Dana Sturdevant to help train clerical staff at the call center and front desk in participant centered services.

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

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

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

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

- Which community partners did your agency select?
- Which strategies did you use to promote the positive changes with Fresh Choices?

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- What went well and what would you do differently?

Response:

Community partners selected to promote the positive changes with Fresh Choices were: Multnomah County Primary Care Practice, Nurse Family Partnership, Early Childhood Services, Head Start and local pediatricians. Strategies used to promote the positive changes were in-services done at offices 'All Staff' meetings, providing posters and information bulletins at local offices and promotion at leadership meetings. What went well were the materials supplied by the State and WIC staff was well trained for the promotions. What we might do differently is include more organizations and offices.

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

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

- How did your agency collaborate with the state WIC Research Analysts in evaluating Fresh Choices?
- How were you able to utilize, if appropriate, information collected from your agency?

Response:

Multnomah County Health Department WIC collaborated with the States' WIC Research Analysts through phone interviews. Information collected was used to promote the efficiency and appropriateness of WIC as a positive, prevention minded adaptable organization to county management.

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

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

Activity 1: Using state provided resources, each agency will assess their breastfeeding promotion and support activities to identify strengths and

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weaknesses and identify possible strategies for improving their support for breastfeeding exclusivity and duration by December 31, 2009.

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

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

Response:

Breast feeding assessment strengths were: 1) no visible formula in clinic, 2) front desk staff referring to appropriate counselor when client wanting to switch from BF to formula, and 3) the use of infant cues training helped staff identify common concerns with BF moms and to address them. Weaknesses included: 1) no IBCLC for immediate BF concerns; and 2) lack of current staff training in advanced breast feeding. To address these concerns, Multnomah County Health Department WIC is sponsoring 3 staff (one at each clinic site) for IBCLC certification. IBCLC certified staff will lead a common approach to improving BF longevity and exclusivity in all 3 WIC clinic sites.

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

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

- Which strategy or strategies did your agency implement to improve breastfeeding exclusivity and duration?
- Based on what you saw, what might be a next step to further the progress?

Response:

Much of this response was addressed in Goal 4, Activity 1. Referring clients to an appropriate counselor when wanting to switch infant to formula seemed to be the one strategy that helped a lot of WIC moms get through periods of change in their infant. The next step to further this process is a coordinated community wide effort to support breast feeding at the hospital and at home. Community awareness and developing support from other programs as well as a focused approach led by an IBCLC will help continue this process and; hopefully, improve BF longevity.

