



Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

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JANUARY 5-8, 2009

BOARD MEETINGS

FASTLOOK AGENDA ITEMS OF INTEREST

Pg 2	12:00 p.m. Monday Swearing In Ceremony
Pg 2	9:30 a.m. Tuesday Work Session: FY 2009 Budget Overview of the Health Department
Pg 3	2:00 p.m. Tuesday Work Session: County Attorney Presentation
Pg 3	9:00 a.m. Wednesday Work Session: Health and Human Services Policy Panel
Pg 3	9:30 a.m. Thursday Appointment of 2009 Board of Commissioners Vice-Chair
Pg 4	9:30 a.m. Thursday Appointments to the Community Health Council
Pg 5	9:35 a.m. Thursday Columbia-Cascade River District Memorandum of Understanding
Pg 5	10:00 a.m. Thursday Transportation Division

Thursday meetings of the Multnomah County Board of Commissioners are cable-cast live and taped and may be seen by Cable subscribers in Multnomah County at the following times:

Thursday, 9:30 AM, (LIVE) Channel 30

Saturday, 10:00 AM, Channel 29

Sunday, 11:00 AM, Channel 30

Tuesday, 8:15 PM, Channel 29

Produced through MetroEast Community Media

(503) 667-8848, ext. 332 for further info

or: <http://www.metroeast.org>

Monday, January 5, 2009 - 12:00 PM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

SWEARING IN CEREMONY

Multnomah County Board of Commissioners Deborah Kafoury, Judy Shiprack and Diane McKeel extend a cordially invitation to their swearing in celebration Monday, January 5, 2009 at 12:00 noon in the Multnomah Building, First Floor Commissioners Boardroom, 501 SE Hawthorne, Portland. A reception will immediately follow the swearing in ceremony.

Tuesday, January 6, 2009 - 7:30 AM to 9:30 AM
Multnomah Building, Third Floor Conference Room 315
501 SE Hawthorne Boulevard, Portland

LOCAL PUBLIC SAFETY COORDINATING COUNCIL EXECUTIVE COMMITTEE MEETING

A quorum of the Multnomah County Board of Commissioners *may* be attending the Local Public Safety Coordinating Council Executive Committee meeting. This meeting is open to the public. For agenda topics and/or further information, contact LPSCC Executive Director Carol Wessinger at 503 988-5894.

Tuesday, January 6, 2009 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD WORK SESSION

WS-1 Fiscal Year 2009 Budget Overview of the Health Department. Presented by Lillian Shirley. 2.5 HOURS REQUESTED.

Tuesday, January 6, 2009 - 2:00 PM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD WORK SESSION

WS-2 County Attorney Presentation on Legal Authority and Hierarchy, Governance, Public Meetings and Public Records Laws, Legal Requirements of Public Officials and Functions of the County Attorney's Office. Presented by Agnes Sowle. 2 HOURS REQUESTED.

Wednesday, January 7, 2009 - 9:00 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD WORK SESSION

WS-3 Health and Human Services Policy Panel: Prevention. Presented by Lillian Shirley and Joanne Fuller. 2 HOURS REQUESTED.

Thursday, January 8, 2009 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

Appointment of Commissioner District 3 Judy Shiprack as Multnomah County Vice-Chair for the 2009 Calendar Year Pursuant to Section 3.60 of the Multnomah County Home Rule Charter

CONSENT CALENDAR - 9:30 AM **DEPARTMENT OF COMMUNITY SERVICES**

- C-1 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to COVINGTON PLACE ROW HOMES ASSOCIATION INC.
- C-2 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to GEORGE R. & JOYCE G. LINGELBACH

- C-3 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to NANCY L. MONTEITH
- C-4 RESOLUTION Authorizing the Repurchase of a Tax Foreclosed Property by the Former Owners Tong & Nang Thai Tang
- C-5 Approval of Auto Wrecker Certificate Renewal for Harold M. & Irma M Milne for Loop Hi-Way Towing, 28609 SE Orient Drive, Gresham, OR 97080

DEPARTMENT OF COUNTY HUMAN SERVICES

- C-6 ORDER Authorizing Designees of the Mental Health Program Director to Direct a Peace Officer to Take an Allegedly Mentally Ill Person into Custody

DEPARTMENT OF HEALTH

- C-7 Budget Modification HD-08 Reclassifying 5 Positions within Various Divisions of the Health Department, as Determined by the Class/Comp Unit of Central Human Resources; and the Modification of FTE Between Various Other Positions
- C-8 Budget Modification HD-12 Reclassifying Twelve Positions within the Integrated Clinical Services Division of the Health Department, as Determined by the Class/Comp Unit of Central Human Resources

REGULAR AGENDA

PUBLIC COMMENT - 9:30 AM

Opportunity for Public Comment on non-agenda matters. Testimony is limited to three minutes per person. Fill out a speaker form available in the Boardroom and turn it into the Board Clerk.

NON-DEPARTMENTAL - 9:30 AM

- R-1 Appointment of Dan Pierce and Reappointment of Bonnie Malone and Aron Stephens to the Community Health Council

DEPARTMENT OF COMMUNITY SERVICES – 9:35 AM

- R-2 Columbia-Cascade River District Memorandum of Understanding. Presented by Jane McFarland, Multnomah County Principal Planner and Rich Faith, City of Troutdale. 15 MINUTES REQUESTED.

DISTRICT ATTORNEY'S OFFICE – 9:50 AM

- R-3 BUDGET MODIFICATION DA-01 Appropriating \$44,717 in Edward Byrne Memorial Grant Dollars for Elder Abuse Investigative Services

NON-DEPARTMENTAL - 10:00 AM

- R-4 Multnomah County's Response to the Winter Storms in Late December 2008. Presented by Commissioner Diane McKeel, Department of Community Services, Road Services Personnel and Invited Others. 15 MINUTES REQUESTED.

DEPARTMENT OF HEALTH – 10:15 AM

- R-5 NOTICE OF INTENT to Submit a Grant Application to the National Association of Chronic Disease Directors "ACHIEVE" Grant Program
- R-6 Budget Modification HD-13 Appropriating \$670,115 in Grant Funding from the Centers for Disease Control and Prevention (CDC) and \$11,500 from the Oregon Association of Hospitals and Health Systems (OAHHS) to Support the Health Department's Regional Health System Emergency Preparedness Program

DEPARTMENT OF COUNTY HUMAN SERVICES – 10:20 AM

- R-7 NOTICE OF INTENT to Apply for a National Center for Injury Prevention and Control of the Centers for Disease Control (CDC) Research Grants for Preventing Violence and Violence-Related Injury
- R-8 NOTICE OF INTENT to Apply for United Way funding for Continuation of the Domestic Violence Enhanced Response Team (DVERT)

COUNTY ATTORNEY'S OFFICE – 10:25 AM

R-9 RESOLUTION Confirming the Interim Designations for Multnomah County Chair, Multnomah County Commissioner District 1, Multnomah County Commissioner District 3 and Multnomah County Commissioner District 4, in the Event of a Vacancy

BOARD COMMENT

Opportunity (as time allows) for Commissioners to provide informational comments to Board and public on non-agenda items of interest or to discuss legislative issues.



**MULTNOMAH
COUNTY**

Deborah Kafoury
Multnomah County
Commissioner District 1

Judy Shiprack
Multnomah County
Commissioner District 3

Diane McKeel
Multnomah County
Commissioner District 4

Cordially invite you to attend their swearing-in celebration
Monday, January 5, 2009
12:00 noon

Multnomah Building Board Room
501 SE Hawthorne Blvd.
Portland, Oregon 97214

A reception will immediately follow the swearing-in ceremony

BOGSTAD Deborah L

From: BOWEN-BIGGS Tara C
Sent: Friday, January 02, 2009 12:17 PM
To: KAFOURY Deborah; COGEN Jeff; SHIPRACK Judith C; MCKEEL Diane
Cc: LEE Beckie; MADRIGAL Marissa D; LASHUA Matthew; WIREN Corie; BOGSTAD Deborah L; RINEHART Tom
Subject: FW: Proposed Agenda for Swearing-In

Hello everyone,

Below please find the proposed agenda for Monday's swearing-in ceremony.. Ted and Jeff will share the MC duties. Please let me know if you have concerns that we need to address before Monday.

Thanks and welcome aboard!

TBB

Tara Bowen-Biggs

ph. (503)988-3953

tara.c.bowen-biggs@co.multnomah.or.us

From: SCHOLES Rhys
Sent: Friday, January 02, 2009 11:56 AM
To: RINEHART Tom
Cc: BOWEN-BIGGS Tara C; BOGSTAD Deborah L
Subject: Proposed Agenda for Swearing-In

Set-up: Nobody on the dais, small podium on the witness table facing the audience. Commissioners, Attorney and Chair all sit at the front near the podium.

1. Commissioner Cogen welcomes our guests and introduces the newly elected Commissioners and the County Attorney
2. The County Attorney administers simultaneous oaths. Audience applauds, Commissioners sit down.
3. Chair Wheeler appreciates the new Commissioners and introduces them individually for brief remarks.
4. Commissioner Kafoury speaks.
5. Commissioner Shiprack speaks.
6. Commissioner McKeel speaks.
7. Chair Wheeler thanks our guests for coming and invites them to the reception.

Rhys Scholes
 Communication Policy Director
 Office of Multnomah County Chair Ted Wheeler
503-988-5273



LPSCC
Executive Committee meeting
AGENDA

Tuesday, January 6, 2009

**** 7:30 to 9:30am ****

Room 315

Announcements & Introductions

Approve minutes from December 2, 2008

LEGISLATIVE FOCUS

Governor's Budget	45 minutes
Joe O'Leary, Governor's Public Safety Advisor	
Department of Corrections	25 minutes
Max Williams, Director, DOC	
Portland Police Bureau	5 minutes
Chief Rosie Sizer	
Sheriff's Office	5 minutes
Sheriff Bob Skipper	
Court System	5 minutes
Presiding Judge Jean Maurer	
Metropolitan Public Defenders	5 minutes
Lane Borg, Director	
Department of Community Justice	5 minutes
Scott Taylor, Director	
Department of County Human Services	5 minutes
Joanne Fuller, Director	
Department of Health	5 minutes
Lillian Shirley, Director	
Roundtable Discussion	15 minutes

NEXT MEETING

Tuesday, February 3, 2009

JANUARY 6, 2009

9:30 AM

WS-1

**(packet materials
to be
distributed at meeting)**

MULTNOMAH COUNTY OREGON

1/06/2009



FY 2009 Health Budget Presentation Worksession Follow-Up

Issues/Discussions/Questions	Follow-Up	Completed
Health Department		
Provide information on Governor's Kids Proposals' likely affect of FY 2010 Health Department budget?		
What are the recommended strategies for the Chair/Board to promote public health in a variety of policy arenas?		
What are the recommend strategies for advocacy regarding periodontal care for pregnant women and others?		
Provide data on national increase in abortions in the recent past.		
Provide the names of Health Department presenters today.		
Would like future policy issue/discussion scheduled on water quality/provenance.		



Ted Wheeler, Multnomah County Chair

501 SE Hawthorne Blvd., Suite 600
Portland, Oregon 97214
Phone: (503) 988-3308
Email: mult.chair@co.multnomah.or.us

To: Board of County Commissioners
Sheriff, District Attorney, Department Managers
Budget Office
Chair's Office
Board Clerk

From: Ted Wheeler
Jana McLellan
Bill Farver

RE: Board Budget and Policy Discussions

Dr: January 5, 2009 REVISED (changes for 2-10 and 2-17)

This winter and spring promises to be one of the most challenging in recent memory. We are planning at this point to prepare an Executive Budget that reduces our ongoing expenditures (or increases revenue) by up to \$35 million. Traditionally, our briefing sessions with new Board members involve individual department background briefings. However, many of the issues the County will struggle with involve larger, cross departmental or cross jurisdictional questions.

Therefore, we have organized two sets of presentations for you in January and February. One will be department based. Each department will prepare an overview of their work, with special emphasis on the departmental-based challenges we will need to address as part of our budgeting work this spring.

The other will be panel discussions featuring broad, cross departmental issues. These will provide a systems context to the decisions we will help make within individual departments. The panel discussions will also include opportunities to discuss the state budget, revenue options, and employee compensation possibilities. The lead for each panel discussion will be responsible for inviting panel members and structuring the discussion.

The schedule below lists the dates and times of the departmental briefings and the panel discussions. Both of these sessions will be open to the public and you are encouraged to invite interested citizens to attend. While public testimony will not be a part of these discussions, our office will organize subsequent meetings to hear concerns and ideas from the communities and general public. The following is a list of the policy topics followed by a more complete description of the questions we will be addressing.

DATE/ TIME	TOPIC / LEAD (Panel discussions in CAPS)	QUESTION(S) POSED
1-6 9:30 – noon	Health Department Lillian Shirley , Director	What are the core functions of the department? What are the most pressing policy concerns?
1-6 2-4 pm	Governance and Charter Agnes Sowle, County Attorney	General overview of County legal authority and hierarchy, governance issues, public meetings and public records laws, ethics.
1-7 9-11 am	PREVENTION Lillian Shirley , Health Dept. Director Joanne Fuller, Human Services Dept. Director	In the midst of reductions, is prevention a philosophy that should still guide our decision making? How should it be defined for purposes of assisting decision makers? What are the most effective, evidence based prevention practices currently in use in Multnomah County? What is the extent of services covered under the SUN umbrella. What is the role of the SUN Council and SUN partners in the ongoing work of the SUN program?
1-13 9- noon	Human Ser. Dept. Joanne Fuller, Director	What are the core functions of the department? What are the most pressing policy concerns?
1-14 9-11 am	SAFETY NET Joanne Fuller, Human Services Dept. Director Lillian Shirley , Health Dept. Director	In view of the planned State and County reductions, what will be the current definition of the social service safety net? How do we distinguish between physical safety and basic treatment? If the Governor's reductions in human services are fully implemented, what is the status of services for mandated and discretionary basic needs? How will possible changes on the state and federal levels in health care impact our service delivery system?
1-15 10:30 – noon	GOVERNOR'S BUDGET Rhys Scholes Phillip Kennedy- Wong	What impact would the Governor's proposed budget have on services delivered by Multnomah County? How will the County work with community advocates and the State Legislature to continue these essential services?

1-21 9- 10 am	Orientation – Public Safety System – Adult and Juvenile Peter Ozanne, Deputy COO for Public Safety	How the parts of the system work together. Stream of Offenders graphic and/or skit.
1-21 10 to noon	Department of Community Justice Scott Taylor, Director	What are the core functions of the department? What are the most pressing policy concerns?
1-22 1-3 pm	Sheriff's Office Bob Skipper, Sheriff	What are the core functions of the department? What are the most pressing policy concerns?
1-27 9-11 am	District Attorney's Office Mike Schrunk, DA	What are the core functions of the department? What are the most pressing policy concerns?
1-28 9-10:30 am	ADULT PUBLIC SAFETY Peter Ozanne, Deputy COO for Public Safety	DRAFT Can the public safety system truly operate as a system? If so, what should its priorities be? Part I: The Adult Criminal Justice System What are the system's priorities? What works to increase public safety? What is the system's commitment to evidence-based practice?
1-28 10:30 – noon	JUVENILE PUBLIC SAFETY Peter Ozanne, Deputy COO for Public Safety	DRAFT Part II: The Juvenile Justice System What are the system's priorities? What works to increase public safety? What's the system's commitment to evidence-based practice?
2-3 9-10 am	Dept. of County Management Carol Ford, Director	What are the core functions of the department? What are the most pressing policy concerns?

2-3 10-11 am	Dept. of Community Services Cecilia Johnson, Director	What are the core functions of the department? What are the most pressing policy concerns?
2-3 11- noon	Library Molly Raphael, Director	What are the core functions of the department? What are the most pressing policy concerns?
2-4 9-11 am	SUPPORT SERVICES Jana McLellan, Chief Operating Officer Cecilia Johnson, Dept. of Community Services Director	Are there more efficient methods to provide services across jurisdictions, in the following areas: Business Support Services (i.e. IT, HR, Facilities, Fleet, Budget & Accounting); Operations and Maintenance of Roads & Bridges What are partnership opportunities the County should consider focusing on in "common" operations and support services across jurisdictional boundaries? What are project or operational partnerships that may add value to the taxpayer by: Adding capacity Increasing value Providing cost efficiencies Eliminating duplication of services
2-10 9 – 11 am	Information Technology	What are the core functions of the department? What are the most pressing policy concerns
2-11 9-11 am	CAPITAL NEEDS Karyne Kieta, Budget Director	What are the major infrastructure investments/ challenges that the County is facing and what are the funding approaches available to help meet those challenges? (e.g Facilities; Bridges)
2-17 9-10 am	Revenue Forecast Karyne Kieta, Budget Director	Second Quarter spending report Update general fund forecast
2-17 10-12 am	STATE AND LOCAL REVENUE OPTIONS Rhys Scholes . Communications and Policy, Chair's	How can we fund the services the community needs? Revenue options for Multnomah County Revenue options for the State of Oregon Should we prioritize our efforts for new revenue based on the amount of revenue potentially available or based on political feasibility? How should we balance local efforts with state efforts? Should Multnomah County ask voters to support a levy in November 2009?

	Office	Should Multnomah County pursue any other local taxes? Should Multnomah County play a leadership role in advocating Property Tax Limitation Reform?
2-24 9-11 am	OPTIONS FOR REDUCING EMPLOYEE COSTS AND SAVING JOBS Travis Graves, Human Resources Director	Are there alternatives to addressing the budget situation through reducing employee costs and in turn saving jobs? What options are available to which employees may apply and what are the pros and cons of each. Which options are subject to what type of labor negotiations or challenges? How are other jurisdictions approaching this issue?

Multnomah County Health Department

FY09 Adopted Budget New Board
Briefing January 6, 2009

**The Health Department assures, promotes, &
protects the Health of the people of Multnomah
County**

***Assure*
access to
necessary
and dignified
health care**

***Promote*
the health of
all County
residents**

***Protect*
the health of
all County
residents**

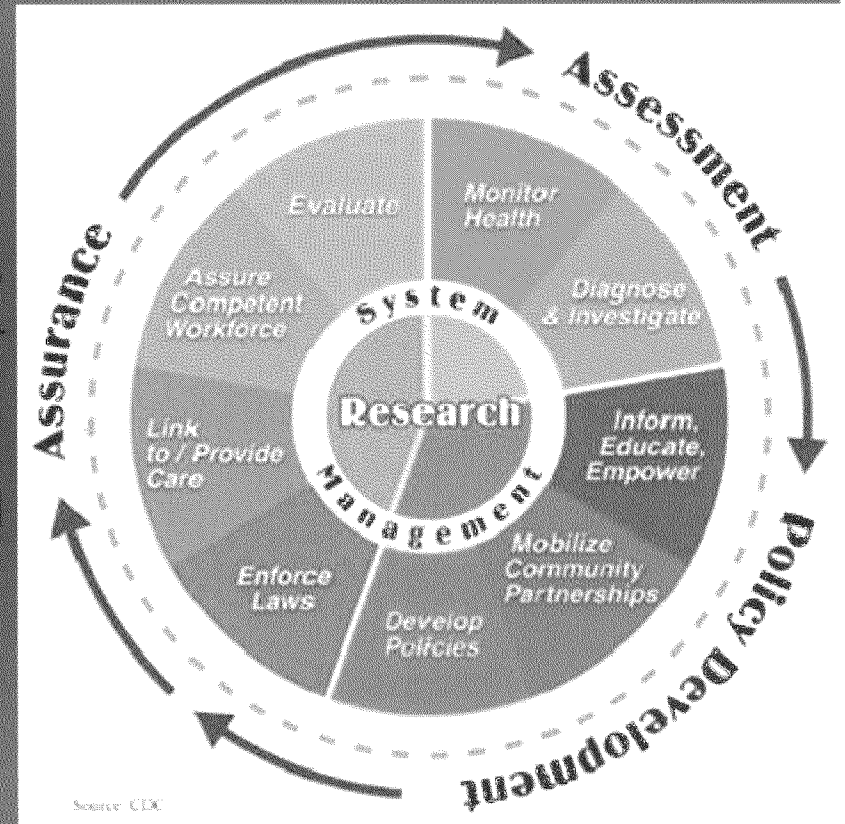


The Public Health System

- Federal Government
 - Health & Human Services
 - Centers for Disease Control (CDC)
 - Health Resources & Services (HRSA)
 - Substance Abuse & Mental Health Services (SAMHSA)
- State Government
 - State Health Agency
- Local Government
 - Local Health Department

Our Services - Public Health

Public Health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire regions.



Our Mission

The Health Department...

Assures

Medical & dental
services in County
clinics and jails

Screen for OHP,
Medicaid, Medicare

Promotes

Provide health
education &
information in
schools, workplaces
& other community
settings

Protects

Investigate &
control spread of
communicable
diseases

Control mosquito &
rat populations

...the health of the people of Multnomah
County

Our Strategic Plan

FY05-09

Goal 1: Community has greater control over factors that influence health

Goal 2: Dignified access to care

Goal 3: Protect public and prepare for public health emergencies

FY10-14

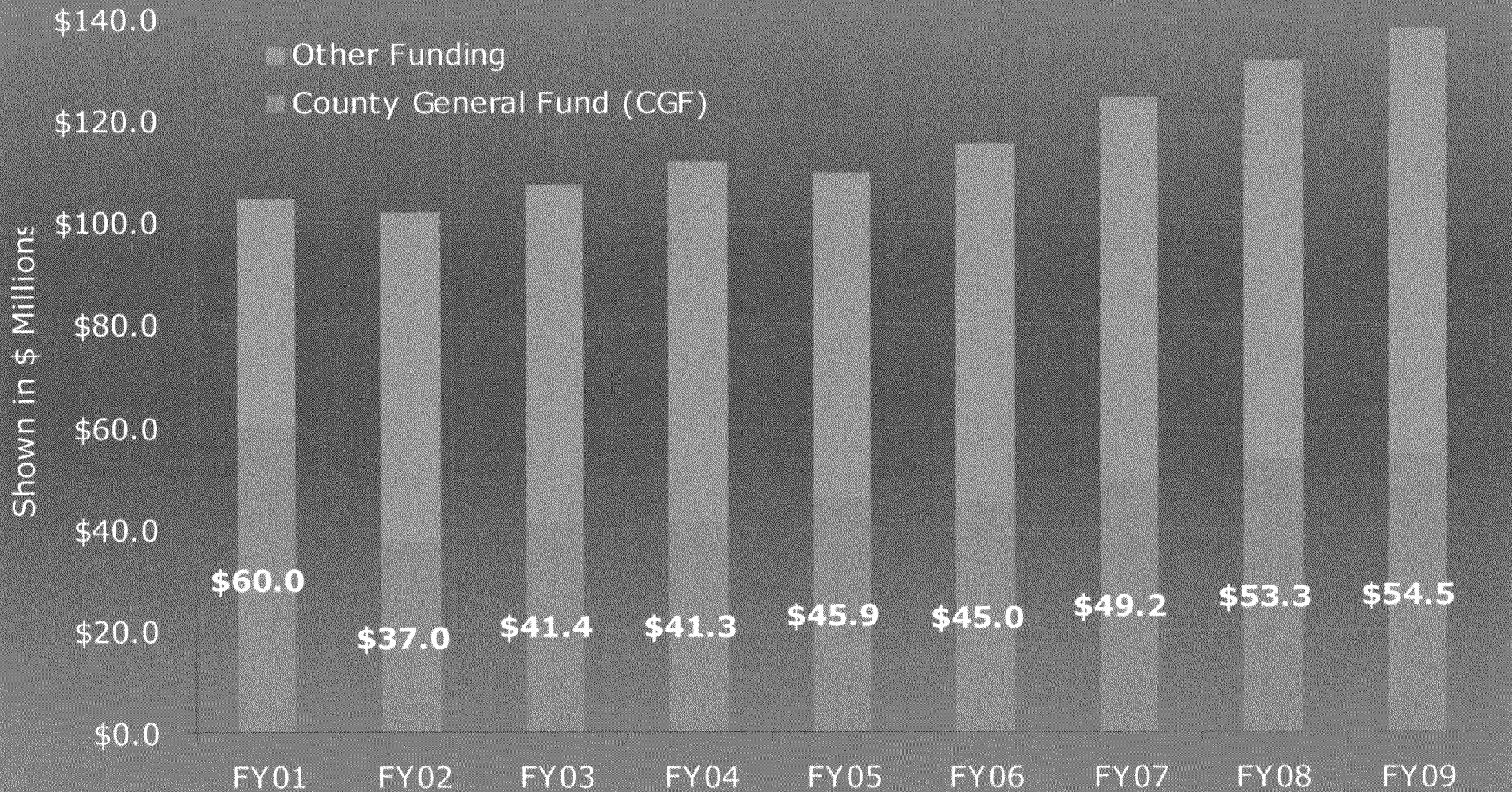
Goal 1: Community has greater control over factors that influence health

Goal 2: Improve the health of our diverse communities

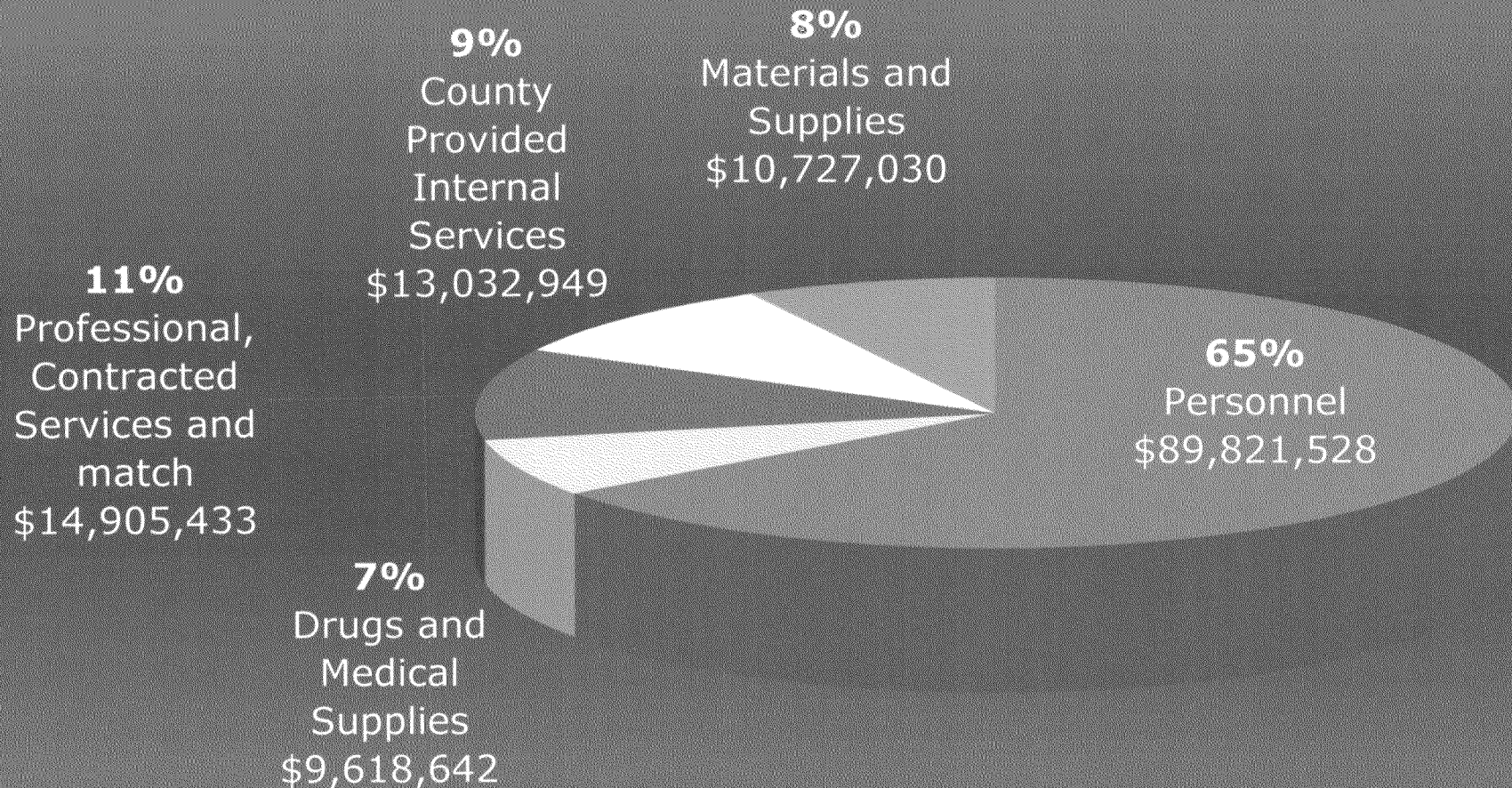
Goal 3: Adaptive, accountable learning organization