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ATTACHMENT 6

MULTNOMAH COUNTY IMMUNIZATIONS PROGRESS REPORT AND PLAN 2008 – 2011

Local Health Department: Multnomah County Health Department

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

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

Year 1: July 2008-June 2009				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
<p>A. Meet the HRSA immunization rate goal of 85% among 24-month-olds according to the 4:3:1:3:3:1 measure over three years.</p> <p>January 2008 rate among primary care clinics is 74% so ideal rate increase will be 3.66% or higher each year to meet goal.</p>	<p>Develop and implement a reminder/recall system for children aged 15-24 m/o missing the fourth dose of DTaP.</p> <p>Provide training for clinical staff on:</p> <ul style="list-style-type: none"> - reducing missed opportunities by giving every shot due at each visit - deferring shots only when medically appropriate - utilizing minimal spacing <p>Work with WIC staff to ensure understanding of immunization screening and referral.</p>	<p>Improved immunization rates by 3.66% and decreased missed shot rates based on quarterly assessment reports from OHS.</p> <p>Evaluate by:</p> <ul style="list-style-type: none"> - number and dates of trainings - number of staff trained - results of pre/post tests or by qualitative method. 	<p>Integrated Clinical Services (ICS) run monthly lists, by clinic, off EPIC of children that are missing their 4th DTaP. Each clinic follows up with clients in their own way but, primarily, clients are called once and if no response, a reminder notice is sent asking them to come in. Children re-appear on the list from month/month if they do not come in for the immunizations.</p> <p>Five trainings were held in the spring and summer for 58 staff on the basics of forecasting and the other principles of immunizations (i.e. reducing missed opportunities, utilizing minimal spacing, etc.) In addition, a training was held at the semi-annual Skills Fair on adult immunizations to 12 participants.</p> <p>The January 2009 UTD immunization rate shows a slight decrease of 3% from January 2008. However, the Missed Shot rate decreased by 1.3% and the Late Start rate decreased by 1.4% in this same time period.</p> <p>Met with WIC staff to review screening and referral process for immunizations. Many WIC clients have</p>	<p>There appears to be some discrepancy in the data received from OHS and that generated in EPIC regarding the 4th DTaP. The data from OHS indicates a much higher rate of children who are missing the 4th DTaP than EPIC. Possibly, this could be related to the fact that OHS takes into account any child who has ever received at least one shot at a clinic, then they are forever that clinic's client, even if they have moved on to a different medical home. EPIC only takes into account children that are established clients and whom are seen regularly. More discussion on this topic and the different systems and methodologies used may be warranted in the future.</p> <p>Integrated Clinical Services have continued to roll out the Building Better Care (BBC) model. As such, they have decentralized their services and, rather than have one vaccine lead at each clinic, more staff at every clinic are tasked with giving both childhood and adult immunizations. Therefore, during this transition period, we will</p>

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

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

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Year 1: July 2008-June 2009				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
			established medical homes where they receive immunizations.	have to continue focusing on training on immunization-specific information. Thus, we don't project there will be an increase in immunization rates of more than 1% in the foreseeable future.
B. Develop and implement a sustainable vaccine education training program over three years.	<p>Develop curriculum and materials for vaccine education training.</p> <p>Develop a plan to conduct trainings on vaccine coding, forecasting schedules and data entry.</p> <p>Implement trainings for new hires and current staff.</p> <p>Explore feasibility of developing an online training curriculum or utilizing pre-existing online resources.</p>	<p>Description of classes and schedule established.</p> <p>Evaluate by number of trainings held, number of staff trained, results of pre/post tests (or other method of evaluation), decrease in number of coding errors and increase in immunization rates.</p> <p>Evaluate various pre-existing online programs and compare to what is needed for staff development and training within the Department.</p>	<p>Throughout the year, 11 trainings were conducted on vaccine coding and use of IRIS/ALERT databases to 102 staff members.</p> <p>To prepare for the new Tdap school requirement, MCHD collaborated with MESD and OHS to provide two large trainings for 125 MESD and MCHD staff. Evaluations from the trainings indicated they were an overall success with staff understanding the new school law requirement more thoroughly.</p> <p>The CIP worked with schools of nursing to provide opportunities during fall, winter and spring clinics for over 50 student nurses to learn more about immunizations, forecasting and vaccine storage/handling as well as giving injections.</p> <p>An online program was developed to train staff on understanding the screening questions on the Vaccine Administration Record (VAR) in order to mitigate giving vaccines to clients for which contraindications exist.</p>	<p>We learned that attendance at trainings is more assured when the clinics request them rather than have them prescheduled.</p> <p>The coding data quality remains about the same as last year as a result of the trainings based on monthly data quality checks. The transition from Locally Owned hepatitis and PPV23 vaccine to State-supplied, in particular, has been somewhat difficult. That, along with periodic additions to 317 guidelines make coding an ongoing challenge.</p> <p>As more Medical Assistants are working in the Primary Care clinics and need more background in immunization basics, two online trainings on immunizations have been posted in the web-based MCHD Immunization Manual. These include the CDC's self-study program and the Vaccine Healthcare Centers Network's Immune Readiness Course. These are in addition to the recently-developed VAR training. Additional online trainings will be added to the website as suitable ones become identified and available.</p>