FY09 Adopted Budget

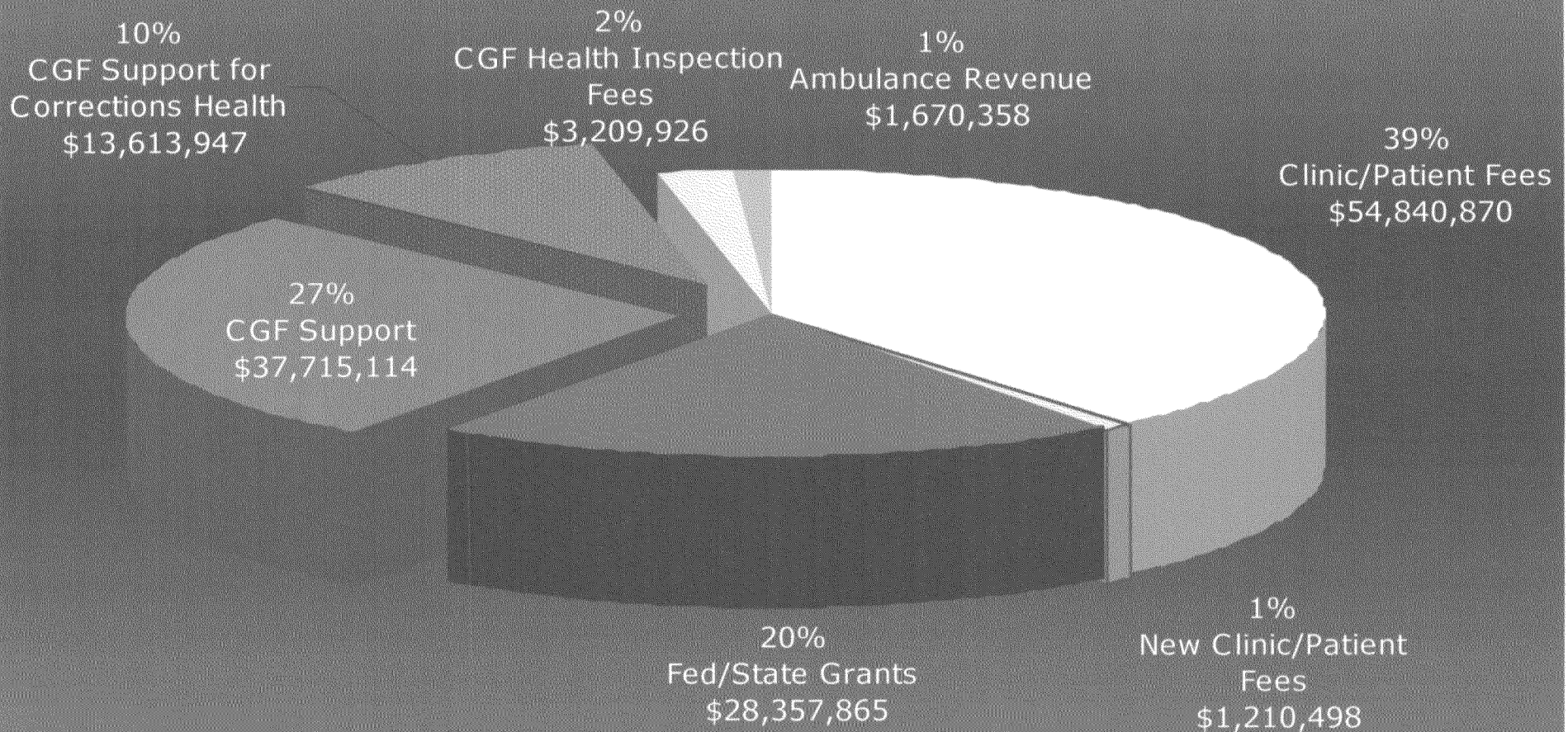
Adopted Budget Comparison



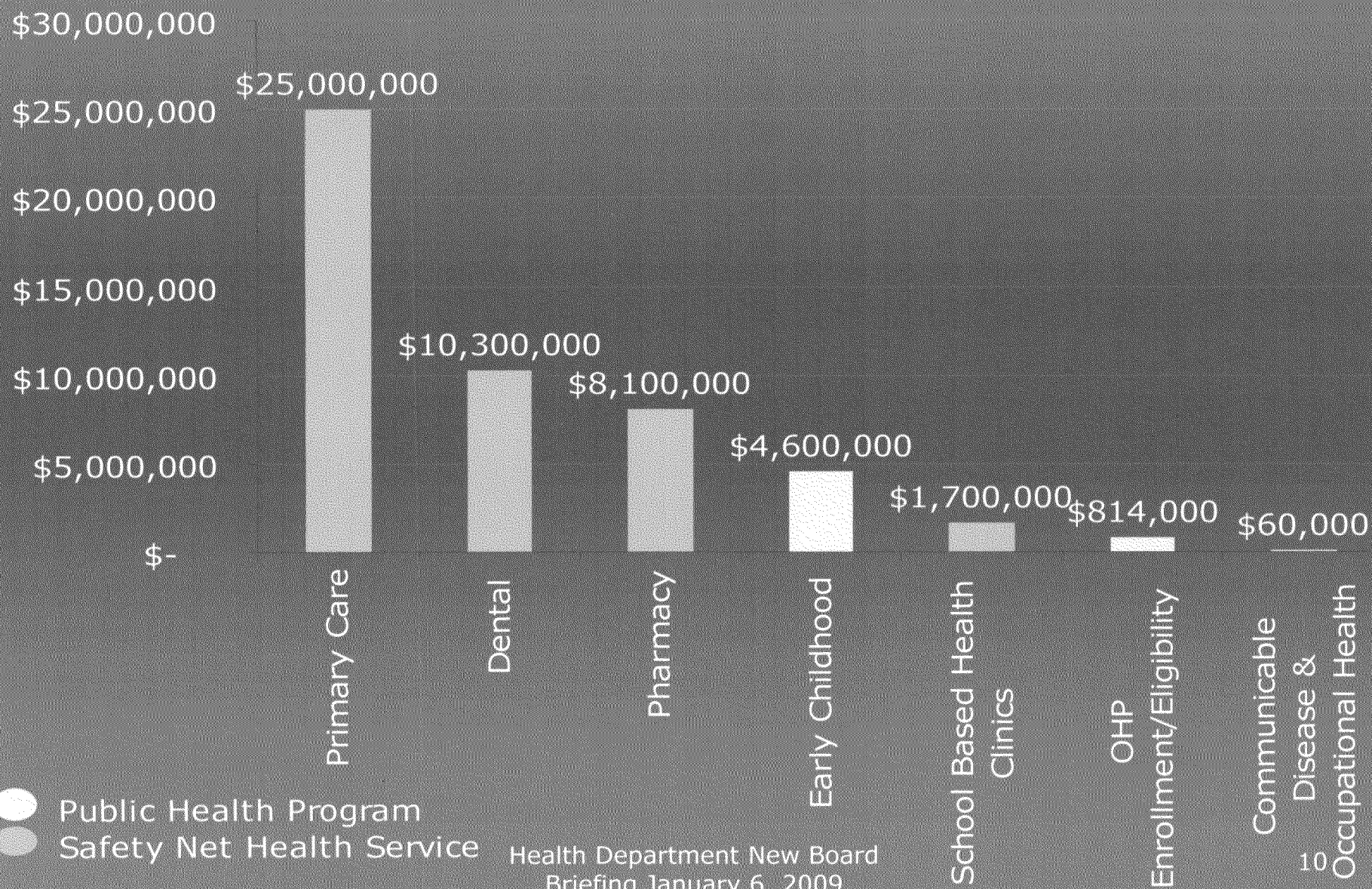
Budget Summary: Expense



Budget Summary: Revenue

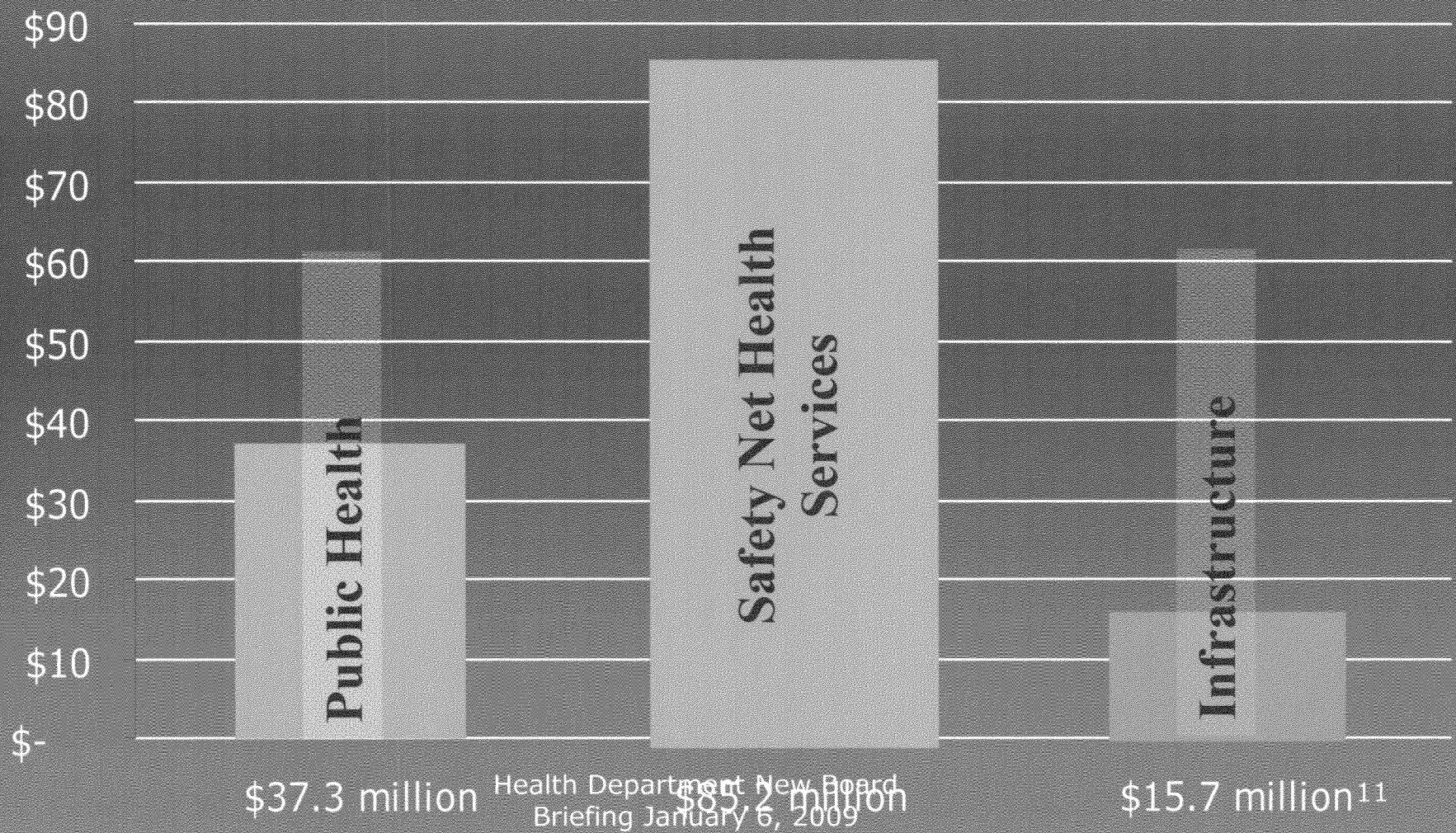


Budget: Insurance Revenue



Budget Aligned with Services

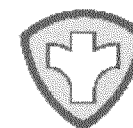
FY2009 Adopted Budget



Budget Summary: Monitoring



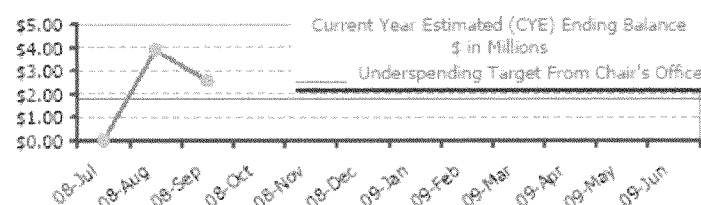
Multnomah County Health Department FY2008-09 Financial Dashboard For the Period Ending: September 2008



Public Health
Prevent. Promote. Protect.

Balance at the End of FY09.

(How Accurate are the Estimates?)



Projected Year
End Balance
\$2,565,344

Percentage of
Year Complete
25%

Traditional Income Statement

	Adopted Budget	Revised Budget	Actual	Projected Year End	% of Revised
GGF Support	\$ 54,538,990	\$ 54,538,990	\$ 9,089,831	\$ 54,538,990	100%
Other Revenue	\$ 83,658,592	\$ 83,658,592	\$ 17,506,106	\$ 80,382,522	96%
	\$ 138,197,582	\$ 138,197,582	\$ 26,595,937	\$ 134,921,512	98%
Expense	\$ 138,197,582	\$ 138,197,582	\$ 30,877,687	\$ 132,356,166	96%
Surplus/(Deficit)			\$ (4,281,750)	\$ 2,565,346	

Key Measures

	Page(s)
All Revenue (Grants, Insurance, Fees)	3-3
Health Care Fee Revenue	4-5
Expenses (All Types All Funds)	6-7
Corrections Health Outsourced Medical	8
EMS Actual Compared to Budget	9

Principles and Best Practices Guiding our Work: Quality, Prevention & Equity

Principles & Best Practices Guiding our Work: *Quality*, Prevention, Equity

Quality

- Building Better Care
- Dental Access
- EPI/Surveillance
- School Based Health Center Redesign
- Health Promotion Framework

Principles and Best Practices Guiding our Work: Quality, *Prevention*, Equity

Prevention

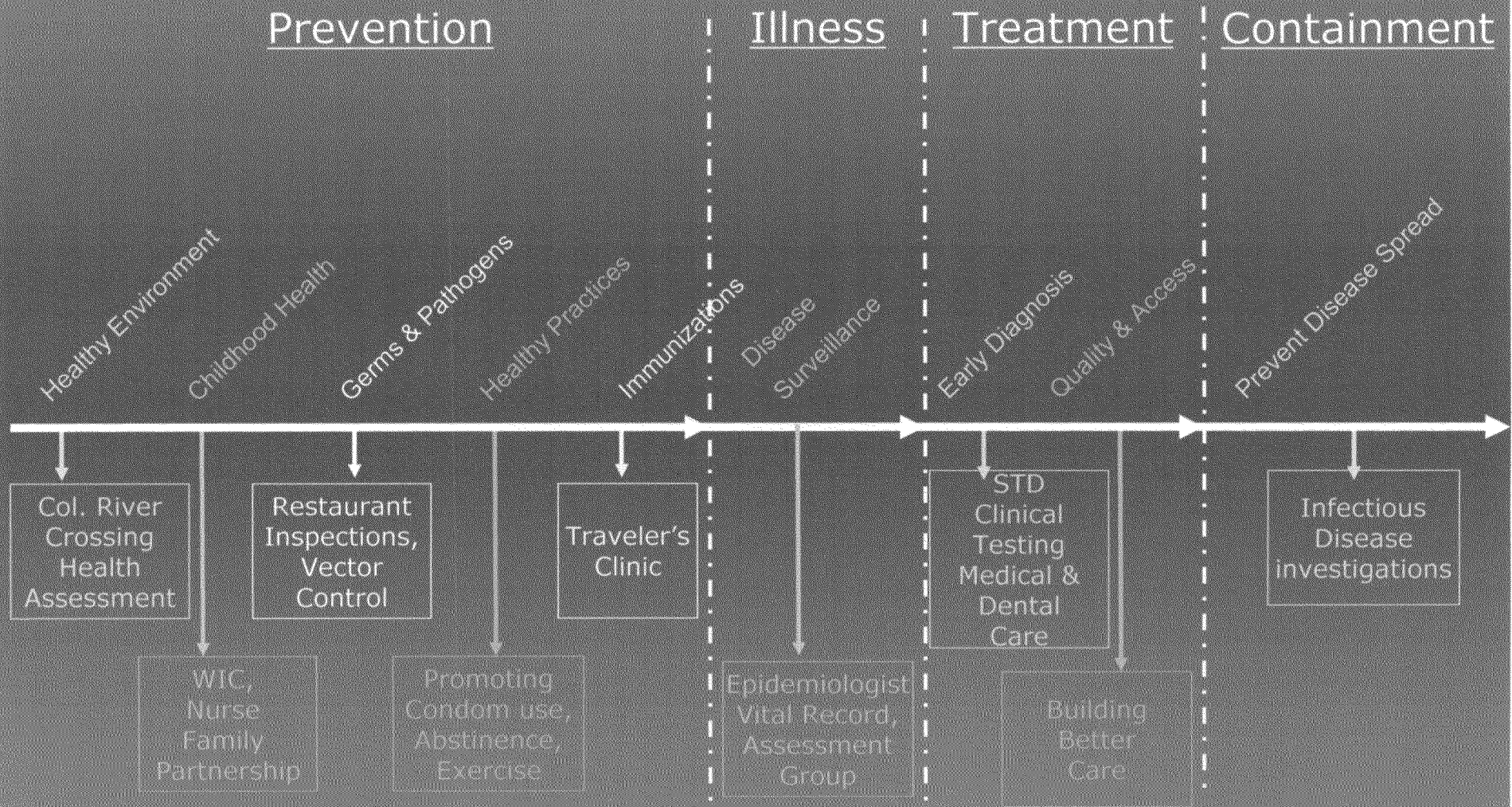
- Guides *who* we serve & *how* we serve them
- More than treat illness & prevent death
- Focus upstream on prevention
- Prioritize socially vulnerable families & communities

Principles and Best Practices Guiding our Work: Quality, Prevention, *Equity*

Equity: Some communities in Multnomah County have

- Higher rates of disease
- Poorer health outcomes
- Barriers to health care access

Focus on: Prevention



Focus on Prevention: Targeting the Leading Causes of Death & Disease

Causes:

1. Tobacco Use
1. Poor nutrition + physical inactivity

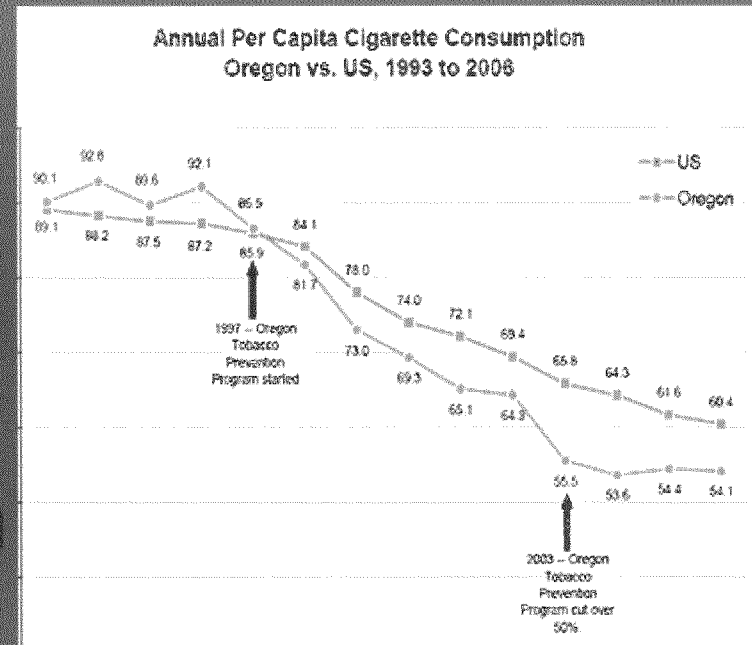
County Programs:

- Indoor smoking limits
- Menu labeling
- Health Impact Assessment
- Healthy Eating Active Living Program

Focus on: Prevention Works

In Oregon cigarette consumption dropped faster than the national average soon after the State began a Tobacco Prevention and Education Program, then slowed once the program was de-funded.

.(Source: Oregon Department of Human Services)



Focus on: Promoting Health In Childhood

There are 156,000 children in Multnomah County; more than 1 in 5 visited a Health Department clinic last year.

In Multnomah County nearly 50 percent of all children living in poverty receive services from our Safety Net Health Services .

Focus on: Promoting Health In Childhood

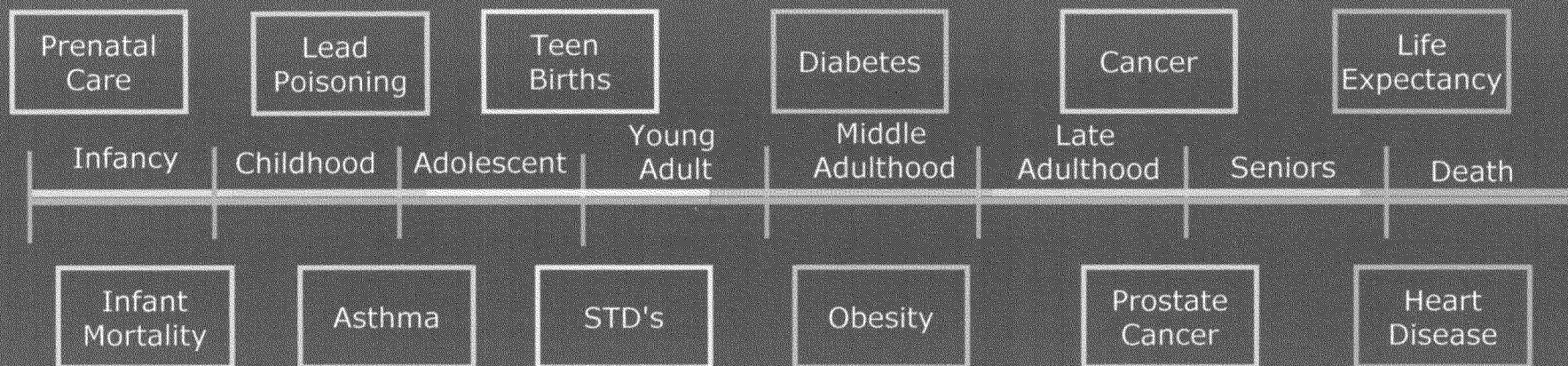
About 9,500 babies are born each year in Multnomah County:

- 50 die before their first birthday
- 200 are born to girls under age 18
- 600 are low birth weight
- 900 had a mother who smoked during pregnancy

Outside the clinical setting, we provide targeted prevention and education services aimed at improving the health of all children.

Focus on: Health Equity

Life Continuum...



...from a Health Perspective

Focus on: Health Equity

Underlying Socioeconomic Factors

Education

**Exposure to
Environmental
Hazards**

**Healthcare
Access**

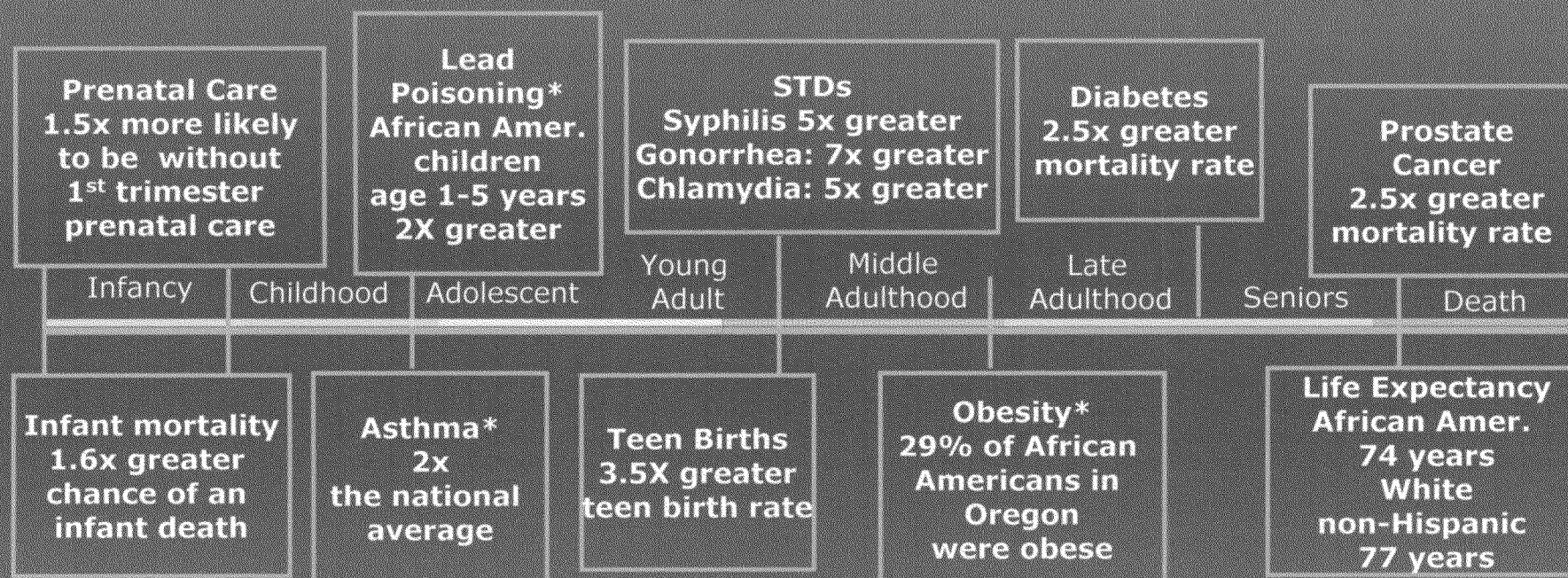
**Income/
Occupational
Class**

**Substandard
Housing**

Lack of Power

Justice System

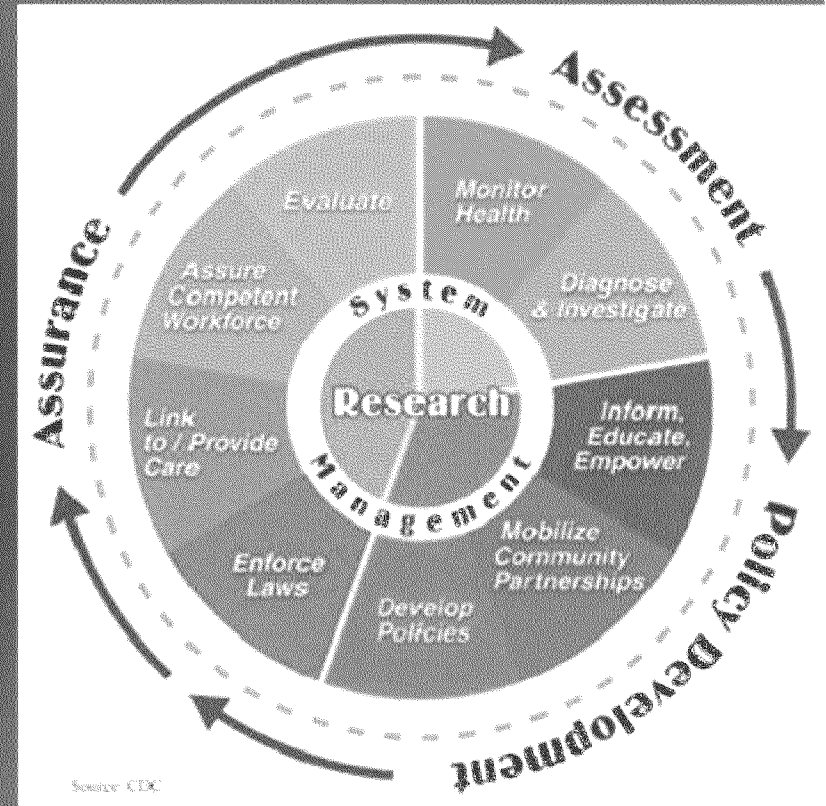
African American Health Inequity Life Continuum



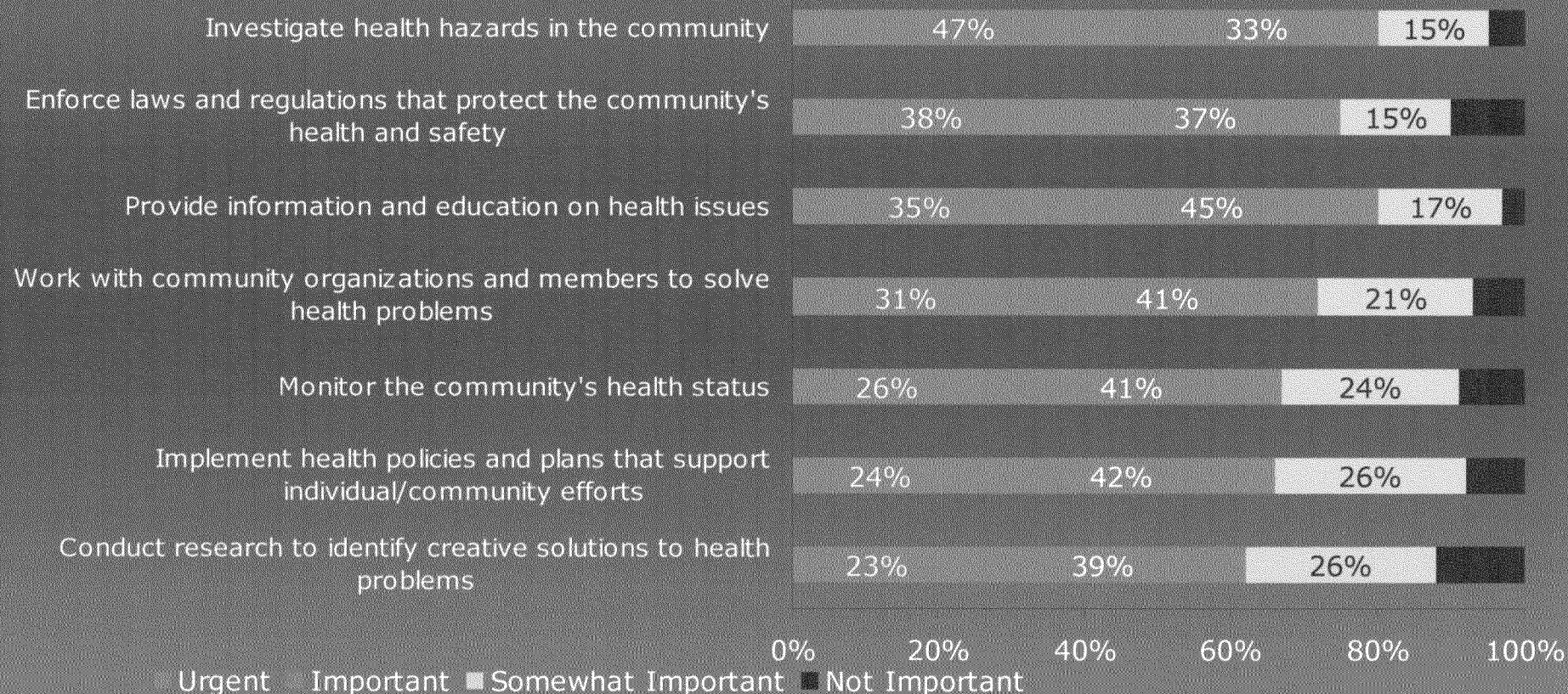
Public Health Services

Our Services - Public Health

Public Health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire regions.



The Public's Priorities for Health Departments



Source: Northwest Health Foundation opinion research findings October 2008)

Protection

Public health departments maintain safe and healthy conditions in communities:

- *Safe healthy* restaurants, daycare centers and foster homes
- *Vaccinate* children & adults
- *Investigate & control* communicable diseases
- Help communities *create healthier environments*
- *Protect from exposure* to lead, mold, rats, mosquitoes & toxins
- Help people *adopt healthier behaviors*

Emergency Preparedness

Public health education & emergency preparedness reduces human suffering:

By preparing for and responding to the health effects of catastrophes such as earthquakes, disease outbreaks and industrial disasters public health reduces the impact of these disaster on communities.

Public Health Saves Money

Healthy people spend less on medical care. Investing \$10 per person annually in community programs that increase physical activity, improve nutrition, and prevent smoking could save Oregon more than \$193 million in the next five years.

(Source: Trust for America's Health)

Public Health Services

- Epidemiology
- Environmental Health
- Communicable Disease & Occupational Health
- STD, HIV & Hep C Prevention & Treatment
- Early Childhood Home Visit Nursing Program
- Community Immunization Program
- African American Sexual Health Equity Program
- Medicaid Enrollment & Eligibility Screening
- Public Health Emergency Preparedness

Success in Leadership, Partnership & Innovation

- Environmental Health
 - multiple awards for excellence & innovations.
- AMA/CDC Pandemic Flu Award
 - for excellence in Pandemic Influenza Community Mitigation Planning
- Lowest rates of syphilis & gonorrhea on the West coast

Success in Leadership, Partnership & Innovation

- 30% decline in TB cases since 1996
- Early implementation of emerging best practices
- No disparities in access to HIV care
- Community based approach to Health Equity

Public Health is...

"A broad social enterprise, more akin to a movement, that seeks to extend the benefits of current knowledge in ways that will have the maximum impact on the health status of a population. It does so by identifying problems that call for collective action to protect, promote and improve health, primarily through preventive strategies."