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Year 2: July 2009 – June 2010				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results³	Progress Notes⁴
A. Increase the up-to-date rate (4:3:1:3:3:1) for 2-year-olds seen at MCHD by 1% a year over the next two years.	Continue providing training for clinical staff on: <ul style="list-style-type: none"> - reducing missed opportunities by giving every shot due at each visit - deferring shots only when medically appropriate - utilizing minimal spacing Reassess current plan and modify as needed.	Improved immunization rates by 1% and decreased missed shot rate based on quarterly assessment reports from OHS. Evaluate by: <ul style="list-style-type: none"> - number and dates of trainings - number of staff trained - results of pre/post tests or by qualitative method 	To be completed for the FY 2010 report	To be completed for the FY 2010 report
B. Continue implementation of a sustainable vaccine education training program over three years.	Continue in-person trainings for new hires and current staff. Conduct various activities related to planning and implementation of online training. Pilot the training with a particular clinic staff.	Evaluated by number of trainings held, number of staff trained, results of pre/post tests (or other method of evaluation), decrease in number of coding errors and increase in immunization rates. Evaluate by surveying participants in pilot of online training program.	To be completed for the FY 2010 Report	To be completed for the FY 2010 Report

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

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

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Year 3: July 2010 – June 2011				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results⁵	Progress Notes⁶
A. Increase the up-to-date rate (4:3:1:3:3:1) for 2-year-olds seen at MCHD by 1% a year over the next two years.	Continue providing training for clinical staff on: - reducing missed opportunities by giving every shot due at each visit - deferring shots only when medically appropriate - utilizing minimal spacing Reassess current plan and modify as needed.	Improved immunization rates by 1% and decreased missed shot rate based on quarterly assessment reports from OHS. Evaluate by: - number and dates of trainings - number of staff trained - results of pre/post tests or by qualitative method	To be completed for the FY 2011 Report	To be completed for the FY 2011 Report
B. Continue implementation of a sustainable vaccine education training program over three years.	Continue in-person trainings for new hires and current staff. Conduct various activities related to refining online training.	Evaluated by number of trainings held, number of staff trained, results of pre/post tests (or other method of evaluation), decrease in number of coding errors and increase in immunization rates. Increased number of staff taking the online training program.	To be completed for the FY 2011 Report	To be completed for the FY 2011 Report

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

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

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Outreach Activities: July 2008 – June 2011

Activity 1

Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results⁷	Progress Notes⁸
Increase knowledge of Immunization School Law among child care facility staff over three years.	Conduct two trainings per year in the Fall on school law for staff working at children's facilities, Head Starts and private/alternative schools.	Increase in knowledge and understanding of school law purpose and process. Evaluate by number of trainings held, number of staff attending, results of pre/post tests (or other method of evaluation) and quality of reports submitted.	Conducted training for 15 State certifier staff on new school law requirements. Other groups trained include: - two groups of 15 providers in the Childcare Provider Network; - three trainings to 34 staff at 29 different agencies/schools. Evaluations indicate trainings were very useful and informative. Submissions from these staff were generally very complete and required minimal, if any, follow-up.	State certifier staff are becoming more aware of the importance of discussing with prospective certified childcare providers, the requirement to report immunization status on children in their care each year.

Activity 2

Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results⁹	Progress Notes
Increase knowledge and understanding of vaccine storage and handling among delegate agency staff.	Conduct annual trainings for delegate agency staff based on OHS Standard Operating Procedures for Vaccine Management and MCHD's Administrative Guidelines.	Evaluate by number of participants attending and results of pre/post tests (or other method of evaluation). Increased notification rate by agencies when vaccine appliance excursions occur.	Conducted training for staff from all delegate agencies on importance of appropriate vaccine management services. Notification of when temperature excursions occur has increased as awareness has increased.	Re-certification of all delegate agencies is due in FY 2009-2010 which also provides training opportunities and double checks for compliance.

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

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

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

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