--Bernard Turnock, MD, MPH

Safety Net Health Services

Our Community Health Centers provide quality health services for people who experience barriers to accessing care

- Clinical Best Practice
- Improve Access to Care
- Accountability
- Support Workforce Retention/Development

Safety Net Health Services

- Primary Care clinics
- Dental – school & community based dental & dental clinics
- HIV Health Services
- School Based Health Centers & Teen clinic
- Homeless Services-healthcare for children & adults

Safety Net Health Services

- Women's Infants, and Children (WIC) Nutrition program
- Pharmacy
- Lab and X-Ray-supporting all the health clinics
- Language and Interpretation services
- Corrections Health-in jail and juvenile detention

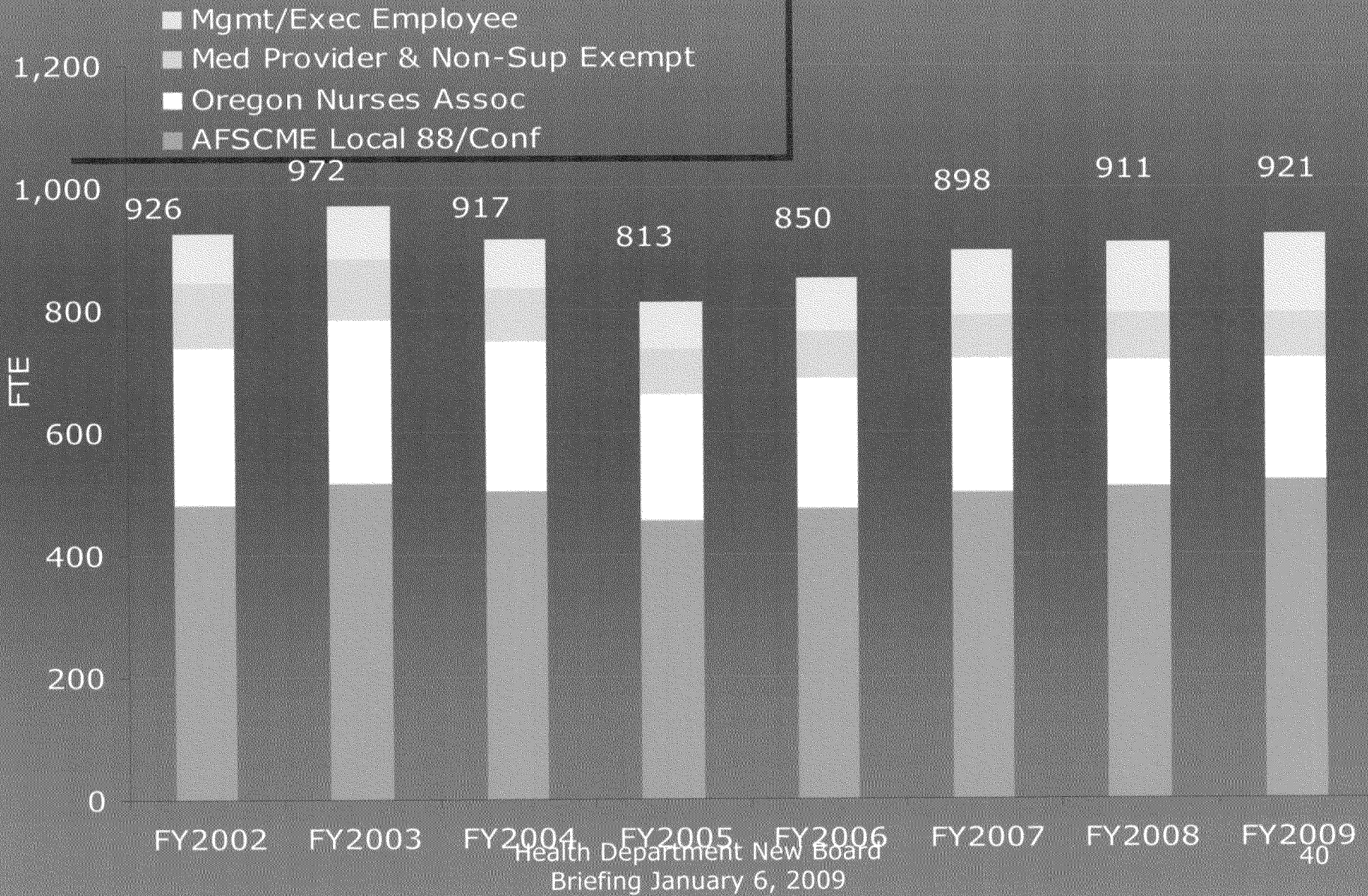
Success for Multnomah County

- Partnerships
- Leadership
- Building Better Care
- Dental Access
- CAWEM pilot
- Electronic Health Record (EHR)
- Pharmacy Drug Assistance
- School Based Health clinics redesign
- WIC

Infrastructure: The Foundation for our House

- Aligned with the Department's mission and principles of quality, prevention and equity
- Supports Quality and Accountability
- Leadership and calculated risk taking allows for innovation
- Workforce Management and Business processes link to Equity

Infrastructure: Workforce Overview



Infrastructure Services

- Health Policy (e.g. smoke-free housing, menu labeling)
- Health Research, Assessment, Program Design and Evaluation services
- Grant Writing
- Diversity and Quality Team (DQT)
- Workforce Development & Training
- Health IT
- Business Services
- Department Leadership

HD Infrastructure Successes:

Quality

- Building Better Care
- Obesity Prevention Strategies (i.e. HEAL, menu labeling)
- Building Partnerships Across Differences (BPAD)
- Facilitative Leadership
- Succession Planning

HD Infrastructure Successes:

Technology

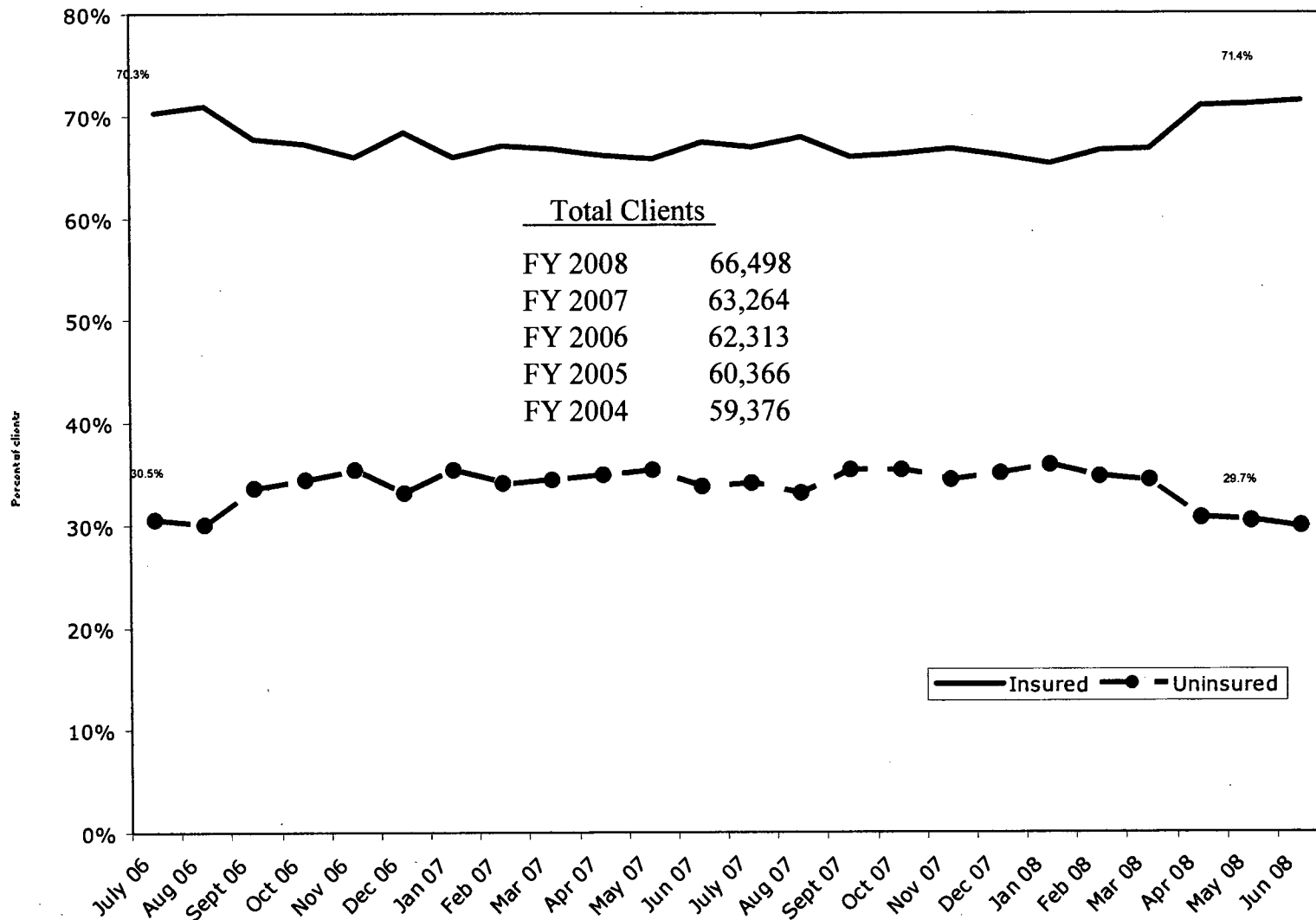
- EHR/Practice Management
- On-line Services (i.e. Food Handlers Card Testing)
- Employee Engagement

Leadership

- Disabilities Summit
- LGBT Conference
- Regional Health Systems Emergency Preparedness
- Smoke Free Housing
- Tri-county Health Officer

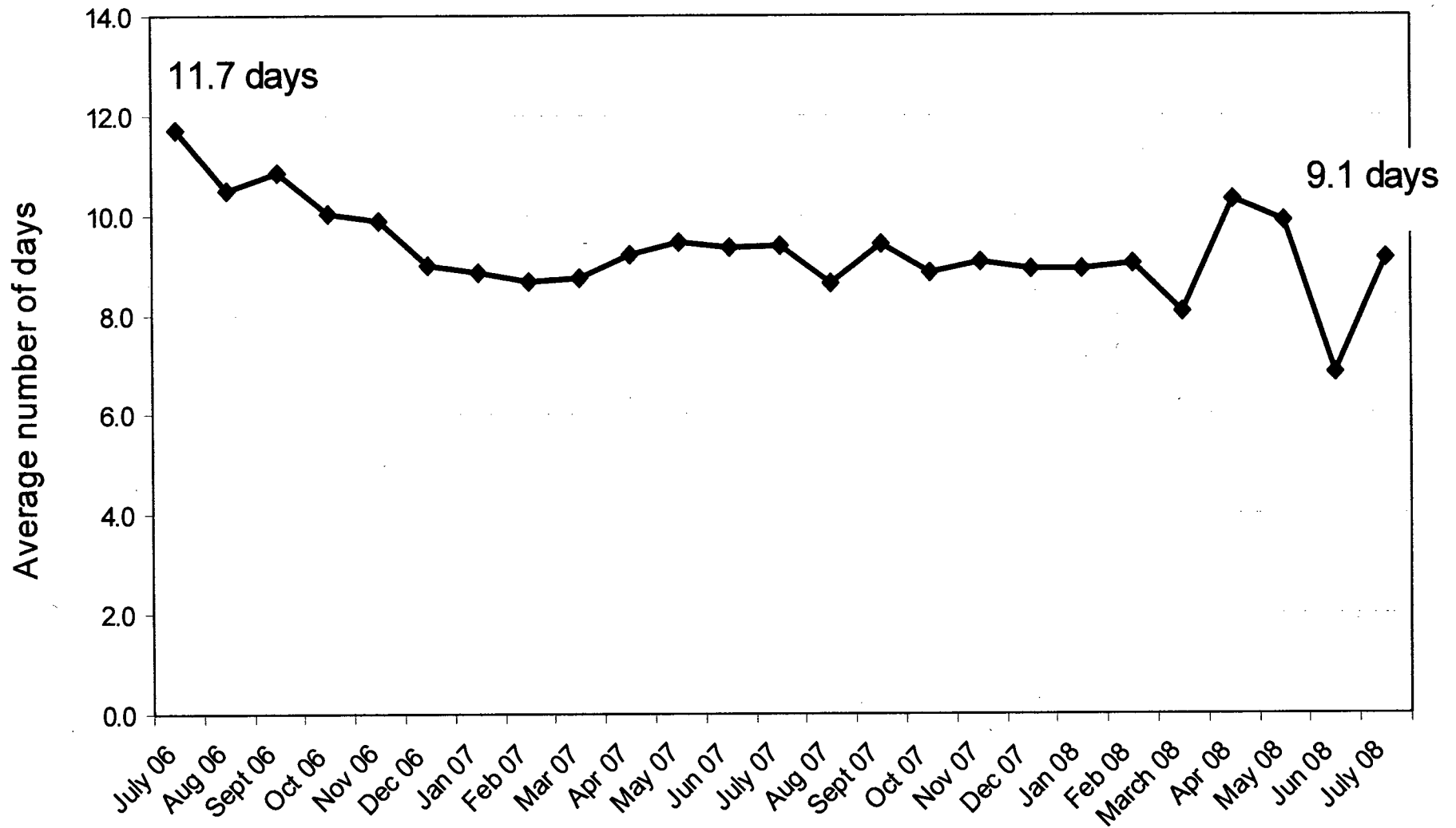
How We Measure Performance:

% of clinic clients without insurance



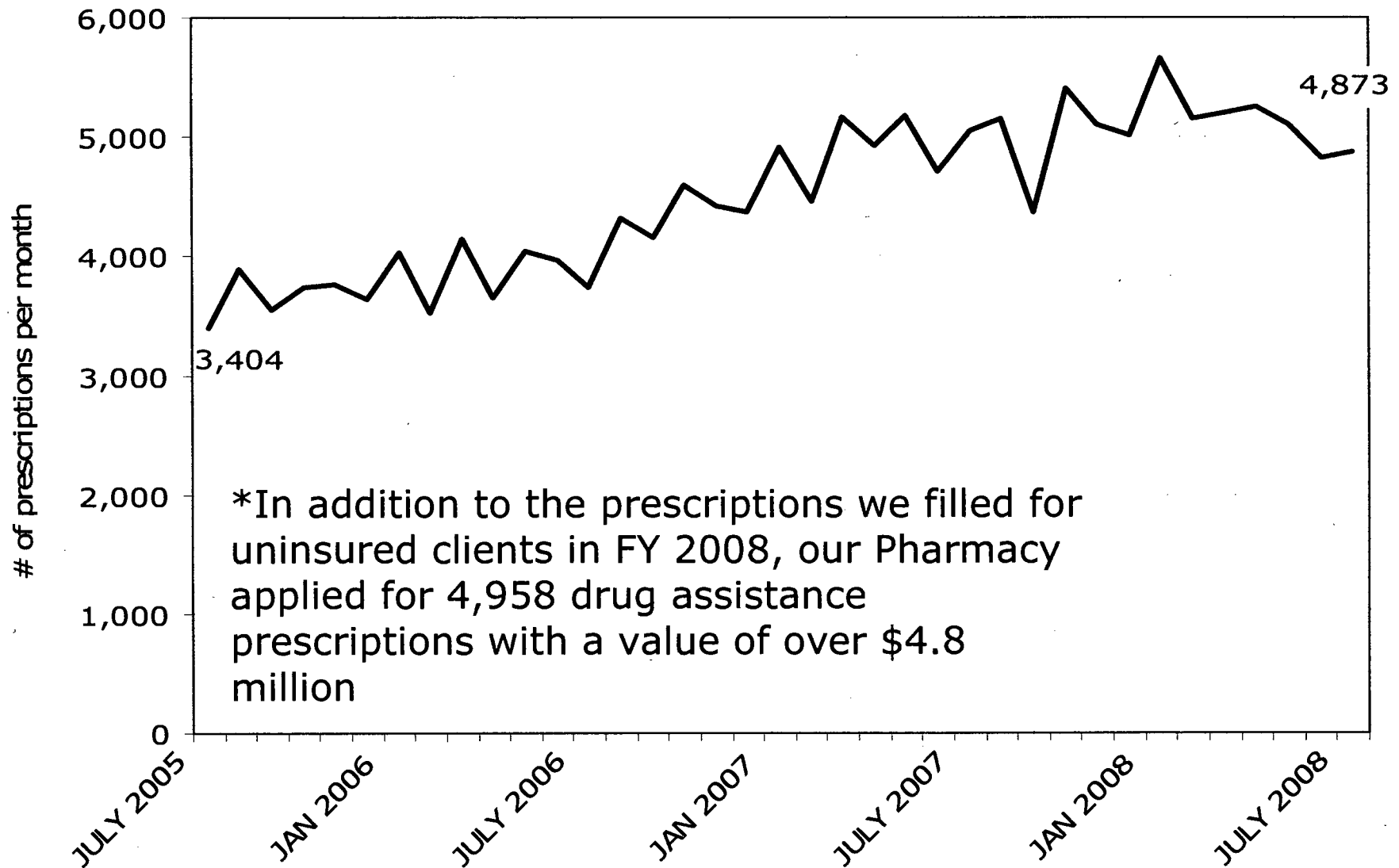
How We Measure Performance:

Average Days to Appointment for New Clients



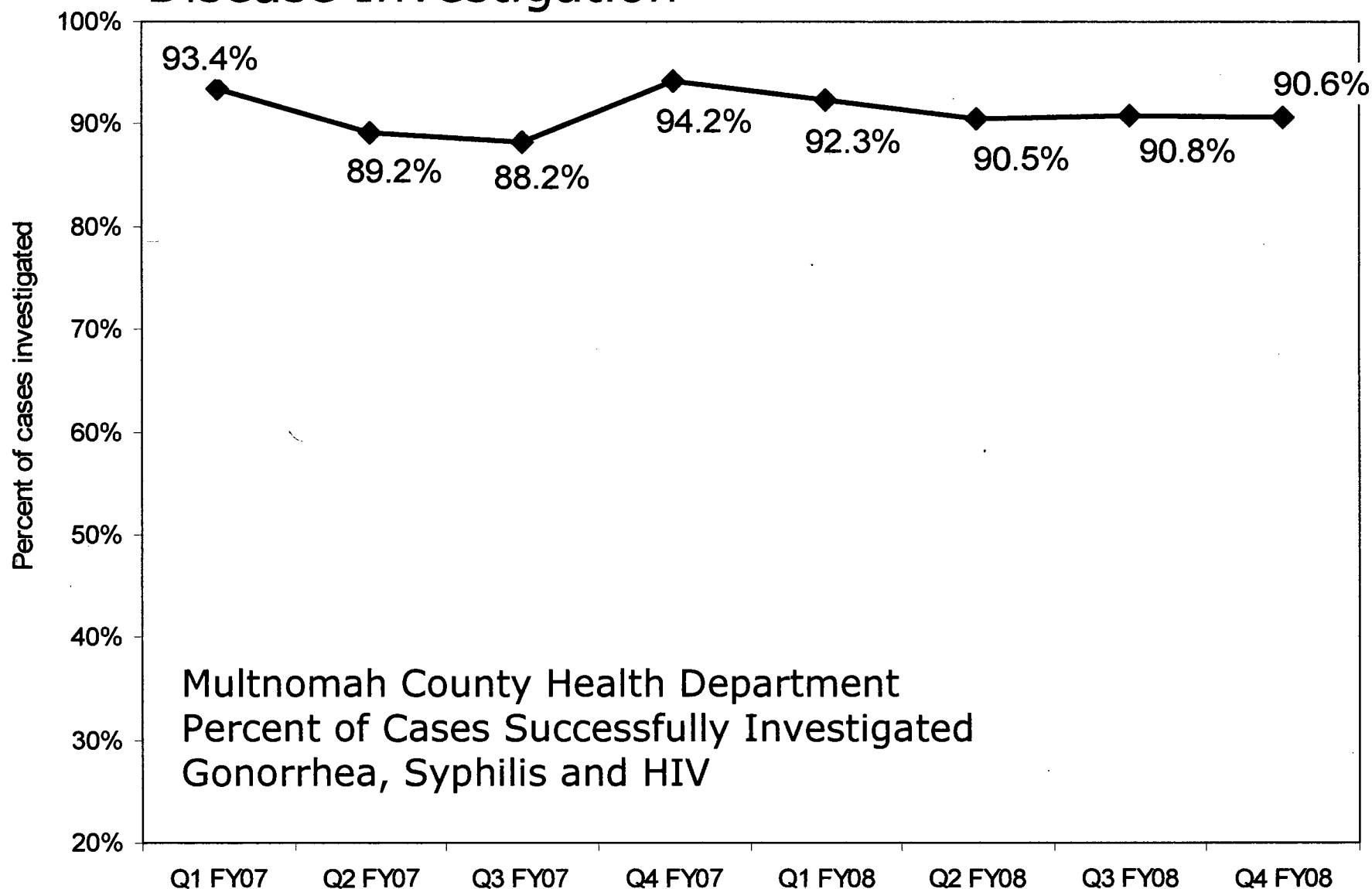
How We Measure Performance:

Pharmacy Rx for Uninsured Clients



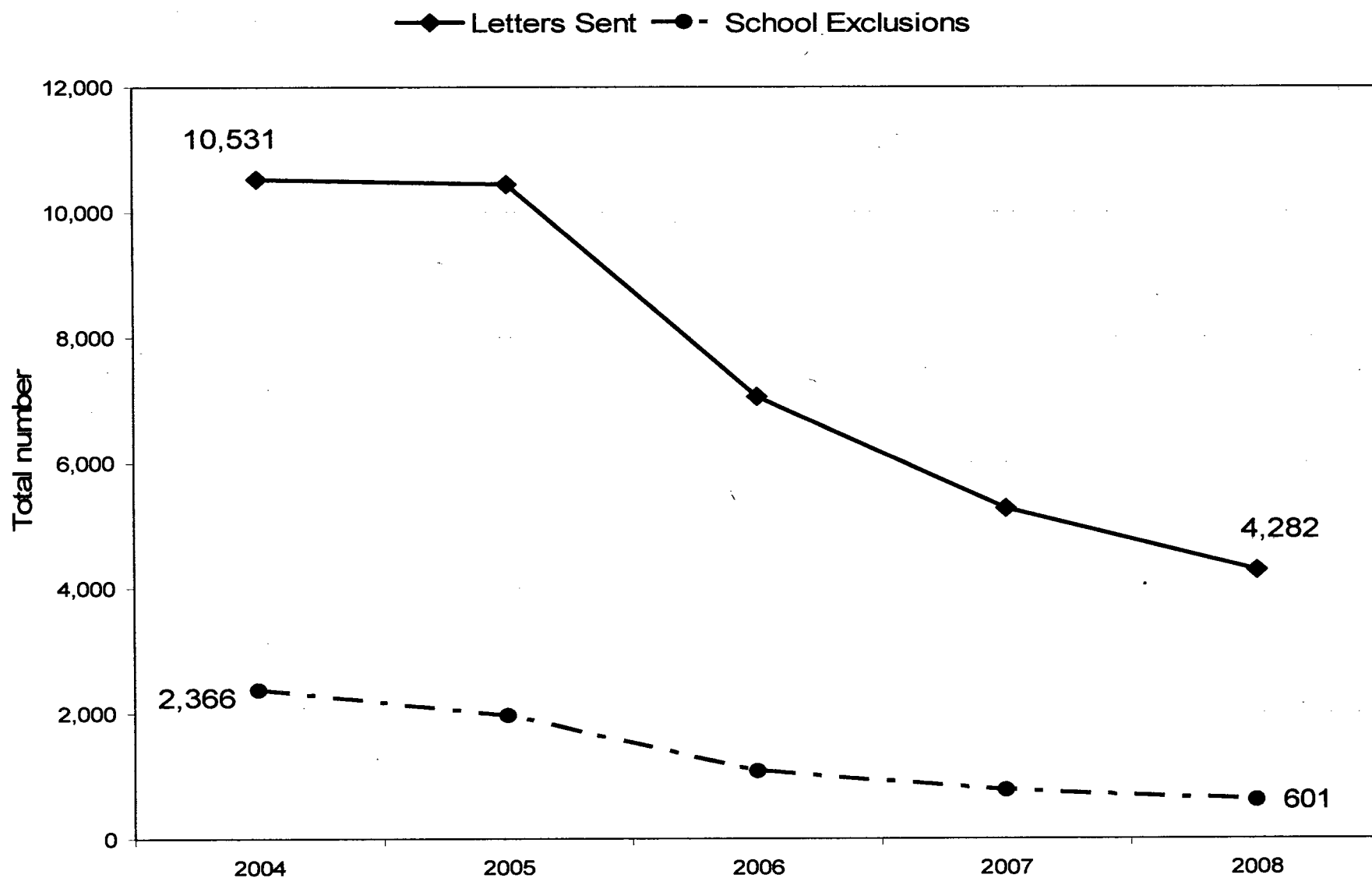
How We Measure Performance:

Disease Investigation



How We Measure Performance:

Immunization Letters & Exclusions



Issues and Challenges

State Impacts FY09 and FY10

Revenue

- Partnerships
- Coverage
- Downstream State Impacts

Policy

- Eligibility
- State & Federal Regulations
- Triple Aim

Questions?

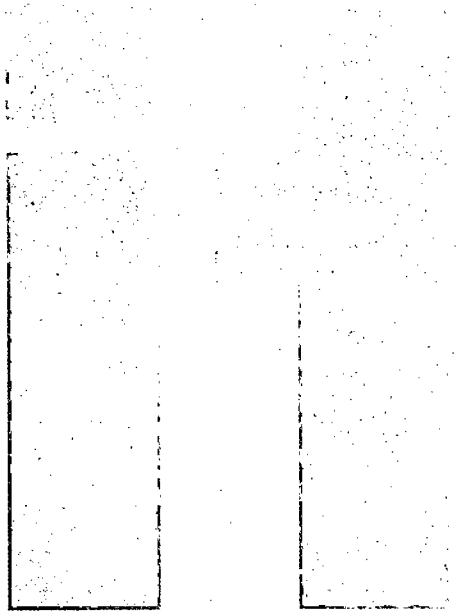


HOUSE CALLS

Some Portland doctors and nurses want to do more than just treat patients—they want to fix the broken US health care system. Here's how a group of community clinics is cutting costs, improving their clients' health, and transforming the doctor's office into a place where patients feel at home.

by JILL
DAVIS

PHOTOGRAPH by ADAM LEVEY



you happen to have private health insurance through your employer, you won't come to Multnomah County's **Mid-County Health Center** for medical care. The clinic is housed in a concrete box of a building on SE Division Street near 127th Avenue—its exterior unembellished save for the blue-and-green M that is the county logo. Just past the entrance, a security guard watches over the parking lot; another sits near the intake bays of the waiting area, just beneath the sign reading "Welcome to Mid-County Health Center" in five languages.

The Mid-County Health Center is one of the Portland metro area's seventy-five community health clinics—those nonprofit or community-run clinics that are eligible for federal funding and serve very low-income people as well as the uninsured. Between 70 and 75 percent of the patients on its roster are enrolled in the **Oregon Health Plan**, the state's Medicaid program, which covers some 386,000 people. The other 25 percent (besides the small number of patients on Medicare) have no insurance at all.

Owing to the clinic's contract with the US Department of Health and Human Services, refugees who settle in Oregon receive their very first medical checkups in the United States here, and many stay on as long-term patients. At last count, Mid-County was serving clients who spoke fifty-two different languages; to manage this diverse pool of patients, it employs five full-time interpreters.

One morning in November, I meet Mid-County's program manager, Deborah Cockrell, in one of the clinic's two large waiting areas, where fifty or so chrome-and-plastic chairs line the walls and sit in long, economically arranged rows. Thanks to a federal grant, the space is getting a face-lift. ("And boy, we needed it," Cockrell says.) Wood beams, new intake desks, and warmer colors will transform the institutional space into a friendlier one.

Cockrell leads me through a door marked "Employees Only" (in English, Spanish, and Russian this time) and down a long hall decorated with posters—one that's titled "Peoples of Mainland Southeast Asia," one listing the immuniza-

tions that new refugees need—and lined on both sides by exam rooms, twenty-six in all. When I remark with surprise at the size of the place, Cockrell responds with a laugh. "Well," she says, "we're pretty busy."

That turns out to be something of an understatement: the Mid-County Health Center, which opened in 1993, is the busiest community clinic in the metro area. Its twelve doctors and nurse practitioners, nine registered nurses, two licensed social workers, and two licensed practical nurses see, on average, 150 people per day; in 2008, the clinic was on schedule to have logged some forty thousand patient visits.

Given the many challenges the clinic faces every day (the volume of clients, the logistical problem of finding someone who can say "blood sugar test" in an East African language), it seems an unlikely setting from which a major health care innovation might emerge. But in summer 2007, the clinic decided to implement an entirely new approach to caring for its many patients by joining Primary Care Renewal, a project funded and led by **CareOregon**, the Portland-based nonprofit medical plan administrator that serves Oregon Health Plan enrollees. (Mid-County was joined by four other health centers: Central City Concern's **Old Town Clinic**, which primarily serves Portland's homeless population; **Virginia Garcia's Cornelius Center**, which serves migrant and low-income families in Washington County; Oregon Health & Science University's **Family Medicine Clinic at Richmond**; and **Legacy Emanuel's internal medicine clinic**, both resident clinics).

Primary Care Renewal's goals are deceptively simple: the clinics want to prove that they can improve their patients' overall health as opposed to simply treating acute problems like the flu; make doctors and patients happier with their health care experience; and, perhaps most important, reduce costs to the health care system overall. "It makes sense that if you can keep people healthier, then your costs will be under control, because primary care is relatively inexpensive compared to hospital stays or emergency care," says CareOregon medical director David Labby, who helped design and launch the project. If this new model for primary care, called the "medical home" or the "primary care home," proves successful, these five clinics could become showcases for primary care reform around the country.

Before embarking on the project, Mid-County Health Center took care of its patients the way many primary care clinics do—including those that accept only patients with private health insurance. Its doctors, whose schedules were "filled to overfilled," as Cockrell puts it, saw as many patients as possible in a day, a necessity because of the high demand for appointments, and because Medicaid, like most health insurance plans, reimburses clinics only for the visits in which patients actually see physicians.

During the twenty minutes allotted for each appointment, Mid-County's doctors treated everything from lacerations and rashes to chronic conditions like Type II diabetes, hepatitis C, and hypertension. Patients rarely met with their designated doctors, and they certainly didn't know nurses or medical assistants by name. Even more troubling, the doctors and nurses and medical assistants didn't know their patients as well as they could have; staff had no big-picture strategy for monitoring, say, whether a fifty-year-old patient with Type II diabetes was current with blood sugar tests. "We didn't put a lot of attention into tracking chronic conditions," Cockrell says. With demand for the clinic's

For more information on the subjects in red, go to this story on portlandmonthlymag.com and click on the links.

services so great, "We were just focused on trying to get people who needed an appointment in to see someone."

It might be tempting to see Mid-County's situation as symptomatic of just another overburdened public-health clinic. But that is not the case. The quality of primary care in the United States is deteriorating at all levels, according to numerous studies. Supported by the so-called "fee-for-service" insurance system, harried primary care physicians, in order to make a living, must rush from room to room to room, flipping through charts at the last possible minute, a mode of practice that an oft-quoted 2000 editorial in the British Medical Center's journal, *BMJ*, dubbed "hamster health care." ("Doctors are miserable because they feel like hamsters on a treadmill," the piece begins. "They must run ever faster just to stand still.") In a 2006 *New England Journal of Medicine* article titled "Primary Care—Will It Survive?" Thomas Bodenheimer, a doctor at the University of California, San Francisco, and one of the most prolific writers on primary care's problems, summed up the system's dysfunctions: "Patients are increasingly dissatisfied with the care and the difficulty of gaining timely access to a primary care physician; many primary care physicians, in turn, are unhappy with their jobs, as they face a seemingly insurmountable task; the quality of care is uneven; reimbursement is inadequate; and fewer and fewer US medical students are choosing to enter the field." In a report the same year, the American College of Physicians put it even more bluntly: "Primary care, the backbone of the nation's health care system, is at grave risk of collapse."

Cockrell leads me to an office area where Dr. Deane DeFontes works literally elbow-to-elbow with a nurse, a medical assistant, and a team assistant, a spatial arrangement that is integral to the clinic's medical home model. While doctors once worked alone in one room, they now work in teams; "co-location" fosters increased communication among team members. Each team manages a specific roster, or panel, of clients, addressing not only urgent issues but also any chronic conditions, a task made easier by the center's electronic health records system. Doctors still rush from room to room to room (demand for appointments hasn't dropped, and each

PATIENTS WHO ONCE WAITED WEEKS TO GET AN APPOINTMENT NOW CAN USUALLY GET ONE WITHIN THREE DAYS. THEY ALSO KNOW WHO THEIR DOCTOR IS AND WHICH NURSES AND MEDICAL ASSISTANTS WILL TREAT THEM.

team's roster of patients is 10 percent too large), but instead of trying to glean essential information about patients while loping down the hall, the teams now "scrub" the schedules each morning in order to make sure records are in order and to make sure all of the patient's preventive care, such as pap smears, mammograms, and cholesterol checks, has been performed.

Each month, Cockrell pulls data for teams covering everything from the percentage of patient no-shows (a statistic that can point to inefficiencies) to how often patients see their designated pri-

mary care physician (as opposed to a substitute). She also pulls preventive health numbers: the percentage of diabetics who have had their blood sugar tests within six months, for example, or the number of hypertensive patients whose blood pressure is under control. "One team just hit 91 [percent]," Cockrell says, referring to the percentage of diabetics who are up to date on their blood sugar tests. "It used to be, OK, well, if you need one of those tests, come back in three weeks," says Suzanne Maroon, a registered nurse and one of DeFontes's teammates. "Now it's like one-stop shopping.... It's a much better service for patients."

Patients who once waited weeks to get an appointment—a time lag itself is a barrier to providing good health care—now can usually get one within three days. Patients also know who their doctor is, and even which nurses and medical assistants will treat them. "It's what care should have been all along," DeFontes says.

After beginning the project with one team, Mid-County has spread the model throughout the clinic. Now Multnomah County is implementing the model at its East County clinic in Gresham. "The question was, Can we give good, affordable care when our resources are more limited?" DeFontes says.

The answer seems to be yes.

THE PRIMARY CARE Renewal project really began in 2002 and 2003—years when CareOregon's future looked bleak. A recession had recently hit, and then the Oregon Health Plan announced severe cuts to its rolls. "We were facing a problem of nearly going out of business," says CareOregon's Labby. "We knew we couldn't just expect more money [from the government] just because medical costs were rising. We had to have a long-term, sustainable business model."

Patients with difficult, chronic medical problems were by far the most expensive to treat. Twelve percent of CareOregon's clients used some 60 percent of the funding. "Data shows that when you have two, three, four medical conditions, costs skyrocket," Labby says. CareOregon wondered whether it could reduce the money spent on these patients by helping community health centers, which serve many of CareOregon's clients, focus on those with chronic conditions. "The more you can help these people stay healthy, the more you have a chance of keeping them out of the costly emergency room and out of the hospital. That's good for them and good for you," Labby says.

Labby, a general internist, anthropology PhD, and close follower of health care theory, had been reading about Southcentral Foundation's Anchorage Native Primary Care Center, a clinic that was doing things differently. Located in Anchorage, Alaska, the clinic once faced precisely the kinds of problems that many health centers do: patients had to wait weeks—even months—for an appointment, which increased demand for costly urgent appointments and prevented patients from getting the health care they needed.

Then a new administrator came in and insisted the clinic could, and would, deliver world-class health care to the region's Native Americans. Over a period of years, the staff jettisoned the old way of working and, together with patients, rewrote a primary model focused on giving every patient the kind of care he needed—and wanted—when and how he wanted it. "They call their patients 'customer owners,'" Labby says of the patient-centered approach. "Because if you think about where the money comes from, it comes from employers and taxpayers." Not only did the clinic work to improve its customers' physical health, but it also worked on their mental and behavioral health problems—a practice known as whole-person care in popular medical parlance.

In 2006, Labby and thirty others—CareOregon staff, local community health center managers, and even state legislators—took a trip to Alaska. It's not an exaggeration to say the trip had a profound effect. "I took three pages of notes in the first hour," says

Craig Hostetler, executive director of the **Oregon Primary Care Association**. "Everything they did was centered on a strong relationship with the patient and the family—not just cranking a patient through."

And the resulting data was staggering: by employing phone consultations and allowing patients to see nurses in lieu of doctors for certain procedures, the clinic drove down wait times so that every patient who needed an appointment could be seen the very day he or she called. As the number of regular visits with family physicians rose, the number of costly urgent care visits dropped. (The clinic logged some 3,300 urgent care visits in July 2002, before the changes took full effect, and just some 2,000 in July 2007, an all-time low.) The number of emergency room visits also fell, from fifty-nine per one thousand patients in January 2000 to thirty-five per thousand in January 2008. Southcentral, which serves fifty-five thousand Native Americans at every income level, now is recognized as a model for how health care systems should function.

But Southcentral had some advantages that Portland's community care centers do not—it receives a set amount of money per patient from Indian Health Services and other agencies (along with some other fee-for-service funding), which means that clinic leaders can spend the money as they see fit. Also, Southcentral is affiliated with a hospital and a mental health center. This makes whole-person care a bit easier to manage. Was it possible, CareOregon and Portland clinic directors wondered, to replicate the excellent care within the limits of a fee-for-service system? "Ultimately, we agreed that we couldn't not try it," Labby says.

CareOregon offered a grant to the five community health centers to work on Primary Care Renewal, which would be guided by five principles: it would be a customer-driven system instead of a schedule-driven one; it would focus on the relationship between the clinic staff and the client; employ a team-based approach; embrace proactive care so that instead of, say, waiting for a fifty-five-year-old woman to call and schedule a mammogram, the clinic would call her; and it would integrate behavioral health. Behavioral health turns out to be important, since, as Labby puts it, the way a patient takes care of himself between doctor visits is what's most important to health.

The foundations for the idea of medical home began in the late 1960s, when parents of kids with complex health problems complained that their children's medical records were scattered among many physicians and locations. "The system was fragmented; no one was in charge," Labby says. In response to the problem, the **American Academy of Pediatrics** coined the phrase "medical home" in 1967, arguing that what parents needed was a centralized place for medical records and a coordinating doctor.

With its definition much expanded and primary care in shambles, the medical home model today is being hailed as a way to solve the health system's problems. It's been touted by the four largest trade associations representing primary care doctors, including the American Academy of Pediatrics and the American College of Physicians, and even by President-elect Barack Obama. The medical home also figured into the 2007 Healthy Oregon Act, which directed the Oregon Health Fund Board to revamp the Oregon Health Plan and develop a state health program that, among other things, emphasizes preventive care and chronic disease management and "promotes a primary care medical home."

But a considerable knowledge gap remains between the medical home as a theory and a practice. Few clinics have tried to implement the model, which means that no one really knows how or if it could work on a large scale. Locked into a fee-for-service insurance system, clinics have no incentive to hire medical assistants and nurses, who are integral to the team-based approach to care. "... [The] current policy buzz may be stimulating unrealistic expectations about the medical home's immediate potential," a group

of doctors, including two from the respected Washington, DC-based think tank the **Urban Institute**, wrote in the September/October issue of **Health Affairs**, noting that the medical home model requires successful demonstrations showing how it might operate in a day-to-day clinical setting. "It would not be the first time that a good health policy idea was judged to be a failure because of premature promotion."

That's why Labby and other medical home enthusiasts argue that projects like CareOregon's are so important. Without evidence that it can and will work, the medical home, which on paper reads like a perfect antidote to primary care's ills, may remain theory alone.

WHEN JENINE NAPOLI, forty-six, walks through the halls of Central City Concern's Old Town Clinic on W Burnside Street downtown, the nurses, doctors, and medical assistants stop to chat with her. It's hard not to: Napoli is a habitual smiler, a waver and a gabber, the sort who asks *How you doing?* and won't settle for a one-word answer. She'll talk about anything—including the problems that brought her to the Old Town Clinic in the first place, namely an addiction to crack and alcohol. Low on funds to support her habit, she wrote some bad checks and eventually ended up, for the second time, in Hooper, Central City Concern's detox center.

"This place is a God shot," she says of Central City Concern. "It really is." After twenty-one months of sobriety, Napoli is studying nursing at Portland Community College and lives in an apartment in Central City's Richard L. Harris Building, around the corner from the clinic. She tells me that her primary care doctor is Barbara, her acupuncturist is Chuck, her medical assistant is Patty. "These guys helped save my life," she says. On the day I meet her, her doctor has just taught Napoli a song to help her remember the parts of the nervous system for physiology class.

"Our primary commodity is relationships," explains Ted Amann, Central City's director of health care. "With no relationships, nothing happens." Old Town Clinic's clients, 45 percent of whom have no health insurance and many of whom are homeless, love the clinic not only because they don't feel judged here, but also because they know their needs come first. Old Town is the closest thing to a home many of its clients have. "Even if my situation changes and I have a good job," Napoli tells me, "this is where I'm coming [for care]. Barbara is my doctor, and she always will be."

Since implementing the medical home model, Old Town beefed up its staff for a period of time until it cut its average wait-time for an appointment from seventeen days to three; routine exams and preventive checkups that once fell lower on the priority list now are considered as important as acute problems. The staff works in three teams—Team Burnside Bridge, Team Skidmore Fountain, Team Park Block Pioneers—and each patient knows which team he or she belongs to. Team members' names are displayed at the intake desk.

Other aspects of the medical home have been more difficult to manage. For one thing, because many of Old Town's clients are homeless, it's harder for staff to summon them for regular checkups or remind them about appointments. Old Town lacks the funds to buy an electronic health records system, which can cost some \$1 million; this leaves staff to pore over paper files that can stack a couple of inches thick. And while behavioral health consultants at other clinics primarily may help patients with simple concerns like how to set goals for a weight-loss program or how to handle

stress that might prevent someone from taking his medication on time, that sort of counseling can have little effect on someone who is worried about where he'll sleep tonight. "Most people have no family, no nothing," says Eryn Joyce, the clinic's behavioral health consultant, who also has treated people who are suicidal, or high on methadone, or in extremely abusive relationships.

Perhaps most difficult is changing the culture of the offices themselves. Each clinic in the Primary Care Renewal project faces a unique set of circumstances (serving immigrants, the homeless, working with a revolving cast of medical residents) that makes it impossible to prescribe a single model that works in every setting. Change, for many staffers, is difficult. "We can only move at the speed of relationships," says Maryna Thompson, who manages Legacy Emanuel's internal medical clinic. She adds that developing trust among team members is crucial. "There just isn't a book out there that says, 'This is how thou shalt do primary care renewal!'"

Even learning how to manage seemingly minute details requires an endless process of trial and error. When Multnomah County decided to switch off the automated appointment reminder system, for example, teams at Mid-County had to figure out how to make the calls themselves. (No small task considering the language barriers involved.) On DeFontes's team, one person agreed to coordinate the Spanish calls with an interpreter; one bilingual medical assistant agreed to call the Russian clients; calls made in English fell to the team assistant (and the whole team agreed to create space and time for him to do it); calls in other languages, like Burmese or Arabic, would be funneled through the Multnomah County lan-

**SINCE THE CLINIC BEGAN THE
PRIMARY CARE RENEWAL
PROJECT, THE NUMBER OF
DIABETICS WHO MISS THEIR
SCHEDULED BLOOD SUGAR TESTS
HAS DROPPED BY 26 PERCENT.**

guage line. But not everyone was happy with their new administrative duties. "You have to have buy-in, which is true of all change," says DeFontes, noting that even the medical home doubters have to be brought along.

MARYNA THOMPSON, Legacy Emanuel's internal medicine clinic manager, calls herself a "crusty old nurse," but that's a cover. She's a small, high-energy woman of fifty-five with dark hair that's crisply bobbed. A former CareOregon board member, she came to the teaching clinic two years ago to implement the medical home here.

"Sometimes I liken the [old way of doing things] to [throwing] a party, but you didn't know how many guests would show up or what they wanted," she says. She shows me the screening tool her staff created to improve their chronic care management—essentially a checklist of preventive tests, immunizations, and labs. Stored in the patient's file and updated at every visit, the sheet is an example of how simple changes can have a big effect. Since the clinic began the

Primary Care Renewal project, the number of diabetics who miss their scheduled blood sugar tests has dropped by 26 percent.

Most impressive is how the clinic has saved CareOregon money. By pulling claims data, Thompson found that out of the clinic's nearly four thousand patients, about fifty were chronically going to the emergency room; after interviewing them, Thompson found they were overusing the ER for a variety of reasons. "Maybe it was for chronic pain or psychosocial issues, or maybe just because they didn't want to wait to be seen here," she says. The nurses, behavioral health consultant, and pharmacists decided, as a group, to give those patients even more attention—in some cases, Thompson called members of the patient's family and invited them to participate in discussions about the patient's health plan. "We had to get them back and get them engaged with us," she explains.

The results are paying off. By getting just fifteen to twenty of those patients to use the emergency room less frequently, the clinic is saving CareOregon about \$1 million per year. Thompson's group did the same for no-shows. They pulled a list of patients who chronically missed appointments and called each one—not once, but twice. The no-show rate has dropped by 20 percent.

Those figures seem to prove that the medical home model can improve care. Then again, these clinics are highly motivated. Not all doctors want to change the way they care for patients, or reorganize their offices. Plus, there is the more pressing matter: if it weren't for the CareOregon grant, there would be no incentive, other than magnanimity, for these clinics to make such radical adjustments. The truth is, even if these five clinics prove the model can work, insurance companies must support primary care in a way that actually promotes better health care. "We're still operating in a widget-based system," Labby tells me. "[CareOregon] started with the simple idea that [a doctor's] job is the health of the population. Your job is not your schedule. If your job is your schedule, then your job is not health but [rather] only the number of people who are coming through the door."

This year, CareOregon will begin paying each clinic not just for visits but also for outcomes. But if the medical home is going to become the standard for primary care, then most, if not all, health insurance companies will have to restructure their businesses. "We might be able to demonstrate the outcomes, but the question is, Can the payment system change to support us?" says Thompson. "We're locked into a pay-per-visit system, and changing that is the key to transformation."

The difficulties of cultural change apply just as strongly to the health insurance industry, though. "There is skepticism about whether [the medical home] saves money, about whether the delivery system is capable of change," says Ralph Prows, senior medical director of **Regence BlueCross BlueShield** of Oregon, which has been funding what Prows calls a "medical-home light" pilot project of its own. Yet increasingly, insurers are realizing that the fee-for-service system isn't working for their bottom lines, either. "Double-digit increases in medical costs are not sustainable," Prows says. "And we're meeting recommendations [for patient care] about half the time. It's like a coin toss."

Perhaps, as Labby hopes, clinics that prove costs are lower, patients are more satisfied with their care, and health outcomes are better under the medical home model will gain a competitive advantage and cause a kind of systemwide shift in approach. Or perhaps the change will happen in a more dramatic fashion.

Hostetler, of the Oregon Primary Care Association, once sat on a panel about the future of Oregon health care. When asked what he hoped for, his response shocked the audience. "I said I hope the system gets so bad that we have to throw it out," he recalls.

If it does, perhaps community health centers—those safety nets for the toughest cases—will be recognized and copied for embracing a model of care that actually makes people healthier. ♦

Smoking ban leads to major drop in heart attacks

AP Associated Press

By MIKE STOBBE, AP Medical Writer Wed Dec 31, 6:06 pm ET

ATLANTA – A smoking ban in one Colorado city led to a dramatic drop in heart attack hospitalizations within three years, a sign of just how serious a health threat secondhand smoke is, government researchers said Wednesday. The study, the longest-running of its kind, showed the rate of hospitalized cases dropped 41 percent in the three years after the ban of workplace smoking in Pueblo, Colo., took effect. There was no such drop in two neighboring areas, and researchers believe it's a clear sign the ban was responsible.

The study suggests that secondhand smoke may be a terrible and under-recognized cause of heart attack deaths in this country, said one of its authors, Terry Pechacek of the U.S. Centers for Disease Control and Prevention.

At least eight earlier studies have linked smoking bans to decreased heart attacks, but none ran as long as three years. The new study looked at heart attack hospitalizations for three years following the July 1, 2003 enactment of Pueblo's ban, and found declines as great or greater than those in earlier research.

"This study is very dramatic," said Dr. Michael Thun, a researcher with the American Cancer Society.

"This is now the ninth study, so it is clear that smoke-free laws are one of the most effective and cost-effective to reduce heart attacks," said Thun, who was not involved in the CDC study released Thursday.

Smoking bans are designed not only to cut smoking rates but also to reduce secondhand tobacco smoke. It is a widely recognized cause of lung cancer, but its effect on heart disease can be more immediate. It not only damages the lining of blood vessels, but also increases the kind of blood clotting that leads to heart attacks. Reducing exposure to smoke can quickly cut the risk of clotting, some experts said.

"You remove the final one or two links in the chain" of events leading to a heart attack, Thun said.

Secondhand smoke causes an estimated 46,000 heart disease deaths and about 3,000 lung cancer deaths among nonsmokers each year, according to statistics cited by the CDC.

In the new study, researchers reviewed hospital admissions for heart attacks in Pueblo. Patients were classified by ZIP codes. They then looked at the same data for two nearby areas that did not have bans — the area of Pueblo County outside the city and for El Paso County.

In Pueblo, the rate of heart attacks dropped from 257 per 100,000 people before the ban to 152 per 100,000 in the three years afterward. There were no significant changes in the two other areas.

"The need for protection from secondhand smoke in all workplaces and public places has never been clearer," said Matthew Myers of the Campaign for Tobacco-Free Kids, in a prepared statement. He is president of the Washington, D.C.-based advocacy organization.

But the study had limitations: It assumed declines in the amount of secondhand smoke in Pueblo buildings after the ban, but did not try to measure that. The researchers also did not sort out which heart attack patients were smokers and which were not, so it's unclear how much of the decline can be attributed to reduced secondhand smoke.

One academic argued there's not enough evidence to conclude the smoking ban was the cause of Pueblo's heart attack decline.

The decline could have had more to do with a general decline in smoking in Pueblo County, from about 26 percent in 2002-2003 to less than 21 percent in 2004-2005. If there were stepped-up efforts to treat or prevent heart disease in the Pueblo area, that too could have played a role, said Dr. Michael Siegel, a professor of social and behavioral sciences at the Boston University School of Public Health.

"I don't think it's as clear as they're making it out to be," Siegel said.

On the Net:

CDC publication: <http://www.cdc.gov/mmwr>

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OUR SOCIETY'S SICKNESS

By NIKOLE HANNAH-JONES
THE OREGONIAN

Steve Baker's late-stage colon cancer is an example of how race and income can be barriers to equitable health care, barriers Multnomah County is trying to overcome

For 10 years Steve Baker carried a deadly mass in his gut. And no one knew. It's not that he didn't have symptoms. The 56-year-old had long complained of intestinal problems. Lack of health care can't be blamed, either. Though getting by paycheck to paycheck, the truck dispatcher kept insurance and got regular check-ups.

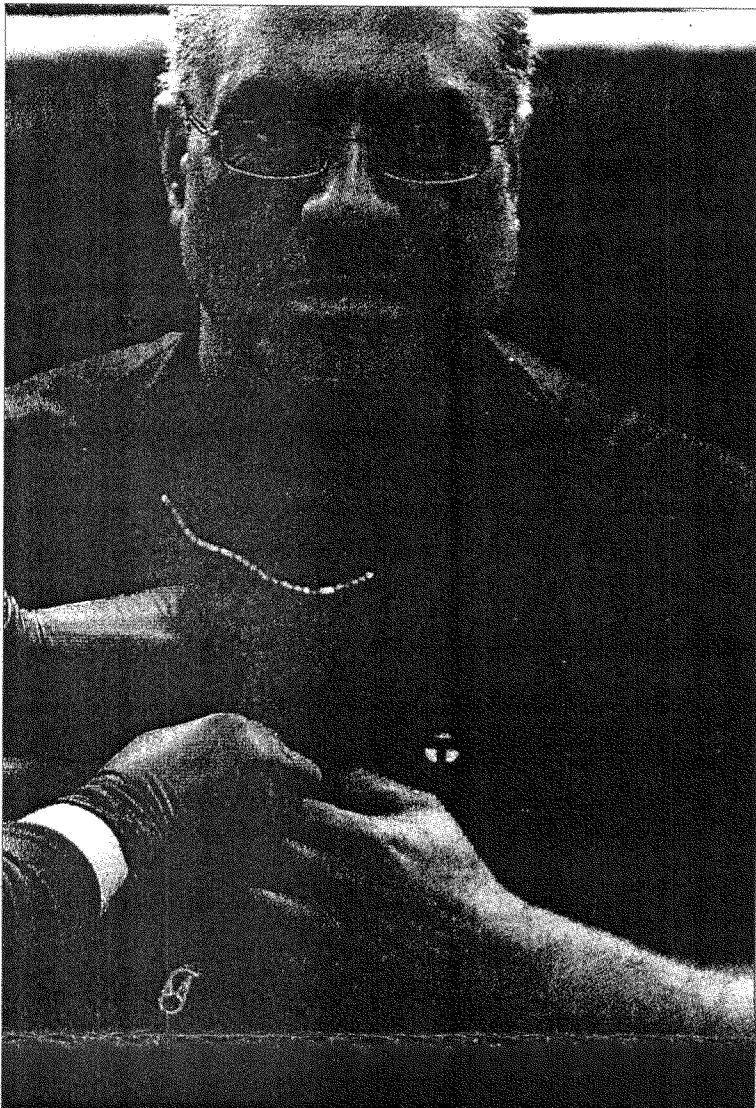
When pain and weakness led him back to the doctor in July, Baker learned he had late-stage colon cancer and it had spread to his liver.

Baker's story is a warning to us all: The society we've built is killing us.

It kills the poor and racial minorities first. Then those slogging away in the middle class. The wealthy live the longest, but even they die sooner than those in less affluent countries with smaller gaps between rich and poor.

The Multnomah County Health Department has joined 100 other health departments across

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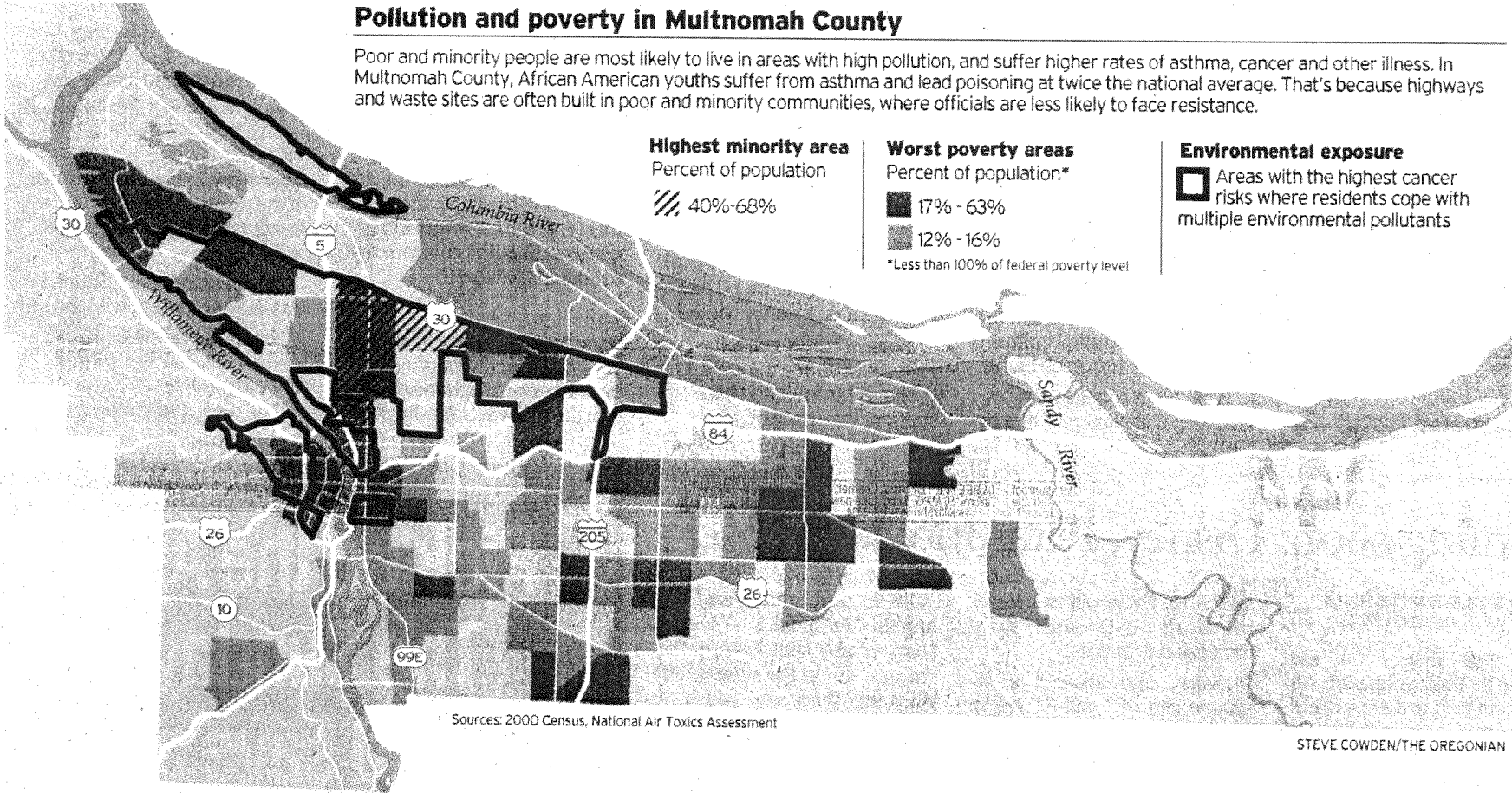


BETH NAKAMURA/THE OREGONIAN

Steve Baker, 56, gets his chemotherapy tube removed at the Northwest Cancer Center. Despite regular doctor visits, Baker had undetected colon cancer for 10 years. Experts say that in a nation as socially stratified as the United States, Baker is among the people most likely get sick and die early. More than personal choice and family history, experts say, our inequitable society is killing us.

Pollution and poverty in Multnomah County

Poor and minority people are most likely to live in areas with high pollution, and suffer higher rates of asthma, cancer and other illness. In Multnomah County, African American youths suffer from asthma and lead poisoning at twice the national average. That's because highways and waste sites are often built in poor and minority communities, where officials are less likely to face resistance.



STEVE COWDEN/THE OREGONIAN

Health: Minorities rate poorly in 11 of 17 indicators

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the nation to examine the social conditions that attack our health and end our lives — and what to do about them.

"We see ourselves as a forward-thinking, progressive community, but when you look at the facts, they tell a different story," Ted Wheeler, Multnomah County commission chairman, says about the initiative that started with public meetings last month.

"Health inequities result from a number of issues — discrimination, oppression, poverty, lack of power. The parts we can do something about we should and will."

In Multnomah County, people of color have worse outcomes than white residents in 11 of 17 health indicators ranging from low-birth-weight babies to death from diabetes, stroke and AIDS, according to a report on health disparities issued last week by the county.

Of course, genes, access to health care and decisions about diet and exercise can extend or cut lives short. But just as important is our unwillingness, scientists say, to deal with pervasive inequities between races and classes. Jobs that don't pay enough to support a family, neighborhoods lacking parks or sidewalks that promote wellness through exercise, and discrimination that creeps from broader society into health care itself conclude to take American lives before their time.

Here's what we know: The middle class is two times more likely than the upper class to die

Health-care disparities

- Low-income people live in neighborhoods with fewer parks, sidewalks and access to fresh foods but with higher concentrations of fast-food restaurants and convenience and liquor stores. Likewise, the most advanced health-care facilities are not located in low-income communities.
- More than 100 studies have documented the impact of racial discrimination and health. Babies born to black college graduates are more likely to die than babies born to white high school dropouts. People who feel they've been discriminated against suffer more cardiovascular disease, breast cancer and other deadly ailments.
- People who feel they have little say in their personal lives and jobs — personal autonomy — carry more chronic stress. For instance, a factory worker who must account for every minute of his day, versus a middle-income worker who has flexibility in his schedule and determines more what he does at his job, has more stress. The higher the income, the more personal autonomy workers feel and the less chronic stress. Further, chronic stress contributes to bad health choices, such as overeating or using alcohol or drugs.
- Personal choice does matter, but middle- and upper-income people who smoke, for instance, still live longer than lower income smokers.

For more information: 503-988-3030, ext. 22068, or go to www.co.multnomah.or.us/health/healthequity

Sources: Matthew Carlson, Portland State University health researcher; reports from the John D. and Catherine T. MacArthur Foundation

before age 65; low-income folks, three times as likely. As a whole, people of color die before white Americans. African Americans, no matter how much money they earn, have the worst outcomes of any group, with 83,570 dying in 2002 who wouldn't have without societal disparities, according to a report by former U.S. Surgeon General David Thatcher.

A study in failed care

Baker sits in his small and tidy North Portland home just off the interstate, a pouch of chemo medicine slung over his shoulder. It seeps into his body through a port in his chest while he recounts the clues to his cancer that went unnoticed. Christy, his high school sweetheart and wife of 37 years, rests her knee against his, filling in the dates and details he can't remember.

While Baker, an African Amer-

ican, has felt the sting of discrimination, he recoils at race or class as the reasons his doctor never checked for cancer or ordered some standard tests.

"I want to believe it was not a racial issue," Baker says, looking at his hands. "Just a lack of education on my part."

But race and class are so much a part of the American tapestry, it can be hard to see the threads.

His daughter, LaRisha Baker, works with health-disparity issues for Multnomah County and sees how all the pieces when put together create an unnerving picture. Discrimination is rarely blatant, she says. These days, it's often unintentional, but can still be deadly.

"I don't want to be a victim and I don't want him to be a victim," she says. "But I sort of feel victimized. That's the scary thing."

Steve Baker says his doctor didn't push a colonoscopy — considered a standard test for men 50 and older — despite his years of intestinal problems. A colonoscopy early on would have improved his chance to survive exponentially. Yet studies show doctors are less likely to give additional tests to black patients, and black males are most likely of all groups to die from cancer, according to the National Cancer Institute.

Baker drove a truck, a blue-collar job that exposed him to chemicals and pollutants. Most of his homes in black Portland were near highways, which county data show have twice the pollution rates of the county as a whole, and diesel particulates 687 times the federal government's acceptable cancer-level risk.

"Stratified societies are less healthy"

The poor and working class, along with people of color, live with chronic stress from discrimination and the day-to-day trials of making ends meet. Chronic stress attacks the immune system, raises blood pressure and increases the risk of heart disease.

"We know highly stratified societies are less healthy," Matthew Carlson, a health researcher at Portland State University, says. "We are not going to see class-based and racial and ethnic disparities decrease unless we change the way society is organized."

Though one of the wealthiest nations in the world, the United States is 45th in life expectancy. People in poorer nations such as Singapore and Bosnia can expect to live longer than Americans. The same is true in wealthier European nations such as Switzerland, Denmark and Austria, where the gulf between the rich and poor is much smaller than here.

No matter how they take care of themselves, Carlson says,

Americans such as Baker tend to be sicker than those in the middle and upper classes.

"It's a lot of small things that add up and have large consequences," he says.

Trisha Tillman, who manages the health-equity initiative for the county, realizes that this community can't fix wealth distribution and prejudice. "But there are things we have control of," she says.

What can be controlled

The county is holding community forums in different parts of town through May, and a team is compiling research on disparities here. Over two years, Tillman says, the county will produce concrete proposals that all of us — schools, private business, TriMet, the county, mortgage lenders and so on — can do to help eradicate the class and race disparities here.

For example, county chairman Wheeler says, the county can stop locating affordable housing near freeways, and houses already there can be retrofitted to help eliminate indoor pollution; businesses can provide a livable wage; schools can ensure their poorest students have the same high-quality

teachers as affluent ones so kids have an equal shot at college and middle-class jobs; the county can expand medical services and also work to ensure that caregivers recognize biases that lead them to treat patients differently based on color and class.

"For me, saying the problem is too large has never been an excuse," Wheeler says. "These are stark facts that are staring us in the face, and as a matter of principle we have an obligation to reduce the disparities."

The inequities must be eliminated not just for people like Steve Baker. Wheeler's health, and all of ours, is riding on it, too.

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